Greater Manchester Health and Care Board

Date: Friday, 31 January 2020
Time: 10.00 - 11.30 am
Venue: Conference Rooms 1 & 2, GMPF Offices, Guardsman Tony Downes House, 5 Manchester Road, Droylsden, M43 6SF

AGENDA

1. WELCOME AND APOLOGIES

2. CHAIR’S ANNOUNCEMENTS AND URGENT BUSINESS

3. MINUTES - ATTACHED
   
   To consider the approval of the minutes of the meeting held on 25 October 2019

4. CHIEF OFFICER’S REPORT - ATTACHED
   
   Report of Jon Rouse, Chief Officer, GM Health and Social Care Partnership

5. HALF YEAR BUSINESS PLAN REVIEW - TO BE PRESENTED AT THE MEETING
   
   Presentation of Jon Rouse, Chief Officer, GM Health and Social Care Partnership

6. TAMESIDE LOCALITY PRESENTATION - TO BE PRESENTED AT THE MEETING
   
   Presentation of Steven Pleasant, Chief Executive, Tameside Council and Accountable Officer, Tameside and Glossop CCG

7. PRIMARY CARE STRATEGY - ATTACHED
   
   Report of Sarah Price, Executive Lead for Population Health and Commissioning, GM Health and Social Care Partnership
8. **DEMENTIA UNITED AND ALZHEIMER'S SOCIETY PARTNERSHIP AGREEMENT - ATTACHED**


9. **GM HEALTH AND JUSTICE STRATEGY - ATTACHED**

Report of Jon Rouse, Chief Officer, GM Health and Social Care Partnership. Presented by Jon Rouse and Jane Pilkington, Deputy Director of Population Health, GM Health and Social Care Partnership

10. **DATES OF FUTURE MEETINGS**

Friday 27 March 2020 10.00 – 11.30am, Rochdale Council Offices, Number One Riverside
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WELCOME AND APOLOGIES

The Chair welcomed all to the meeting and apologies for absence were received from Adrian Belton, Stephanie Butterworth, Tim Dalton, Craig Harris, Warren Heppolette, Karen James, Councillor David Jones, Councillor Richard Leese, Jane McCall, Daren Mochrie, Silas Nichols, Tony Oakman, Steven Pleasant, Jim Potter, Louise Robson, Councillor Andrea Simpson, Pam Smith, Roger Spencer, Neil Thwaite, Sara Todd, Ian Williamson, Alex Whinnom, Janet Wilkinson, Councillor Elise Wilson and Steve Wilson.

CHAIR’S ANNOUNCEMENTS AND URGENT BUSINESS

There were no items of urgent business.

MINUTES OF THE MEETING HELD 26 JULY 2019

Consideration was given to the minutes of the meeting held on 26 July 2019.

RESOLVED/-

That the meeting minutes be approved as a correct record.

CHIEF OFFICER REPORT

Jon Rouse, Chief Officer, GM Health and Social Care Partnership (GMHSCP), provided the GM Health and Care Board (the Board) with an update on activity relating to health and care across the Partnership. The update included key highlights relating to performance, transformation, quality, finance and risk. A summary of the key discussions and decisions of the Partnership Board were also provided. An overview of the context for the agenda of the meeting was provided.

It was reported that the revised index for deprivation had been recently published. This was the first update since 2015 and indicated that Greater Manchester had become more...
deprived since 2015 against the basket of indicators used to measure deprivation. However, there was some good news within the publication of the index in relation to health and wellbeing. It was reported that in nine of the ten districts in GM rankings had improved and in all ten districts there were now less low output areas in the bottom 10%.

It was recognised that the improvements were based on a low starting position and any significant improvements over the next generation would need to start from the very beginning of life in order to provide children and young people with the best chance to maximise their health and wellbeing outcomes.

An overview of the work taking place in GM to provide the best potential for children and young people would be a focus of the meeting. The role of all stakeholders to provide children and young people with the platform to maximise life opportunities was emphasised to the Board.

The university and student mental health programme was highlighted as an example of what could be achieved under devolution by working in partnership to provide the most comprehensive offer in the country for student mental health support.

The Chief Officer was requested to provide an update with regards to capital funding in relation to the full business case for Healthier Together. The process for the business case to HM Treasury was outlined to the Board and it was advised that as this was the number one capital priority, further follow up with Treasury would be undertaken to obtain final approval for the release of the capital resources.

RESOLVED/-

1. That the content of the report be noted.
2. That the update with regards to English indices of deprivation 2019 be noted.
3. That the opportunities for stakeholders to improve the life chances of children and young people and successively the indices of deprivation be further considered.
4. That the update with regards to Healthier Together capital funding be noted.

HCB 48/19    GM MOVING – SPORT ENGLAND MEMORANDUM OF UNDERSTANDING REFRESH

Sarah Price, Executive Lead, Population Health and Commissioning reported the unique relationship which had led to an innovative partnership with Sport England and £10m of funding being realised across Greater Manchester. Since the initial MOU, GM had seen an increase in physical activity by 1.7% (three times the national average) which was a significant step towards the GM Moving target and was beginning to reduce the gap between the least and most active.
Based on her personal experience, Lauren Barclay, Trustee and Founder of Youth Mental Health Matters explained to the Board the importance of sport and physical activity. She asked leaders to recognise that inactivity was not as simple as the result of people’s individual lifestyle choices and further support lasting change to create the conditions to support moving back into daily life.

Tim Hollingsworth, Chief Executive Sport England was introduced to the Board and shared his reflections on the partnership work and progress on the delivery of the framework to tackle inactivity and promote movement to significantly improve health and wellbeing of residents across GM. He highlighted the inequalities and social and economic barriers which exist and the importance of developing support and solutions to improve opportunities to become more active and lead healthier and happier lives.

In summary, Sarah Price highlighted that one of the priorities she wanted to promote to the Board was the business case for active workplaces and demonstrated some of the benefits which could be achieved. Members were encouraged to join the GM Moving #activesoles movement.

The Chair thanked Sport England for the support received across GM to encourage communities to become more active and highlighted the two major sporting events to take place in GM in 2021. Namely UEFA Women’s European Championship football and the Rugby League World Cup.

The GM Mayor added that the inaugural Walking Football World Cup would be hosted in 2020 in Greater Manchester. He highlighted that sport was the life blood of communities and from a health view point was encouraged by the statistics presented on the increase of people’s physical activity and the progress against the ambitious target. He spoke about the important message of emphasising physical activity was for all ages and to assist everybody to be as physically active as they could be and thanked Sport England for their backing and encouraging comments with regards to progress in GM.

RESOLVED/-

1. That the progress and impact of GM Moving to date be noted.
2. That the refreshed MOU (appendix 1), the direction of travel and the shared priorities of focus be agreed.
3. That it be agreed to continue the GMCA’s commitment to support the ambitions of GM Moving and the whole system approach needed to have population scale impact.
4. That it be agreed that the refreshed MOU will continue to be steered by the GM Moving Executive, chaired by Steven Pleasant with senior representatives from GMCA, GM Health and Social Care Partnership, Transport for Greater Manchester, Sport England, GreaterSport, GM Active and representatives from the VCSE.
Progress against the GM Moving Plan will be tracked with regular updates to the GM Health and Social Care Board.

HCB 49/19  IMPROVING MATERNITY OUTCOMES FOR MOTHER AND BABIES ACROSS MATERNITY SERVICES IN GREATER MANCHESTER AND EASTERN CHESHIRE (GMEC)

Julie Cheetham, Associate Director Strategic Clinical Networks (SCN’s) provided an update on the progress of the GM Maternity programme since the publication of the GM Maternity Implementation Plan in 2018 and the direction of travel for the programme moving forward.

Karen Bancroft, Maternity Clinical Lead SCN’s presented some of the highlights in the progress and achievements since implementation in 2017 in line with the vision that women and babies will receive kinder, safer and more personalised maternity services in Greater Manchester and Eastern Cheshire.

These included;

- 123 stillbirths avoided last year in Greater Manchester
- 8 less babies born with brain injury
- 250 additional babies born smokefree in GM in the last year

As co-chair of Greater Manchester Maternity Voices Partnership (MVP), Cathy Brewster supplemented this with an overview of some of the co-produced guidelines developed to standardise the management of care for various conditions, continuity, choice and personalisation.

In support of the report and commendable achievements, further information with regards to how post-natal care was being supported was requested. It was confirmed the maternity and newborn implementation plan outlined improving postnatal care as a key programme of work acknowledging there was further work to be done.

It was reported that Greater Manchester’s midwifery unit, Ingleside, Salford had been described by England’s first chief midwifery officer as the most innovative model of its kind in England. The Board enquired how the GM programme was responding to expectant mothers being able to exercise choice. It was advised that in line with safety considerations, continuity of care was assisting with informing women of the different options available.

RESOLVED/-

1. That the contents of the report be noted.
2. That the ongoing quality improvement programme across all maternity providers be supported.
HCB 50/19 EARLY YEARS AND SCHOOL READINESS UPDATE

Jane Forrest, Assistant Director, Public Service Reform, Greater Manchester Combined Authority (GMCA) provided the Health and Care Board with an update on the School Readiness programme in Greater Manchester and highlighted the activity taking place and impact the work is beginning to have on early years outcomes. It was reported that the latest data for pupils eligible for Free School Meals have improved consistently since 2015 closing the gap between the GM and England average. This highlighted the success of work to date to strengthen support for children from the most disadvantaged communities.

Members highlighted that as a prerequisite organisations work to assist parents and carers to recognise the ambitious objective of the programme. It was confirmed that support for parents and carers to develop and enable their children’s needs from an early stage was recognised. Furthermore, it was advised that the programme sits within the broader scope of the Public Service Reform model which focuses on integration and enabling the front line workforce to develop positive relationships working with parents within their communities.

The significant progress which has already been made across GM to improve school readiness levels was acknowledged. However, it was recognised that further work was required to address remaining gaps and challenges which had been identified by localities as barriers to improving early year’s outcomes.

RESOLVED/-

That the contents of the report and the accompanying presentation be noted.

HCB 51/19 GREATER MANCHESTER CHILDRENS HEALTH AND WELLBEING PROGRAMME

Carole Ewing, children’s health and wellbeing clinical lead and clinical adviser to the Greater Manchester and Eastern Cheshire Strategic Clinical Network provided the Health and Care Board with an update on the progress of the Children’s Health and Wellbeing Framework since its launch in May 2018. Alongside this, the challenges and opportunities for further improvements were also outlined.

Nathan Randels, Youth Focus North West advised members of the opportunities for participation and engagement with children and young people which had led to the co-production of the framework and provided tangible ownership and a sense of belonging to the services which they use. In order to demonstrate that GMHSCP value the voice of young people, a GM Youth Agreement had been developed alongside youth rights in connection with confidentiality materials. It was advised that moving forward, the third sector would oversee a coordinated approach to young people evaluating health services against the GM Youth Agreement.

The GM Mayor noted that whilst the statistics for mental health treatment were improving, the level of response was still not matching the level of concern. Jon Rouse provided an explanation with regards to the indicator and acknowledged that whilst GM was the third
highest performing area in the country and some localities, namely Rochdale where performing at 60%, there was room to aspire for further improvement.

RESOLVED/-

1. That the achievements made within the first year of the programme be noted.
2. That the ongoing direction of travel for the children’s and young people’s programme be supported.

HCB 52/19    Salford Locality Presentation

Anthony Hassall, Accountable Officer, Salford CCG provided the Board with an update on Children’s Integrated Health and Social Care in Salford.

An overview with regards to the integrated relationship of services for children, transformational priorities and an insight into the change being delivered was presented in conjunction with Director for People, Salford City Council, Charlotte Ramsden.

RESOLVED/-

That the presentation be noted.

HCB 53/19    Dates and Times of Future Meetings

Members were notified of the following dates and times of future meetings:

- Friday 31 January 2020, 10am, Guardsman Tony Downes House, Droylsden
SUMMARY OF REPORT:

This report provides the GM Health and Care Board with an update on activity across the Partnership. It includes key highlights relating to performance and finance.

The report also provides a summary of the key discussions and decisions of the Partnership Executive Board.

KEY MESSAGES:

This report contains key updates and issues relating to the Greater Manchester health and care system and the people who work in it. It features system updates such as Progress on Greater Manchester’s response to the NHS Long Term Plan, the Pennine Acute Trust Transaction Programme and Rapid Diagnostic Centres for suspected cancers.

The report also features key updates on Greater Manchester’s performance against national standards, such as Accident and Emergency and Cancer. It also provides a comparison of planned activity for this year compared to last year. Also featured in this report is an update on Finance as at August 2019, providing key points and narrative around the system’s financial position. A section of this report is also dedicated to highlighting the key risks which may impede the delivery of the GM vision for health and care, and mitigating actions being taken to minimise the potential impact of these risks.
PURPOSE OF REPORT:

The purpose of the report is to update the GM Health and Care Board on key items of interest across the GMHSC Partnership.

RECOMMENDATIONS:

The GM Health and Care Board is asked to:

- Note and comment on the content of the update report.

CONTACT OFFICERS:

Paul Lynch, Deputy Director – Strategy and System Development
paul.lynch@nhs.net

Conor Dowling – Strategy and System Development
conor.dowling@nhs.net
1.0 KEY UPDATES AND ISSUES

1.1. People Updates

1.1.1. Anthony Hassall, formerly the Accountable Officer of NHS Salford CCG commenced his secondment role as Regional Chief People Officer with NHS England North West on 1 January 2020 until 31 March 2021.

1.1.2. We are pleased to announce that Steve Dixon, the Chief Financial Officer of the CCG has been appointed by NHS England as the Interim Accountable Officer during this period.

1.1.3. We congratulate both Anthony and Steve on their appointments and wish them every success in their respective new roles.

1.1.4. A warm welcome back to Craig Harris, Accountable Officer at NHS Wigan CCG who had been recovering from a short illness since October 2019. Paul McKevitt, previously the Chief Financial Officer of Wigan Borough Council was appointed NHS England as the Interim Accountable Officer during this 12-week period. Paul relinquished his duties at Wigan Council during his period of ‘acting’ up and we would like to place on record our sincere thanks for his additional contribution to Wigan CCG at such short notice.

1.1.5. Jon Rouse leaves his Chief Officer role at the GM Health and Social Care Partnership on 31st January to take up the position of City Director and Head of Paid Service at Stoke-on-Trent City Council. Jon has led the Partnership since 2016.

1.1.6. In recognition of Jon’s contribution, the Greater Manchester Chair, Lord Peter Smith comments that “Jon….has worked tirelessly to help Greater Manchester deliver its shared health and social care vision. Our collective achievements made for the population of Greater Manchester over the last three years have been significant, from real gains in health such as having achieved our lowest ever rate of smoking and highest ever level of physical activity - to improvements in early cancer diagnosis and survival rates, school readiness, maternal safety, social care quality, primary care access and mental health services, among many others.” We wish Jon all the best as he moves on to pastures and challenges new.

1.1.7. Following an interview process in December 2019, Sarah Price was confirmed as Interim Chief Officer. She will lead the Partnership, following Jon’s departure, until permanent arrangements are confirmed, which is expected to be within the next six months. Sarah was previously the Partnership’s Executive Director of Population Health and Commissioning and has been in post since March 2017, following four years as Chief Officer.
at Haringey CCG in London. We look forward to supporting Sarah in her new role as Greater Manchester moves into the next five years of health and care devolution.

1.2. **Progress on GM Delivery Plan/NHS Long Term Plan response**

1.2.1. We are finalising *Taking Charge – the Next Five Years: Our Delivery Plan 2020-2024* our plan for the next stages of the Greater Manchester devolved health and care system. It will represent the GM system’s implementation approach for the Health and Social Care Prospectus (published earlier in the year) and incorporate our response to the requirements set out in the NHS Long Term Plan (LTP).

1.2.2. We have set out our plan in the context of key city-region strategies and policies such as the Greater Manchester Strategy (GMS), GM Unified Model of Public Services, the GM Transport Strategy 2040, the GM Housing Strategy and the Local Industrial Strategy. The plan will also place a strong emphasis on environmental sustainability.

1.2.3. The Delivery Plan is the product of an extensive and inclusive process across the Partnership, overseen by the Partnership Executive Board. The plan reflects the views of the system gathered through workshops in the summer and autumn and the engagement we have had with residents over the period of the first Taking Charge plan: both at GM and locality level. The Partnership Executive Board has reviewed the drafts of the plan and offered its support, including for the plan’s Executive Summary which outlines GM’s system priorities.

1.2.4. The last step in our completing the plan is to secure clarity on the funding that will come into Greater Manchester via the NHS LTP. Clarity on levels of transformation funding will enable us to prioritise where we commit our resources over the period to 2024. Board members will recall from previous updates that are two main sources for transformation funding: fair share funding and targeted funding.

1.2.5. Under the fair shares funding, each system has been allocated an indicative funding amount to meet LTP commitments – distributed on a fair share basis. For GM, the indicative funding level to 2024 is £253m. Through dialogue with NHS England/Improvement, we have confirmed that GM will have the ability to determine how to apply the fair share monies – subject to delivery of the LTP requirements and particularly those relating to mental health and primary, medical and community services (PCMS).

1.2.6. In addition to the indicative funding available to all systems, there will also be a budget available via NHS England/Improvement to fund targeted schemes.
and for specific investments. The position in respect of the targeted funding for GM is less clear than that for the fair shares.

1.2.7. We have sought to get on the front foot and make a positive proposal to the national bodies on arrangements for the targeted funding in Greater Manchester. Our approach is based on a track record of effective management of the first transformation fund from 2016 onwards; that we have a mature, integrated system in GM that is ‘investment ready’; and that, uniquely, we can leverage wider assets alongside NHS investment to support population health, prevention, social movement and health innovation.

1.2.8. We have urged that the funding package is agreed quickly so that we know what transformation resources will be available for the 2020-24 period and that we can complete our 2020-24 Delivery Plan with confidence of deliverability based on affordability.

1.2.9. Once we have confirmation of this, we will bring the Delivery Plan to this Board for final sign off at an appropriate time. Once the Delivery Plan is approved, we intend to produce a shorter, more public-facing document that combines the Delivery Plan and the Health and Social Care Prospectus. This will become the second Taking Charge plan covering the period to 2024.

1.3. **PAT Transactions Programme Update**

1.3.1. All partner organisations are committed to securing the long-term viable future for all of the Pennine Acute Hospitals NHS Trust (PAT) hospital sites and services.

1.3.2. The plan is to split and reorganise PAT;

- Salford Royal NHS Foundation Trust (SRFT) formally acquires the Oldham, Bury and Rochdale sites as part of its Northern Care Alliance NHS Group (NCA)

- Manchester University NHS Foundation Trust (MFT) to formally acquire NMGH as part of the Manchester Single Hospital Service.

1.3.3. A complex acquisition process and the significant capital investment being sought from Government mean that it is not possible to complete the formal acquisitions by 1 April 2020.

**Interim arrangements agreed**

1.3.4. In order to provide certainty for the committed and valued staff who work across PAT hospitals and the population they serve, SRFT and MFT have agreed a plan with NHS England/Improvement (NHSE/I) to put in place
management contract arrangements from 1 April 2020 to oversee the running of the respective hospitals and services that the two Trusts are planning to acquire.

1.3.5. Fairfield General Hospital, The Royal Oldham Hospital and Rochdale Infirmary will continue to be managed by SRFT and its Care Organisation director leadership teams as part of the NCA Group. NMGH will be managed by MFT and the NMGH leadership team will form part of the MFT Group.

1.3.6. There is a significant amount of work to be done to agree the detail of the management contracts, but a great deal of planning has already been undertaken, and all partners are fully committed to working together to achieve these new arrangements by 1 April 2020.

1.3.7. These management arrangements are a positive step forward and are part of securing a stable, longer term solution for those hospitals and services across the north of Greater Manchester for patients, service users, staff and the wider community.

1.3.8. NHSE/I is putting in place arrangements to ensure that the changes are implemented safely and effectively, bringing more certainty to PAT staff, and strengthening the long-term sustainability of services.

1.3.9. PAT as a statutory NHS organisation (employer and service provider) will continue to exist at 1 April 2020, and the management contracts do not constitute a formal legal transaction, so there will not be a requirement for PAT staff to transfer employment (TUPE) to SRFT and MFT by April 2020.

1.3.10. The formal transactions to bring the PAT hospitals permanently into the respective Foundation Trusts will be completed during 2020/21 and by April 2021 at the latest.

1.3.11. The two formal legal transactions will be able to progress at different speeds based on their particular circumstances, with SRFT targeting acquisition of Bury, Oldham and Rochdale by October 2020.

**Service alignment and engagement with staff**

1.3.12. A staff briefing and letter was circulated to all staff on 18 December. It set out the arrangements which will be put in place by 1 April 2020 as a major step towards implementing the full transactions which will separate and reorganise Pennine Acute Trust (PAT) so that Salford Royal formally acquires our Oldham, Bury and Rochdale sites as part of the NCA, and MFT to formally acquire NMGH as part of the Manchester Single Hospital Service.
1.3.13. Trusts will continue to communicate with staff and staff-side organisations across the PAT hospitals during this important period of change. Planning work associated with the service alignment will continue (last year input and views were sought from senior clinicians and managers across 120 workshops).

1.3.14. This year should be a positive and exciting step forward for everyone who is connected to PAT and its services.

1.4. **Management arrangements for NMGH as part of MFT**

1.4.1. From 1 April, NMGH will be managed by MFT. MFT recognises the achievements of the existing leadership team at NMGH and will build on both these achievements and the supporting management arrangements.

1.4.2. The Chief Executive for NMGH will be Dena Marshall. Dena is currently Chief Executive of Royal Manchester Children’s Hospital

1.4.3. In addition to the existing senior team structure, additional resource will be provided to strengthen leadership capacity in workforce/HR, informatics, estates and transformation.

1.5. **Future capital investment**

1.5.1. MFT, SRFT, local healthcare commissioners and Local Authority partners all acknowledge that substantial investment is required to redevelop the NMGH site and also to upgrade parts of the Oldham site and IT infrastructure across all PAT sites.

1.5.2. MFT is leading the development of a case for significant investment in NMGH as part of the Government’s Health Infrastructure Plan, (HIP). Planning for this is progressing at pace and NMGH staff will become increasingly involved from now onwards.

1.5.3. SRFT have been developing proposals for investment across Bury, Oldham and Rochdale with a significant focus on Royal Oldham Hospital. These proposals will be prioritised within the GM Strategic Estates Plan and sponsored for capital funding following the 2020 Government Spending Review.

1.6. **Cancer – Rapid Diagnostic Centres**

1.6.1. The NHS Long Term Plan sets out an ambition to transform cancer care so that from 2028, an extra 55,000 people each year will survive for five years or more following their cancer diagnosis and three in four cancers (75%) will be diagnosed at an early stage. The Plan sets out that this will in part be delivered by the roll out RDCs in each cancer alliance (in our case Greater...
Manchester Cancer is our alliance; there are 19 alliances across England starting from 2019/20, as part of the broader strategy to deliver faster and earlier cancer diagnosis and improved patient experience.

1.6.2. RDC’s will also help to support the new Faster Diagnosis Standard which will be introduced from April 2020, to ensure that all patients who are referred for the investigation of suspected cancer find out within 28 days if they do or do not have a cancer diagnosis.

1.6.3. The National RDC Specification, published in July 2019, proposes a phased approach to implementation over a five-year period (2019-2024). NHSE set out the ambition that in time, RDC’s will offer a single point of access for all patients with suspected cancer.

1.6.4. By early 2020 (phase 1) all Cancer Alliances are expected to have at least one RDC operational for:

- Patients with non-specific symptoms which could indicate cancer; and
- A cohort of patients with site-specific symptoms of cancer who are currently served by an underperforming two week wait or 62-day pathway.

1.6.5. The RDC model in Greater Manchester has evolved from the Multidisciplinary Diagnostic Centre (MDC) project which was part of the national Accelerate Coordinate Evaluate (ACE 2) programme, delivered in our conurbation at the Royal Oldham and Wythenshawe hospital sites, as a successful two-year pilot between April 2017 and March 2019. Through this ACE 2 programme, these pilot sites contributed to the national thinking on RDC’s.

1.6.6. The expertise developed by these pilot sites led to the Greater Manchester Cancer Board in July 2019 agreeing that the Northern Care Alliance and Manchester University NHS Foundation Trust would on behalf of the Greater Manchester Cancer system lead the initial development of RDCs (phase 1) on behalf of GM.

- For Northern Cancer Alliance this will include patients referred from Salford, Oldham, Bury and Heywood Middleton & Rochdale CCGs, who will be seen at Salford Royal or Oldham hospitals.
- For Manchester University NHS Foundation Trust this will include patients referred from Manchester and Trafford CCGs, who will be seen at Wythenshawe hospital.
1.6.7. An RDC service for GM patients is now being implemented with services going live for patients (consistent with the phase 1 national plans) in February/March 2020.

1.6.8. During 2020/2021 once NCA and MFT have increased the geographical access to the non-specific symptom pathway and introduced the first site-specific RDC pathway in their relative localities, there will be a clearer understanding of the numbers of patients, numbers of diagnostic tests, the workforce required, triage arrangements, how many days per week and where else the service should be located across GM. The information gathered during the initial phase of implementation will then inform the GM Cancer Board and cancer system as to where and how RDC implementation is progressed and rolled out across the whole of GM.

1.6.9. Plans for the development of an RDC offer for patients in other localities (Bolton, Wigan, Tameside and Stockport) will be finalised in 2020/21 with a view to offering wider population coverage as we move through the implantation phases. It is anticipated the RDC’s will work in a complementary way and the model encourages a rapid standardised coordinated service for the diagnosis of cancer in GM.

1.6.10. The GM Cancer Alliance has established a GM RDC Programme Board, which will provide assurance to the GM Cancer Board on the development and implementation of RDCs across Greater Manchester. The Cancer Alliance team will also be working with NHSE on a commissioning and contracting model with continual engagement and negotiation with all Greater Manchester localities through the existing forums.

1.6.11. Initial funding for the phase 1 programme for RDC’s has been allocated. The GM Cancer Alliance is expected to submit proposals to NHS England on next phase planning in early 2020.

1.7. System Performance

1.7.1. There are a number of standards that the GM Health and Social Care Partnership are monitored against. Appendix 1 of this report contains a broader dashboard, with a somewhat wider set of metrics that will also breakdown of performance by locality.

- **Urgent Care 4-hour standard (National standard is 95% of those attending an accident and emergency department are seen within four hours)** - The published 4-hour performance for Greater Manchester for December 2019 was 74.5%. The GM performance for 4-hour standard is tracking below last year which is concerning. Winter pressures has contributed and the Christmas and New Year holiday period, along with an earlier than expected presentation of flu across
GM. Other factors include the continued increase self-presenters at A&E, some constraints on workforce and insufficient progress in reducing unnecessarily long lengths of stay in some hospitals.

Across GM during December trusts have seen a wide variation in performance due to the winter pressures and demand and the impact of reduced flow (discharges) over the holiday period. The trusts in GM who normally perform well against the 4-hour A&E standard have also struggled during periods of high demand from ambulances and walk in activity, which has impacted on performance but generally they have regained performance relatively quickly. However, some systems have continued to require additional oversight and support. The focus across GM has been on maintaining safety with systems and facilitating mutual aid to support ambulance diverts when systems are experiencing particularly high levels of demand.

All systems across GM have developed plans in preparation for winter and GM hosted a winter preparation event in October 2019. The GM event agreed key priorities for local system and GM actions to support winter preparedness. These remain focused to support our three key priorities:

- The delivery of a single GM clinical assessment service that is integrated with community-based teams’ urgent care response.
- Implementing a GM streaming, same day emergency care and GM acute frailty standard.
- Reducing the number of patients with long lengths of stay.

**Delayed Transfers of Care (DTOC)** - Published data for NHS England shows there was a daily average of 384.91 of beds occupied by patients delayed in their transfer of care during November 2019, a rate of 17.4 per 100,000 population. This is above our working standard level of 200 beds per day and we are taking targeted action with underperforming systems to rapidly improve including now working with the national Better Care Fund DTOC Improvement Team to develop a support offer for GM to support the spread in best practice and addressing some of the key issues in GM. There is significant variation across Greater Manchester with higher performing localities such as Wigan, Rochdale and Oldham, contrasting with Manchester, Trafford and Salford.

**Ambulance Response Times and reducing handover delays** – The proportion of ambulance handovers taking over 60 minutes is 7.8% for GM against 8.8% nationally, this is a deterioration from October with handovers at 6.1%. Handover delays have been significantly impacted
by the pressures within ED departments and constrained flow within acute trusts.

- **Referral to Treatment (National Standard is 92% of patients should wait less than 18 weeks for planned treatment)** - The published data for November 2019 shows GM’s position to be 84.3%. This is in line with the North West Region and England performances of 85.1% and 84.3% respectively. However, it represents a deteriorating position. Localities have plans in place to improve their position within the capacity and finance parameters available to them. However, there are external factors that are making life difficult, specifically the pensions rules that have limited medical sessions.

- **Elective Waiting List Growth (National Standard is there is no increase in the number of patients waiting on a waiting list in March 2020 than at March 2018)** - The number of patients waiting across GM on waiting lists is reported in November 2019 as 20.3% higher than in March 2018. However, this is an artificial position and we have to take account of the different baseline (March 2019) at MFT, which reduces the figure to 12.3%. However, this is still higher than the North West position of 6.7%. In this context, it is relatively pleasing that the number of patients waiting for 52 weeks or more was only 28 for November. GMHSCP is assured that all those waiting more than 52 weeks are being managed appropriately and individually within a range of exceptional situations.

- **Diagnostic Waiting Times (National standard is for no more than 1% of people waiting 6 weeks or more for a diagnostic test)** - Data for November 2019 shows that GM’s position for diagnostics waiting time has improved to 1.8%. Endoscopy, MRI and echocardiography remain particular areas of pressure. The issues seen earlier in the year at Salford Royal are being tackled through an improvement plan and performance shows this. The high percentage at Stockport FT is reportedly due to staffing issues experienced earlier in the year.

- **Cancer** - There are a number of standards for cancer services. The most challenging are outlined below.

  - The “two weeks wait (breast symptoms, cancer not suspected)” standard was not achieved in November 2019 at 84.4% against a standard of 93%. This represents an improvement of more than 10% on the previous month. The key issues are related challenges in the consultant and radiology workforce. There are a number of mutual aid schemes across GM currently in place to support improvement.
• The “two weeks wait from cancer referral to specialist appointment” standard was almost achieved in November 2019 with a performance of 92.9% against a standard of 93%. This is an improvement in performance of 1.9% from October. The issues in breast services have impacted on the GM performance in this standard.

• Patients treated within 62 days of their initial referral was not achieved and deteriorated slightly in November to 74.1%. The GM Cancer Board are working to provide a focus for improvement on this standard and support individual trusts with their improvement schemes. This target also reflects very significant variation in performance. GM HSCP is particularly concerned with the 62-day performance level in the north east sector of Greater Manchester, with Oldham, Bury and Rochdale the lowest performers. This is one of the main reasons why this month GM HSCP has established a dedicated Performance Improvement Group for the North East Sector to support the local systems to improve their position with respect to cancer waiting times and a small number of other key constitutional standards.

• In terms of the cancer 31-day standards, performance within GM remains excellent and achievement of these standards has been sustained for over 12 months.

• Improving Access to Psychological Therapies (IAPT) waiting times (National standards: 75% of patients to be seen within 6 weeks and 95% of patients within 18 weeks) – GM met the access, recovery and 18 week waiting time standards in November, narrowly missing the 6 week waiting time standard with performance of 74.4%, although this was an improvement on the October position. Recovery plans have been received from localities in GM which struggle to achieve these standards and plans are now in place to recover performance to meet the national standards.

• Estimated diagnosis rate for people with dementia (National standard is 66.6%) – GM has consistently achieved a level of performance beyond the standard for over 12 months, and the latest performance for the month of November was 76.3%. GM is amongst the highest performing areas in the country for dementia diagnosis rate and also a very high performer for care planning and post diagnostic support according to the latest CCG IAF dashboards.

• Early intervention psychosis (National standard is for 53% of patients to be treated within 2 weeks of referral) – GM achieved
performance of 75% in October and has sustained a level of performance above the national standard for over 12 months.

- **Eating disorders 1st treatments within national standards (Urgents, 1 week, 95%, Routines 4 weeks, 95%)** – Although not quite achieving the 95% standards for either of these metrics, the last quarterly published performance shows that GM performance was over 90% in both cases.

- **Primary care access & 7-day services** – The latest CCG IAF dashboard shows GM as the top ranked STP in terms of the proportion of the population benefitting from extended primary care access and GM is also ranked 3rd/top 25th percentile for the delivery of 7-day services metric.

- **Population health indictors** – The latest GM scorecard measuring performance and the level of improvement against national performance levels evidences good achievement in terms of improvement for the proportion of babies with low birth weight, school readiness for those on free school meals, the percentage of adults who are physically inactive (24.5%) and employment rates for 50-64-year olds (70.9%).

- **Key transformation metrics** – The latest GM transformation metrics dashboard demonstrates that for most metrics the direction of travel is positive, with particularly strong performance around reducing non-elective length of stay and total bed days.

- **Indices of Deprivation between 2015 and 2019** - There has been improvement in the Health & Disability Domain across GM with 9 of the 10 localities showing a relative improvement in rank compared with all other English local authorities. On the same Domain, all ten localities have less areas in the lowest ranked 10%. This contrasts with the overall position whereby 9 localities’ ranking has worsened with Manchester showing the only improvement (from 5th to 6th overall). This means that overall the GM population is experiencing relatively better health but within the context of increasing relative deprivation.

1.8. **Planned Activity**

1.8.1. The table below shows NHS activity levels, variance against operational plan and growth against the same period last year (April to November). The reduction in referrals is encouraging and shows that primary care is becoming more effective at managing demand within the community.

1.8.2. The key non-elective activity figure is for 1+ nights which measures patients admitted to hospital. The performance at month 8 is encouraging as it shows
that fewer urgent bed days have been utilised than last year or had been anticipated this year.

1.8.2.1. Most points of delivery on the table are within tolerance limits with the exception of the lower volume ordinary electives and follow-up outpatient attendances. The lower than anticipated number of ordinary elective admissions is concerning and probably explains some of the increase in waiting lists.

1.8.3. As stated above, one contributing factor to this and the reduction in outpatient activity is likely to be the impact of pensions rules on the number of sessions that doctors are willing to work. For each point of delivery there is some variation between localities, and we continue the appropriate dialogue and seek assurance from localities.

<table>
<thead>
<tr>
<th>GM Total</th>
<th>YTD Actual Activity</th>
<th>YTD Planned Activity</th>
<th>YTD % Var. to Plan</th>
<th>Year on Year Growth</th>
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</thead>
<tbody>
<tr>
<td>Referrals (Total)</td>
<td>757,043</td>
<td>774,836</td>
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<tr>
<td>GP Referrals</td>
<td>461,803</td>
<td>465,911</td>
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<tr>
<td>Other Referrals</td>
<td>295,240</td>
<td>308,925</td>
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<td>OP (Total)</td>
<td>2,026,386</td>
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<tr>
<td>OP 1st Attendances</td>
<td>672,184</td>
<td>679,313</td>
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<td>OP Follow Up Attendances</td>
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<td>1,346,290</td>
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<td>Elective (Total)</td>
<td>268,358</td>
<td>268,665</td>
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<tr>
<td>Elective (Day Case)</td>
<td>232,112</td>
<td>229,232</td>
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<td>Elective (Ordinary)</td>
<td>36,246</td>
<td>39,433</td>
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<td>Non Elective (Total)</td>
<td>249,672</td>
<td>256,899</td>
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<td>0 day LOS</td>
<td>95,462</td>
<td>96,108</td>
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<td>1+day LOS</td>
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<td>892,727</td>
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2.0 FINANCE – UPDATE AS AT NOVEMBER 2019 (MONTH 8)

2.1. GM has a planned surplus of £7.5m in 19/20 against which GM financial performance will be measured as an ICS.

2.2. Our year to date position (as at Month 8) shows a £6m deficit against plan reflecting a deterioration within the Provider sector. Our last update in October (M5 position) highlighted significant challenges across the GM system some of which have now been realised and reflected within our latest forecast position showing a net c£10m deficit at year end.

2.3. GMHSCP are working hard with the system, Finance Advisory Committee (FAC) and NHSE/I colleague to deliver the aggregate GM control total in
order to protect the element of Provider Sustainability Funding (PSF) that the system allocated to overall system delivery. Two organisations have declared overperformance which can be used to offset known underperformance which has allowed GM to retain its Q1 and Q2 ‘system PSF’ and forecast to do so for Q3. Via FAC, we continue to work to balance the system to deliver the 2019/20 control total recognising there remain significant risks in this position.

2.4. The key points to note in relation to the financial position are:

- **NHS Provider sector** – All Providers in GM agreed their 2019/20 Control Totals. Providers have reported a £9.8m deficit against M8 plan and are forecasting a deficit of £11.3m against Plan. The deficit relates mainly to one Trust who have now submitted a detailed ‘system recovery action plan’ as part of a locality wide plan to demonstrate measures in place to address this. We are aware of risks being highlighted by other Trusts and are working to manage these.

- **CCGs** – the CCG sector is reporting a break-even position both year to date (M8) and forecast position. The commissioning sector has been able to generate surpluses to provide headroom of c£3.4m to help manage the overall GM position. Trafford CCG is eligible to receive CSF of c£7m in 2019/20 subject to meeting specific NHSE conditions. The CCG has met the conditions for both Q1 & Q2 and this is vital to secure delivery of Q3 and Q4 checkpoints.

2.5. Despite this forecast position for CCGs overall, there remain significant financial challenges translating to a c£20m financial risk to delivering plans which is not reflected with the forecast position. GMHSCP is actively meeting with these CCGs to ensure these risks are mitigated within the locality and subsequent risks taken to FAC as part of system wide discussion on delivery of GM performance.

2.6. Local Authorities – the forecast outturn position for Local Authorities, before the utilisation of unplanned access to reserves or underspends, shows an overspend of c£48.4m. This overspending continues to be driven by external residential placements for Looked After Children and foster care. Local Authorities have indicated that this pressure will be met from increased access to reserves from £35m at plan to £83m at year end.

2.7. **NHSE Primary Care capital:** GM has received £10.6m capital funding in 2019/20 to support investments in Primary Care. The 2019/20 capital plan is fully committed and reflects pre-commitments from previous years and in-year priorities as shared by localities and approved by GMHSCP capital
steering group within the affordability envelope. Schemes are held in reserve and released once any slippage monies become available.

3.0 GOVERNANCE

3.1. The Health and Care Board is asked to note the recommendations supported by the Partnership Executive Board at the meetings on 26 September 24 October and 22 November 2019. A complete decision log can be found in Appendix 2.

4.0 RECOMMENDATIONS

4.1. The GM Health and Care Board is asked to:

- Note and comment on the content of the update report.
Greater Manchester Master Dashboard - Bolton

**Locality:** Bolton

**Patients Admitted, Transferred Or Discharged From A&E Within 4 Hours - December, 2019**

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<th>England</th>
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**Access Rate to Children and Young People’s Mental Health Services - October, 2018**

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**Antimicrobial resistance: appropriate prescribing of antibiotics in primary care - October, 2019**

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**Total Bed Days per 1,000 Weighted Population - November, 2019**

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**COC - % of Beds in Residential or Nursing Homes Rated ‘Outstanding’ or ‘Good’ - December, 2019**

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**COC - % GP Practices Rated ‘Outstanding’ or ‘Good’ - December, 2019**

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**Delayed Transfers of Care - Per 100,000 - October, 2019**

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**Diagnostics Tests Waiting Times - November, 2019**

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**Elective Admissions per 1,000 population - November, 2019**

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**Emergency Admissions Aged 65 and Over per 1,000 population - November, 2019**

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<th>Bolton</th>
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**Emergency Admissions for Asthma Aged 0-18 per 1,000 population - November, 2019**

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<tbody>
<tr>
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</tbody>
</table>

**Emergency Admissions for Diabetes Aged 0-18 per 1,000 population - November, 2019**

<table>
<thead>
<tr>
<th>England</th>
<th>Bolton</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.5%</td>
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</tbody>
</table>

**Emergency Admissions for Epilepsy Aged 0-18 per 1,000 population - November, 2019**

<table>
<thead>
<tr>
<th>England</th>
<th>Bolton</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.2%</td>
<td>1.2%</td>
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<td>1.2%</td>
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</tbody>
</table>

Key:
- Selected Locality
- Greater Manchester
- England

Note: bars to the left of the chart are most desirable
Patients Admitted, Transferred Or Discharged From A&E Within 4 Hours - December, 2019

Access Rate to Children and Young People’s Mental Health Services - October, 2018

Antimicrobial resistance: appropriate prescribing of antibiotics in primary care - October, 2019

Total Bed Days per 1,000 Weighted Population - November, 2019

% Aged 65+ Discharged to Residential Care - November, 2019

COC - % of Beds in Residential or Nursing Homes Rated ‘Outstanding’ or ‘Good’ - December, 2019

COC - % GP Practices Rated ‘Outstanding’ or ‘Good’ - December, 2019

Cancer - 62-Day Wait From Referral To Treatment - November, 2019

Referral To Treatment - % Waiting List Change from March 2018 - November, 2019

Delayed Transfers of Care - Per 100,000 - November, 2019

Diagnostics Tests Waiting Times - November, 2019

Elective Admissions per 1,000 population - November, 2019

Emergency Admissions Aged 65 and Over per 1,000 population - November, 2019

Improving Access to Psychological Therapies Access Rate - October, 2018

Improving Access to Psychological Therapies Recovery Rate - October, 2019

Non Elective Admissions - One Day Plus Length of Stay per 1,000 population - November, 2019

Emergency Admissions for Asthma Aged 0-18 per 1,000 - November, 2019

Emergency Admissions for Diabetes Aged 0-18 per 1,000 - November, 2019

Emergency Admissions for Epilepsy Aged 0-18 per 1,000 - November, 2019

Key:
- Selected Locality
- Greater Manchester
- England

Note: bars to the left of the chart are most desirable
### Patients Admitted, Transferred Or Discharged From A&E Within 4 Hours - December, 2019

<table>
<thead>
<tr>
<th>Locality</th>
<th>England (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sal</td>
<td>78.1</td>
</tr>
<tr>
<td>Man</td>
<td>78.1</td>
</tr>
<tr>
<td>BOL</td>
<td>76.3</td>
</tr>
<tr>
<td>Old</td>
<td>76.3</td>
</tr>
<tr>
<td>WIG</td>
<td>73.9</td>
</tr>
<tr>
<td>Bur</td>
<td>73.9</td>
</tr>
<tr>
<td>Old</td>
<td>74.1</td>
</tr>
<tr>
<td>Tam</td>
<td>71.5</td>
</tr>
<tr>
<td>Old</td>
<td>71.5</td>
</tr>
<tr>
<td>Sto</td>
<td>67.3</td>
</tr>
<tr>
<td>Gm</td>
<td>67.3</td>
</tr>
</tbody>
</table>

- **England**: 79.6%

### Access Rate to Children and Young People’s Mental Health Services - October, 2018

<table>
<thead>
<tr>
<th>Locality</th>
<th>England (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sal</td>
<td>56.0</td>
</tr>
<tr>
<td>Man</td>
<td>56.0</td>
</tr>
<tr>
<td>BOL</td>
<td>54.1</td>
</tr>
<tr>
<td>Old</td>
<td>54.1</td>
</tr>
<tr>
<td>WIG</td>
<td>50.5</td>
</tr>
<tr>
<td>Bur</td>
<td>50.5</td>
</tr>
<tr>
<td>Old</td>
<td>48.8</td>
</tr>
<tr>
<td>Tam</td>
<td>43.8</td>
</tr>
<tr>
<td>Old</td>
<td>43.8</td>
</tr>
<tr>
<td>Sto</td>
<td>23.9</td>
</tr>
<tr>
<td>Gm</td>
<td>23.9</td>
</tr>
</tbody>
</table>

- **England**: 36.9%

### Antimicrobial resistance: appropriate prescribing of antibiotics in primary care - October, 2019

<table>
<thead>
<tr>
<th>Locality</th>
<th>England (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tam</td>
<td>10.0</td>
</tr>
<tr>
<td>Man</td>
<td>10.0</td>
</tr>
<tr>
<td>BOL</td>
<td>9.0</td>
</tr>
<tr>
<td>Old</td>
<td>9.0</td>
</tr>
<tr>
<td>WIG</td>
<td>8.0</td>
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<tr>
<td>Bur</td>
<td>8.0</td>
</tr>
<tr>
<td>Old</td>
<td>8.0</td>
</tr>
<tr>
<td>Tam</td>
<td>8.0</td>
</tr>
<tr>
<td>Old</td>
<td>8.0</td>
</tr>
<tr>
<td>Sto</td>
<td>4.1</td>
</tr>
<tr>
<td>Gm</td>
<td>4.1</td>
</tr>
</tbody>
</table>

- **England**: 9.3%

### Total Bed Days per 1,000 Weighted Population - November, 2019

<table>
<thead>
<tr>
<th>Locality</th>
<th>England (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>BOL</td>
<td>78.6</td>
</tr>
<tr>
<td>WIG</td>
<td>78.6</td>
</tr>
<tr>
<td>Tam</td>
<td>76.7</td>
</tr>
<tr>
<td>Old</td>
<td>76.7</td>
</tr>
<tr>
<td>Sto</td>
<td>75.6</td>
</tr>
<tr>
<td>Gm</td>
<td>75.6</td>
</tr>
<tr>
<td>Man</td>
<td>75.6</td>
</tr>
<tr>
<td>Old</td>
<td>74.2</td>
</tr>
<tr>
<td>WIG</td>
<td>73.5</td>
</tr>
<tr>
<td>Bur</td>
<td>73.5</td>
</tr>
</tbody>
</table>

- **England**: 77.4%

### Cancer - 62-Day Wait From Referral To Treatment - December, 2019

- **England**: 77.4%

### Emergency Admissions Aged 65 and Over per 1,000 population - November, 2019

<table>
<thead>
<tr>
<th>Locality</th>
<th>England (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sal</td>
<td>22.9</td>
</tr>
<tr>
<td>Man</td>
<td>22.9</td>
</tr>
<tr>
<td>BOL</td>
<td>22.9</td>
</tr>
<tr>
<td>Old</td>
<td>22.9</td>
</tr>
<tr>
<td>WIG</td>
<td>22.9</td>
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<tr>
<td>Bur</td>
<td>22.9</td>
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<tr>
<td>Old</td>
<td>22.9</td>
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<tr>
<td>Tam</td>
<td>22.9</td>
</tr>
<tr>
<td>Old</td>
<td>22.9</td>
</tr>
<tr>
<td>Sto</td>
<td>22.9</td>
</tr>
<tr>
<td>Gm</td>
<td>22.9</td>
</tr>
</tbody>
</table>

- **England**: 51.8%

### Emergency Admissions for Asthma Aged 0-18 per 1,000 population - December, 2019

<table>
<thead>
<tr>
<th>Locality</th>
<th>England (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>WIG</td>
<td>11.3</td>
</tr>
<tr>
<td>Tam</td>
<td>11.3</td>
</tr>
<tr>
<td>Old</td>
<td>11.3</td>
</tr>
<tr>
<td>Bur</td>
<td>11.3</td>
</tr>
<tr>
<td>Old</td>
<td>11.3</td>
</tr>
<tr>
<td>Sto</td>
<td>11.3</td>
</tr>
<tr>
<td>Gm</td>
<td>11.3</td>
</tr>
</tbody>
</table>

- **England**: 11.3%

### Emergency Admissions for Diabetes Aged 0-18 per 1,000 population - November, 2019

<table>
<thead>
<tr>
<th>Locality</th>
<th>England (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>BOL</td>
<td>10.0</td>
</tr>
<tr>
<td>Old</td>
<td>10.0</td>
</tr>
<tr>
<td>WIG</td>
<td>9.0</td>
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<tr>
<td>Bur</td>
<td>9.0</td>
</tr>
<tr>
<td>Old</td>
<td>8.0</td>
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<tr>
<td>Tam</td>
<td>8.0</td>
</tr>
<tr>
<td>Old</td>
<td>8.0</td>
</tr>
<tr>
<td>Sto</td>
<td>4.1</td>
</tr>
<tr>
<td>Gm</td>
<td>4.1</td>
</tr>
</tbody>
</table>

- **England**: 9.3%

### Emergency Admissions for Epilepsy Aged 0-18 per 1,000 population - December, 2019

- **England**: 47.7%

### Delayed Transfers of Care - Per 100,000 - October, 2019

<table>
<thead>
<tr>
<th>Locality</th>
<th>England (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>WIG</td>
<td>87.4</td>
</tr>
<tr>
<td>Bur</td>
<td>87.4</td>
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<tr>
<td>Old</td>
<td>87.4</td>
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<tr>
<td>Tam</td>
<td>87.4</td>
</tr>
<tr>
<td>Old</td>
<td>87.4</td>
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<tr>
<td>Sto</td>
<td>87.4</td>
</tr>
<tr>
<td>Gm</td>
<td>87.4</td>
</tr>
</tbody>
</table>

- **England**: 52.9%

### Diagnostics Tests Waiting Times - November, 2019

- **England**: 7.5%

### Elective Admissions per 1,000 population - November, 2019

- **England**: 13.0 per 1,000 population

### Referral To Treatment - % Waiting List Change from March 2018 - November, 2019

<table>
<thead>
<tr>
<th>Locality</th>
<th>England (%)</th>
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<tbody>
<tr>
<td>Tam</td>
<td>92.4</td>
</tr>
<tr>
<td>Man</td>
<td>92.4</td>
</tr>
<tr>
<td>BOL</td>
<td>92.4</td>
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<tr>
<td>Old</td>
<td>92.4</td>
</tr>
<tr>
<td>WIG</td>
<td>92.4</td>
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<tr>
<td>Bur</td>
<td>92.4</td>
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<tr>
<td>Old</td>
<td>92.4</td>
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<tr>
<td>Tam</td>
<td>92.4</td>
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<tr>
<td>Old</td>
<td>92.4</td>
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<tr>
<td>Sto</td>
<td>92.4</td>
</tr>
<tr>
<td>Gm</td>
<td>92.4</td>
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</tbody>
</table>

- **England**: 93.2%

### Master Dashboard - Stockport

- **Average**: 2018
- **Average**: 2019

### Key:
- Selected Locality
- Greater Manchester
- England

**Note:** bars to the left of the chart are most desirable
GM HSC Partnership Executive Board – 26 September 2019

**Implementation Plan for Greater Manchester Health and Social Care Prospectus and Long-term Plan 2020-24**

The Board was asked to consider the first draft of the Greater Manchester Delivery Plan 2020-24 (the Plan) which outlines the implementation path for the Health and Social Care Prospectus and how Greater Manchester would deliver on its responsibilities under the NHS Long Term Plan.

Subject to the Board’s agreement it is intended that the draft Plan would be submitted to NHS England and NHS Improvement (NHSE/I) on 27th September 2019. The final version of the plan is due for submission in mid-November 2019.

The draft Plan would also form the basis for further engagement with the GM system during October with a view that a revised version would be presented further consideration at the next Board on the 24th October 2019.

The final version of the plan is due for submission to NHSE/I in mid-November 2019.

<table>
<thead>
<tr>
<th>Report summary</th>
<th>Recommendations</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>GM HSC Partnership Executive Board – 26 September 2019</strong></td>
<td>The Partnership Executive Board were asked to:</td>
<td>The recommendation was supported. It was also agreed that further consideration would be provided to the development and refinement of the Implementation Plan at the scheduled PEB away session in November 2019.</td>
</tr>
<tr>
<td><strong>Implementation Plan for Greater Manchester Health and Social Care Prospectus and Long-term Plan 2020-24</strong></td>
<td>• Support the draft Delivery Plan for submission as the initial return to NHS England and NHS Improvement and as the basis for further engagement with the GM system.</td>
<td></td>
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</table>
## Report summary

<table>
<thead>
<tr>
<th>Greater Manchester Partnership Development – Progress Report</th>
<th>Recommendations</th>
<th>Outcome</th>
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</thead>
</table>
| This item was presented as a confidential report which provided members with an update on the various work streams contributing to the delivery of the Partnership’s Target Operating Model based on principles agreed in June 2019. | The Partnership Executive Board were asked to:  
  - Note the update;  
  - Note any comments provided at the meeting with regards to the programme and management and the revised GM HSC team structure; and  
  - Note that a further update would be provided to the Board at the next meeting. | The recommendations were supported. |

<table>
<thead>
<tr>
<th>Improving Specialist Care Programme Update</th>
<th>Recommendations</th>
<th>Outcome</th>
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</table>
| An update on the progress of the Improving Specialist Care Programme was provided by Anthony Hassall, Commissioner Lead for Improving Specialist Care Programme. | The Partnership Executive Board were asked to:  
  - Note the update and the contents of the report and the decisions made by the JCB. | The recommendation was supported.  
  
  In addition, the Board concurred that further consideration should be given to providing an update on Primary Care Board governance at a future meeting. |
1. **Respiratory** – as modelled, all existing sites and consistent with the Model of Care
2. **Vascular** – as modelled to be sited as a Hub and Spoke configuration and consistent with the Model of Care
3. **Benign Urology** – as modelled to be sited as a Hub and Spoke configuration and consistent with the Model of Care
4. **Paediatric Surgery** – as modelled to be sited as a tiered configuration and consistent with the Model of Care
5. **Breast** – as three equitable Hub sites and consistent with the Model of Care but included an options appraisal covering each of Site configuration options 1, 2, 3 and 4.

The JCB also confirmed support for the Programme to engage formally with NHS England in respect of Strategic Sense Check 1 for service change and with the GM Joint Health Scrutiny Committee to review the proposed changes.

### Developing GM Metrics for Social Care and Transformation

The report provided an update on the development and early findings from the minimum dataset for

- The Partnership Executive Board were asked to:
  - Note the content of the update; and.

The recommendations were supported.
### Report summary

Adult social care (MinASC) and transformation metrics. Data was now being received from all GM's ten local areas and validated by local ASC analysts and the GM Business Intelligence Team. There are 22 MinASC metrics and out of the 22 metrics, only 7 reports now remain to be developed.

The report further provided an overview of the set of transformation metrics in each of the ten localities used to measure progress on transformational plans. The outcomes for June 2019 were available upon request from the Head of Business Intelligence, GMHSCP Team.

The Board acknowledged the work being undertaken to strengthen business intelligence and continuous improvements in developing dashboards which support programmes and provide cross cutting information across GM.

### Recommendations

- Note that further direction on next steps and frequency of reporting to PEB would be provided.

### Outcome

The recommendations were supported.

### Corporate Services Delivery Vehicle Update

The report provided an update and completion timetable for the required work to secure a Host for the new Corporate Services Delivery Vehicle (CSDV) including, NHS Greater Manchester Shared Services.

The Partnership Executive Board were asked to:

- Receive and note the report to ensure that were sighted on the next phase of the establishment of the CSDV

The recommendations were supported.
### Appendix 2 – GMHSC Partnership Decision Log (September – November 2019)

<table>
<thead>
<tr>
<th>Report summary</th>
<th>Recommendations</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>● Note the preferred hosting decision be noted.</td>
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<tr>
<td></td>
<td>The Partnership Executive Board were asked to:</td>
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<tr>
<td></td>
<td>● Note the progress and impact of GM Moving to date;</td>
<td></td>
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<tr>
<td></td>
<td>● Agree the refreshed MOU, the direction of travel and the shared priorities of focus;</td>
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<tr>
<td></td>
<td>● Note the required leadership commitment to support the ambitions of GM Moving and the whole system approach needed to ensure the wider population scale impact being sought;</td>
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<tr>
<td></td>
<td>● Agree that the refreshed MOU would continue to be steered by the GM Moving Executive, chaired by Steven Pleasant, with senior representatives from GMCA, GM Health and Social Care Partnership, Transport for Greater Manchester, Sport England,</td>
<td>The recommendations were supported.</td>
</tr>
</tbody>
</table>
### GM HSC Partnership Executive Board – 24 October 2019

<table>
<thead>
<tr>
<th>Report summary</th>
<th>Recommendations</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Taking Charge – The next five years: update and next steps</td>
<td>The Partnership Executive Board were asked to:</td>
<td></td>
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<tr>
<td></td>
<td>• Note the estates prospectus and the proposed operating framework; and</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Approve the document, subject to further discussions taking place at the Provider Federation Board on 25th October 2019.</td>
<td></td>
</tr>
<tr>
<td>GM HSC Partnership Executive Board – 24 October 2019</td>
<td>The recommendations were supported.</td>
<td></td>
</tr>
</tbody>
</table>

The Executive Summary for *Taking Charge: The Next Five Years – Our Delivery Plan 2020-24* was presented for consideration as the basis for informing the required final sign off for the Delivery Plan which was expected to be presented to the Board in December 2019 and the Health and Care Board in January 2020.

The executive summary included a set of system priorities for the first two years of the plan which had been tested through workshops with the GM system. The Board reflected on the feedback from last month’s PEB that a clear set of collective
Appendix 2 – GMHSC Partnership Decision Log (September – November 2019)

<table>
<thead>
<tr>
<th>Report summary</th>
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<th>Outcome</th>
</tr>
</thead>
</table>
| commitments needed to be articulated in the Plan. A request was made for additional information concerning the expected timelines and it was further suggested that the programme should be rolled-out beyond locality estates groups. Confirmation was provided that the team currently reviewing the next phase in terms of delivery and programme training and awareness would be extended to include additional stakeholders including primary care. | The Partnership Executive Board were asked to:  
- Note the update;  
- Note NWAS’s continuing support for partnership development and engagement;  
- Acknowledge the positive impact of NWAS’s increased engagement and partnership development on the performance figures. | The recommendations were supported. |

North West Ambulance Service (NWAS) Strategy

The presentation provided an overview of the North West Ambulance Service including an insight into the strategic direction, goals, partnerships, workforce and challenges facing the service.

Details of the performance figures with regards to conveyances to acute hospitals in Greater Manchester, ambulance activity along with figures for alternatives to transport ‘see and treat’ and ‘hear and treat’ were also provided.

Acknowledging that the new collaborative schemes have enabled support for safer care closer to home which has resulted in a cumulative reduction of |
### Winter Planning Incorporating Development of Clinical Assessment Service

The summary report provided assurance concerning the winter planning arrangements for GM including the re-establishment of the GM Clinical Assessment Service (CAS) from 1 November until the end of March 2020 and the launching of a GM Patient and Professional Service Finder App.

A winter planning approach in early summer through the GM UEC Improvement and Transformation Board had highlighted both locality-specific and GM-wide opportunities for improvement.

<table>
<thead>
<tr>
<th>Report summary</th>
<th>Recommendations</th>
<th>Outcome</th>
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</table>
| ambulance patients conveyed to Urgent and Emergency Care (UEC), it was proposed that further opportunities to collaborate and integrate would increasingly assist in the management and impact of footfall activity at UEC on ambulance turnaround times. The developing role of Primary Care Networks was considered, and it was suggested that a collective pragmatic approach would be required to assist with GP network partnerships and further support the development of out of hospital care. | The Partnership Executive Board were asked to:  
- Note the content of the report;  
- Confirm its support to the winter planning approach outlined in the paper; and  
- Note the ongoing contribution to capacity planning, the review process and wider GM initiatives provided by Executive members and respective | The recommendations were supported. |
## Appendix 2 – GMHSC Partnership Decision Log (September – November 2019)

<table>
<thead>
<tr>
<th>Report summary</th>
<th>Recommendations</th>
<th>Outcome</th>
</tr>
</thead>
</table>
| It was suggested that further data analysis including primary care and NWAS data should be reviewed by localities to obtain insight and address barriers within locality planning. | organisations, localities or sectors. | |}

The report confirmed that Andrew Foster would be succeeded by Silas Nicholls as joint chair of the in GM UEC Improvement and Transformation Board;

### Review of Outcomes from NHSE/I Workforce Development Tool Testing

The report provided the output of the work undertaken by NHSE/I in conjunction with KPMG to develop an OD model and provide an objective view of ICS workforce development maturity in Greater Manchester.

It explains that eight systems, including Greater Manchester, were selected to work with KPMG to field test the tool, share their strategies and plans, take part in 121s and workshops to jointly agree their maturity level, from “emerging to thriving” in nine areas that contribute to the five priorities described in the interim NHS People Plan.

The Partnership Executive Board were asked to:
- Formally receive the report;
- That further review of OD model and the objective view of ICS workforce development maturity in GM be provided by workforce strategy board and all organisation across the system including the GMCA.

The recommendations were supported.
<table>
<thead>
<tr>
<th>Report summary</th>
<th>Recommendations</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confirmation was provided that the Strategic Workforce Board would further</td>
<td></td>
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<tr>
<td>review the outcomes but consideration to the findings should be provided by</td>
<td></td>
<td></td>
</tr>
<tr>
<td>the Board along with all organisations across the system, including those</td>
<td></td>
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<td>within the GMCA.</td>
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<td>Brexit Update</td>
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<td>The report provided colleagues with an update on the national health and social</td>
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<td>care planning for EU Exit (Brexit) and the local arrangements in place to</td>
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<td>minimise local risks to service delivery.</td>
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<td>The Partnership Executive Board were asked to:</td>
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<tr>
<td>• Note the current preparedness at a national level; and</td>
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<td>• Confirm its agreement to the GM arrangements as for health and social care</td>
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<td>at the local system and organisational level.</td>
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<td>The recommendations were supported.</td>
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<td>GM HSC Partnership Executive Board – 26 September 2019</td>
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<td>Taking Charge – Next Five-year Plan</td>
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<td>The update report provided a narrative of the process taken during the</td>
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<td>production of the document and updated on the Plan Narrative, Finance, Activity,</td>
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<td>Workforce and LTP Metrics returns. It also included key messages from a</td>
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<td>review meeting with the NHSE/I</td>
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<td>The Partnership Executive Board were asked to:</td>
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<td>• Note the update report.</td>
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<td>Whilst he recommendation was supported, it was generally accepted that</td>
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<td>without knowing the overall financial settlement it was difficult to fully</td>
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<td>encompass</td>
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### Report summary
North West Regional team on 6 November 2019 and the actions taken as a result. It had been agreed to include a more detailed list of plan implementation milestones which would be developed further once the Partnership had received greater clarity on the nature of transformation funding through the Long-Term Plan.

In accordance with national guidance, the updated draft narrative was submitted to NHSE/I on 15th November 2019. It is intended that the Health and Care Board would provide the final sign-off for the Delivery Plan in January 2020.

### Transformation Funding 2020/21
The report was presented as a confidential item and describes the availability and use of Transformation Funds in 2020/21 with the focus on the funding requirement for the GMHSCP enhanced core team, along with enabling and transformation programmes against identified resources.

<table>
<thead>
<tr>
<th>Recommendations</th>
<th>Outcome</th>
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<tbody>
<tr>
<td>The Partnership Executive Board were asked to:</td>
<td>deliverables of system priorities into implementation plans.</td>
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<tr>
<td>1. Confirm its support to the proposals as outlined in the report.</td>
<td>It was acknowledged that the agreed settlement for GM was still awaiting final sign off from NHSE/I Chief Operating Officer.</td>
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<td>2. That a further report be presented to the Executive in December.</td>
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*Note:* This section has been redacted owing to the confidential nature of the discussions.

Subject to those amendments discussed at some length and agreed at the meeting, the recommendations were supported.

It was agreed that a further report to reflect comments made at the meeting would be presented to the Executive for consideration in December 2019.
<table>
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<tr>
<th>Report summary</th>
<th>Recommendations</th>
<th>Outcome</th>
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<tbody>
<tr>
<td><strong>Greater Manchester Health and Justice Strategy</strong>&lt;br&gt;The report provided an overview of the Greater Manchester Health and Justice Strategy and included information in relation to:</td>
<td><strong>The Partnership Executive Board were asked to:</strong>&lt;br&gt;• Endorse the draft Integrated Health and Justice Strategy and next steps noting that the final sign-off of this strategy would be at the Health and Care Board meeting on 31st January 2020.</td>
<td>The recommendation was supported.</td>
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<td>• the rationale and the case for change,&lt;br&gt;• the development and engagement process,&lt;br&gt;• priority groups, strategic objectives and intended outcomes,&lt;br&gt;• resources and benefits realisation</td>
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<tr>
<td><strong>GMHSCP Interim Sustainable Development Management Plan (SDMP)</strong>&lt;br&gt;On the 29 August 2019, all the NHS bodies that make up the Greater Manchester Health and Social Care Partnership mirrored the recent decision of the Greater Manchester Combined Authority and declared a climate change emergency, committing to far-ranging action to slash carbon emissions and avert predicted illness and disease. This made Greater Manchester the first “integrated care system”—NHS bodies and council social care working together—to declare a climate emergency.</td>
<td><strong>The Partnership Executive Board were asked to:</strong>&lt;br&gt;• Approve the Interim ICS Sustainable Development Management Plan;&lt;br&gt;• Further consider the proposed strengthening of both leadership and representation for health and social care in the 5 Year Plan governance structures; and&lt;br&gt;• Note that the GMHSCP Sustainable Development Leadership Group</td>
<td>The recommendations were supported.</td>
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</table>
## Report summary

The report provides the Partnerships response to this declaration in the form of an interim ICS Sustainable Development Management Plan (SDMP).

## Recommendations

Membership would be represented by an individual from VCSE organisation.

## Winter Planning Assurance

The report provided the Executive with a summary of the winter planning arrangements for GM including the re-establishment of the GM Clinical Assessment Service (CAS) from 1 November until the end of March 2020 and the launching of a GM Patient and Professional Service Finder App.

The Partnership Executive Board were asked to:

- Note the content of the report;
- Note the ongoing contribution to capacity planning, the review process and wider GM initiatives provided by Executive members and respective organisations, localities or sectors.

The recommendations were supported.
The ambition for primary care is for people in Greater Manchester to live well and to their full potential, with more people in employment, living healthier lifestyles and with good mental health.

The Greater Manchester (GM) five-year primary care strategy was launched in early 2016. It described how providers and commissioners could collectively work towards achieving the Greater Manchester ambition. This plan refreshes that strategy.

Although we are part way through the delivery of the existing primary care strategy, the subsequent arrival of the NHS Long Term Plan (LTP), the focus of neighbourhoods and place-based working provides opportunity to renew the primary care ambition, build on what has already been achieved and continue to address challenges.

KEY MESSAGES:

Greater Manchester aims to provide the best primary care to the population, as well as ensure we have the adaptability and underlying support to continue to do so for many years to come. However, certain things are necessary to achieve this level of sustainability. We need the right number and types of organisations, in the right setting, as well as the right workforce to provide primary care. We need leaders who can work across Primary Care Networks, neighbourhoods, localities and GM to develop systems and local responses fit for both current and future needs. We must also have the infrastructure in place to meet the changing demands of primary care provision as it evolves over time. This includes understanding the environmental impact of everything we do.
The GM primary care strategy and primary care workforce strategy aims to achieve this by expanding the traditional concept of primary care with more focus on digitally enabled, multidisciplinary, integrated preventative support, based in the right place for local populations. This will not only aim to improve the quality of primary care delivery and improved population health outcomes, it will also help to ensure its future sustainability.

PURPOSE OF REPORT

The purpose of this paper is to raise awareness of the refreshed Greater Manchester primary care strategy and primary care workforce strategy. Both strategies describe the renewed ambition for primary care and its contribution to the delivery of Taking charge: The next five years: Our prospectus’.

RECOMMENDATIONS

The Greater Manchester Health and Care Board is asked to:

- Note progress to date
- Agree the refreshed Primary Care Strategy
- Agree the Primary Care Workforce Strategy

CONTACT OFFICERS:

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laura.browse@nhs.net

Angela Osei, Head of Primary Care Transformation, GMHSC Partnership
angela.osei@nhs.net
1.0 INTRODUCTION

1.1. The refreshed primary care strategy aims to deliver the best outcomes for the GM population as well as the workforce. It describes the renewed ambition for primary care and its contribution to the delivery of ‘Taking Charge’, with everyone in Greater Manchester having the opportunity to proactively manage and take more responsibility for their own physical and mental health and wellbeing. This means giving them easily accessible timely access to good quality primary care, seven days a week, in familiar settings close to where they live.

1.2. The NHS Long Term Plan describes how digitally enabled Primary Care Networks (PCNs), will take a proactive approach to managing population health and better identify those that would benefit from more targeted support, including dedicated support to care home residents. It states that fully integrated community-based health care will be provided by multidisciplinary teams including GPs, pharmacists, district nurses, and allied health professionals, working across primary care and hospitals. In Greater Manchester, our ambition exceeds this.

1.3. People and communities in GM will have access to high quality, fully integrated, place-based care and be provided across neighbourhoods of 30-50,000 people. The power of the 67 PCNs will be integral to the design and delivery of these neighbourhoods and will collaborate, as a vital part of their local communities, with general practice, pharmacy, dentistry and optometry operating within a single system.

1.4. With the introduction of new roles working in PCNs, the primary care workforce will be much broader in terms of roles and skills. They will feel recognised and valued, with parity of esteem across organisations and sectors. They will enjoy fulfilling work that provides opportunities for development and career progression.

1.5. Both strategies aim to provide an overarching framework for the whole of primary care (general practice, dentistry, optometry and pharmacy) which is flexible enough to be interpreted at a locality level to meet local needs.

2.0 BACKGROUND

2.1. GM launched its five-year primary care strategy in early 2016 – ‘Delivering integrated care across Greater Manchester: The primary care contribution’ – which outlined how primary care providers and commissioners could collectively work towards achieving the ambition for Greater Manchester.
2.2. The refreshed primary care strategy builds on previous successes, including the roll out of 7-day extended access, training of over 1700 general practice administration and clerical staff, supervised tooth brushing schemes in over 700 early years settings, over 2500 ‘dementia friends’ in community pharmacy and the roll out of enhanced sight tests for people with learning disabilities. These are just a few of the highlights.

2.3. Although we are near the end of the current primary care strategy, it is appropriate to review and reflect on progress in the context of neighbourhoods, place-based working and the publication of the NHS Long Term Plan. This offers a chance to build on what has already been achieved and continue to address the challenges that GM still faces.

2.4. With more responsive primary care, people will experience more joined-up services and have greater involvement in decisions about their care. There will be better access to a wider range of professionals in the community, with different ways of accessing advice and treatment such as digital, telephone and physical services. This place-based approach will redefine services and place individuals, families and communities at the heart.

2.5. The aim is for our GM workforce to experience more satisfying work by concentrating on what they do best – providing high quality health and care to the 2.8m population of Greater Manchester. The outcome of this will be to provide better care for the population and offer the workforce improved work-life balance.

2.6. To make these plans a reality the refreshed primary care and primary care workforce strategies focus on:

- Delivering a neighbourhood, place-based approach, bringing care closer to home
- Supporting personalised care through trusted relationships developed over time
- Improving primary care quality across Greater Manchester, reducing unwarranted variation and supporting better health and wellbeing for everyone
- Making primary care sustainable, to be able to manage both current and future demand

3.0 THE GREATER MANCHESTER PRIMARY CARE STRATEGY AND PRIMARY CARE WORKFORCE STRATEGY

3.1. The refreshed primary care and primary care workforce strategies describe the future for primary care within the context of place-based, neighbourhood working.
3.2. The primary care strategy aims to move away from the traditional approach to health and care, meaning people will be able to access the most appropriate professionals and services locally. This might include physiotherapy, midwifery, district nurses, podiatry, work advisers, social care, or the c15,800 voluntary, community and social enterprise (VCSE) organisations in GM. The primary care workforce strategy aims to tackle the workforce challenges as well as develop a workforce that is fit for the future. New and enhanced roles in primary care, such as pharmacists in General Practice, social prescribing link workers and physician associates, will further ensure that people are always seen by the most appropriate professional, and in the most appropriate setting. Other roles such as community paramedics and first contact physiotherapists provide opportunities for rotational roles across primary, community and secondary care.

3.3. Delivering a Neighbourhood, Place-Based Approach

3.3.1. Both strategies describe the ambition to create a primary care system that understands the relationship between health and the wider determinants of health. This will mean people can access support to identify and address their medical, social and emotional needs in one process, so they receive more timely and appropriate help from the professionals and services best placed to provide it.

Increasingly primary care providers are expanding their services to accommodate the needs of people who would previously have been treated in hospital. Across Greater Manchester, the aim is for primary care to be upskilled to deliver these services. The workforce will be supported to enable them to work with new technologies and innovations while continuing to provide quality services that are accessible to all. New roles, such as the nurse associate, will bring additional capacity and skill mix into primary care. New ways of providing care, such as group consultations, could become a routine model of care for people with long term conditions, and delivered by a much broader range of staff.

3.4. Primary Care Quality

3.4.1. Reducing unwarranted variation and improving quality continues to be a key priority for primary care. Quality means ensuring everyone gets equitable access to consistently high standards of care, with services based on evidence of what benefits patients and delivered in the best way possible by people with the right skills and experience. To keep improving the quality of primary care in Greater Manchester we need to address issues such as inconsistencies in care and health inequalities affecting sections of our population or specific localities and neighbourhoods. For example, improving child and adult mental health, narrowing the gap in life expectancy, and
ensuring parity of esteem with physical health is fundamental to unlocking the power and potential of Greater Manchester communities.

3.5. **Sustainability**

3.5.1. Greater Manchester aims to provide the best primary care to the population as well as ensure they are able to do so for many years to come. To do this we need the right number and types of organisations, in the right setting, as well as the right workforce to provide primary care. We need leaders who can work across Primary Care Networks, neighbourhoods, localities and GM to develop systems and local responses fit for both current and future needs. We must also have the infrastructure in place to meet the changing demands of primary care provision as it evolves over time. This includes understanding the environmental impact of everything we do.

3.5.2. Improving the retention of existing staff will reduce the reliance on new staff or locums to meet increasing demands. Opportunities presented through from ‘Return to Practice’, Retire and Return programmes and International Recruitment will need to be maximised. The workforce will have opportunities to improve their skills which may include rotational working, opportunities to undertake research, mentoring and enabling backfill to undertake training.

4.0 **DEVELOPING THE STRATEGY AND LOCAL ENGAGEMENT**

4.1. An early draft of the primary care strategy was developed by a time limited working group with representation from primary care providers, commissioners, person and community centred approaches and population health.

4.2. Feedback from a range of health and care providers, commissioners and patients and the public was received and included in the strategy. The strategies are aligned to the GM locality plans, the transformation plans for the GM Local Professional Networks, as well as Taking Charge: The Next 5 Years and the NHS Long Term Plan.

4.3. Throughout the engagement process, thinking regarding the strategy has evolved. Through further iterations the strategies reflect the LCOs and PCNs as enablers to the GM neighbourhood model, as well as having greater emphasis on ‘place’ and the opportunities for greater secondary, community and primary care collaboration.

5.0 **IMPLEMENTATION PRIORITIES**

5.1. Across Greater Manchester a range of health and care colleagues attended a workshop to agree how the strategies would be delivered. The group
agreed that a focus on the following would provide the biggest impact while making the best use of limited resources. These include:

- Integrated neighbourhood working
- Digitally enabled primary care
- Improving access to primary care
- Identifying critical gaps in workforce
- New ways of working
- Development and sustainability of the nursing workforce
- Engagement of the temporary workforce (locums)

5.2. The implementation plan details the ‘ask’ of localities and the ‘ask’ of Greater Manchester. Funding, where known, is detailed in the plan. No financial commitments have been made in the strategy or implementation plan on behalf of localities. Where there is a commissioning requirement, this has been detailed in the locality ‘ask’ and will progress through the usual GM governance with no pre-commitments at this point.

5.3. Governance

5.4. Delivery of the primary care strategy will be managed by the GM Primary Care Strategy Implementation Group. The group will report into the Primary Care Provider Board and the Joint Commissioning Board. The Primary Care Workforce Strategy will report through the Primary Care Workforce Core Steering Group, which reports into the Strategic Workforce Collaborative Board.

6.0 RECOMMENDATIONS

6.1. The Greater Manchester Health and Care Board is asked to:

- Note progress to date
- Agree the refreshed Primary Care Strategy
- Agree the Primary Care Workforce Strategy
INTRODUCTION

The ambition for primary care is for people in Greater Manchester to live well and to their full potential, with more people in employment, living healthier lifestyles and with good mental health.

About Greater Manchester
Greater Manchester (GM) has many strengths as well as many challenges. With around 2.8 million people living in Greater Manchester, the population grew by over 170,000 in the last decade. However, there is a £7 million gap between public spend and tax income. Around 65,000 people are out of work, which includes a quarter of 16-19 year olds. Currently the average life expectancy of men and women in Greater Manchester is lower than the England average. Around 441,000 of Greater Manchester residents are aged 65 and over. That figure grew by over 50,000 in the last 25 years. 268 people are rough sleeping in Greater Manchester, with another 18,000 at risk of becoming homeless.

Across Greater Manchester we have 10 local authorities, 15 NHS trusts, a GM police service, a GM fire and rescue service, 10 Clinical Commissioning Groups, over 15,000 voluntary, community and social enterprise organisations and over 2000 points of primary care delivery (including general practice, community pharmacy, community optometry and general dental services). As the first city region with health devolution, we are able to remake the connection between health and other public services that has been lost over the years.
DELIVERING A TRANSFORMED PRIMARY CARE

There is still significant work to do. Although we are part way through the delivery of the existing primary care strategy, the NHS Long Term Plan, the focus of neighbourhoods and place-based working provides opportunity to renew the primary care ambition, build on what has already been achieved and continue to address challenges.

Across Greater Manchester we need the right number and types of organisations, in the right setting, as well as the right workforce to provide primary care. We need leaders who can work across Primary Care Networks (PCNs), neighbourhoods, localities and GM to develop systems and local responses fit for both current and future needs. We must also have the infrastructure in place to meet the changing demands of primary care provision as it evolves over time. This includes understanding the environmental impact of everything we do.

Primary care will be more responsive to people’s needs meaning people will experience more joined-up services and have greater involvement in decisions about their care. There will be better access to a wider range of professionals in the community, with different ways of accessing advice and treatment such as digital, telephone and physical services.

The GM primary care strategy and primary care workforce strategy provide an opportunity to redefine what we mean by primary care. Moving away from the traditional approach will enable people to access the most appropriate professional or service directly. This might include physiotherapy, work advisors, social care as well as the voluntary, community and social enterprise (VCSE) organisations. New and enhanced roles such as social prescribing link workers and community paramedics will help make sure people are always seen by the most appropriate person, in the most appropriate setting.

The primary care workforce in Greater Manchester will be able to concentrate on what they do best i.e. to provide high quality and accessible care for patients. This will provide not just better care for the population but offer the workforce more satisfying work and improve their work-life balance.

To make these plans a reality, our new strategies focus on:

- Developing a model of primary care based on a neighbourhood approach to provide care closer to home
- Supporting personalised care through trusted relationships developed over time
- Improving primary care quality across Greater Manchester, reducing unwarranted variation and supporting better health and wellbeing for everyone
- Making our system sustainable, so primary care provision can manage both current and future demand
Implementation Priorities

Across Greater Manchester a range of health and care colleagues came together to agree how the primary care strategy would be delivered. Together the group agreed that a focus on the following priorities would provide the biggest impact and make the best use of limited resources:

**Integrated neighbourhood working** – including the development of PCNs and primary care, estates and infrastructure, communications and engagement, organisational development and leadership

**Digitally enabled primary care** – including the roll out of online and video consultations and digital access to services

**Improving access to primary care** – including urgent and emergency care and access to routine care

**Identifying critical gaps workforce** – including collecting the right workforce information and planning across the whole of primary care

**New ways of working** – including development of new roles in primary care, employment models, blended roles and rotational working

**Development and sustainability of the nursing workforce** – including recruitment and retention, flexible employment models for both general practice and dental nurses

**Engagement of our temporary workforce** – including a review of the use of locums across all disciplines and roles, engagement and development

**Delivering the strategy**

Delivery of the primary care strategy will be managed by the GM Primary Care Strategy Implementation Group. The group will report into the Primary Care Provider Board and the Joint Commissioning Board. The Primary Care Workforce Strategy will report through the Primary Care Workforce Core Steering Group, which reports into the Strategic Workforce Collaborative Board.

Implementing the vision for primary care means people will be able to access a greater range of health services locally, including specialist consultation, diagnostics, urgent care and non-medical care. We will have a digitally-led primary care service developed as part of the refreshed strategy. The Greater Manchester primary care workforce will experience greater resilience and improved work-life balance. Across Greater Manchester there will be a wider range of services delivered in the community.
GET IN TOUCH

England.primarycaretransformation@nhs.net
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GREATER MANCHESTER PRIMARY CARE STRATEGY

2019 - 2024
CONTENTS

CONTENTS ................................................................. 2
OUR VISION FOR PRIMARY CARE .................. 3
INTRODUCTION ......................................................... 4
OUR MODEL OF CARE .............................................. 9
IMPROVING QUALITY ............................................. 22
SUSTAINABLE PRIMARY CARE ......................... 28
HOW WE WILL DELIVER THE STRATEGY .... 33
OUR VISION FOR PRIMARY CARE

Across Greater Manchester (GM) we aim to deliver the fastest and greatest improvement in the health and wellbeing of our whole population, creating a strong, safe and sustainable health and care system that is fit for the future.

This five-year primary care strategy aims to expand the traditional concept of primary care to create a much wider integrated health system to achieve the broader, long-term vision for Greater Manchester. This will improve the health and wellbeing of Greater Manchester residents and contribute to the further economic viability of the region. The traditional model of primary care will evolve, with more focus on digitally enabled, multidisciplinary, integrated and preventative support, based in the right place for local populations. This will not only improve the quality of primary care delivery and improved population health outcomes, it will also ensure its future sustainability.

The NHS Long Term Plan describes how digitally enabled, Primary Care Networks (PCNs) will take a proactive approach to managing population health and better identify those that would benefit from more targeted support, including dedicated support to care home residents. It states that fully Integrated community-based health care will be provided by multidisciplinary teams including GPs, pharmacists, district nurses, and other health professionals who work directly with patients, working across primary care and hospitals.

In Greater Manchester, our ambition exceeds this.

Our people and communities will have access to high quality, fully integrated, place-based care, provided across established neighbourhoods of 30-50,000 people. The power of our 67 Primary Care Networks (PCNs) will be integral to the design and delivery of these and will collaborate, as a vital part of their local communities, with general practice, pharmacy, dentistry and optometry operating as a single system. Multidisciplinary working will be commonplace, with strong relationships and seamless care across primary, community and secondary care, Local Care Organisations and the Voluntary, Community and Social Enterprise (VCSE) sector.

People will be able to take more responsibility for and proactively manage their own physical and mental wellbeing, supported by their local community, the VCSE sector and a broad range of health and care professionals. Our aim is for people in Greater Manchester to live well and to their full potential, with more people in employment, living healthier lifestyles and with good mental health.

The primary care workforce will be much broader in terms of roles and skills. They will feel recognised and valued, with parity of esteem across organisations and sectors. They will enjoy fulfilling work that provides opportunities for development and career progression.

This primary care strategy signals a renewed focus on integrated delivery across neighbourhoods, population health and working at scale, while making the best use of the collective skills in primary care and the community to meet current challenges and maximise the opportunities to improve people’s healthy life outcomes. It is about people and places, not organisations and boundaries.
INTRODUCTION

On 1 April 2016 Greater Manchester became the first region in the country to have devolved control over integrated health and social care budgets, a sum of more than £6bn. A year later, Greater Manchester elected a mayor and received extra powers to make decisions locally to tackle the broader problems that affect people’s health and everyday life.

Greater Manchester Context

With around 2.8 million people living in Greater Manchester, the population grew by over 170,000 in the last decade. Around 65,000 people are out of work, which includes a quarter of 16-19 year olds. Currently the life expectancy of men and women in Greater Manchester is below the England average. Around 441,000 of Greater Manchester residents are aged 65 and over. That figure grew by over 50,000 in the last 25 years. 268 people are rough sleeping in Greater Manchester, with another 18,000 at risk of becoming homeless. We are making big changes to ensure the right health and social care is in the right places, and that people are getting the support they need, when they need it. These changes have already begun to make things better, although there is still much more to do.

Across Greater Manchester we have 10 local authorities, 15 NHS trusts, a GM police service, a GM fire and rescue service, 10 Clinical Commissioning Groups, over 15,000 voluntary, community and social enterprise organisations and over 2000 points of primary care delivery (including general practice, community pharmacy, community optometry and general dental services). As the only city region with health devolution, we are able to remake the connection between health and other public services that has been lost over the years.

The basis for change

Because devolution means decisions are now made right here, in Greater Manchester, we can do something about the issues that affect all 2.8 million of us – such as helping children have the best start in life, improving our physical and mental health and helping us stay well for as long as possible. Primary care has a major role to play in this.

The Greater Manchester plan for devolution reflect a clear and distinct philosophy – that the NHS is part of a system of population health, accountable to the people through the framework of local democracy. Devolution continues to offer the unique opportunity to take charge and do things differently to meet local people’s needs.

‘Taking Charge of our Health and Social Care in Greater Manchester’\(^1\) (2015). Described primary care as the driving force behind a new approach focused on predicting and preventing ill health, and at the heart of new models of care that enable this approach to be embedded in all 10 Greater Manchester localities.

The Greater Manchester five-year primary care strategy was launched in early 2016 – ‘Delivering integrated care across Greater Manchester: The primary care contribution’ – outlined how providers and commissioners could collectively work towards achieving the Greater Manchester ambition. This plan refreshes that strategy.

**What we have achieved already**

We want to build on what has been achieved in line with our earlier primary care strategy. The three areas of focus in this updated version expand on many of the successes outlined below.

£41.2m of the Greater Manchester Transformation Fund has been invested in general practice, over four years, to deliver the Primary Care Reform Programme – the Greater Manchester response to the GP Forward View. Primary care will continue to drive forward this ambitious programme as a system to support general practice and facilitate transformational change.

People can now access general practice for routine appointment as well as urgent contact any day of the week, with all Greater Manchester localities offering full population coverage during evening and weekends. This means general practice is providing 1,500 hours of time from GPs, nurses, Health Care Assistants and Pharmacists during evenings and weekends. This also means there is greater scope to provide a variety of services outside of traditional daytime hours.

It is also easier for people to see a pharmacist, either in their community or in general practice. There are over 700 community pharmacies across Greater Manchester, with the majority open during weekends and many open from 6am until midnight. There are now over 100 pharmacists working as part of general practice teams, providing direct patient care for both acute and long-term conditions with a particular emphasis on supporting patients to get the best outcomes from their medicines. This makes pharmacists a very accessible community asset.

Over 700 Early Years settings in four targeted localities have joined in the supervised tooth brushing scheme that forms a key part of our oral health transformation programme for under-fives in Greater Manchester. The ambition is to achieve this across the whole of Greater Manchester.

Nearly 99% of community pharmacies have trained patient-facing staff to be ‘dementia friendly’. This is an estimated 2500 dementia friends in community pharmacies. A similar programme has commenced in dental practices, with further plans to roll out to optical practices. This has contributed to Greater Manchester being officially recognised as an ‘age-friendly’ city-region (the first in the UK). It is our ambition for all primary care providers to be ‘dementia friendly’ by 2021.

So far, 5,000 primary care professionals have been trained as part of the Pride in Practice (PiP) quality assurance service that supports primary care providers to strengthen relationships with the lesbian, gay, bisexual and transgender (LGBT) community. As a result, according to the 2018 NHS GP Patient survey, 100% of transgender patients at PiP-accredited general practices felt their GP was supportive of their gender identity and medical transition. All

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3 Pride in Practice https://lgbtfoundation/prideinpractice
2000 primary care providers will have achieved Pride in Practice status by 2022.

Across Greater Manchester we have rolled out enhanced sight tests for people with learning disabilities. This means that accredited community optical practices can offer longer or split appointments and people with learning disabilities know where they can go and get onward referral and treatment if needed.

Administrative and clerical staff at Greater Manchester general practices are better prepared to actively signpost people to appropriate services and manage clinical correspondence, with over 1,700 of them having received specialist training. Care navigation and active signposting services are increasing the use of services out in the community, reducing GP waiting times and aiming to ensure people receive the appropriate care in the right place at the right time.

Primary care providers are doing more to deliver holistic messages and advice. The ‘Healthy Living’ programme recognises the valuable role that providers can play in supporting people to live healthier lives and in promoting health and wellbeing. Already 95% of community pharmacies in Greater Manchester are ‘Healthy Living’ pharmacies. The Healthy Living Framework has also been developed for optical and dental practices with the roll out commencing during 2019 and fully embedded by 2022.

Across Greater Manchester we are actively promoting primary care to new recruits through initiatives such as the first Greater Manchester-wide primary care careers event, which was attended by more than 200 school and college aged young people.

Our GP Excellence Programme, in partnership with the Royal College of General Practitioners (RCGP), is supporting general practice in important areas such as rescue, resilience, improvement and excellence. So far this has included helping GP practices with their Care Quality Commission (CQC) compliance, delivering organisational resilience, development and GP management training and courses on ‘working at scale’. At least 160 practice managers are being supported in management development and education through diploma courses. Our ambition is to expand GP Excellence to all primary care providers by 2020.

The Greater Manchester Health Care Academy has been established to provide training and support to Community Pharmacists and their wider teams, to ensure that the workforce going forward is fit for purpose, its potential maximised, and staff are developed and supported to meet the needs of the population. Although developed for community pharmacies, there is scope to extend this model to all primary care.

These achievements show that Greater Manchester is on the right track. So does the ‘NHS Long Term Plan’ (LTP), published by NHS England in January 2019, which echoes the Greater Manchester ambition to do things differently. It focuses on prevention and health inequalities, supporting the workforce and making better use of data and technology. It also places primary care at the centre, setting out an ambition to give everyone the best start in life, provide world-class care for major health problems and support people to age well.

The national plan also highlights some specific areas where the Greater Manchester approach is proving successful, such as our stop-smoking services and lung health checks in community settings.

**Responding to fresh opportunities**

Although we are already seeing a difference in Greater Manchester’s primary care provision, we cannot stand still. The LTP, wider shifts in
The local landscape and ambitions will have an impact, including creating fresh opportunities for primary care to improve our population’s health and wellbeing. This is why we have reviewed and updated our primary care strategy.

In early 2019 the original strategic plan was refreshed and updated. ‘Taking charge: The next five years: Our prospectus’ sets out the next steps to improve people’s health, create a sustainable health and care system and help achieve the region’s economic potential. Specific elements of this new plan include rethinking how primary care services are commissioned, transferring more planned treatment to primary care and community settings, and introducing multidisciplinary teams as part of primary care networks to support people with conditions such as heart failure and respiratory disease.

This latest plan will be closely aligned to the new Greater Manchester model of unified public services (known as the ‘GM Model’). This aims to bring all public services closer together, integrating their response to people’s individual needs so that we can address wider health determinants such as housing, employment, policing and transport. We want to work in partnership to build on the principles of early intervention and prevention and take a more proactive approach that supports people to become healthier, resilient and empowered, and able to achieve their full potential.

The GM Model is also about transforming how information is used, empowering the frontline workforce to make more informed decisions about how and when they work with individuals and families, and deliver the appropriate services at the right time.

At the heart of all these plans, including how they relate to primary care provision, is the place-based integrated care approach, built around our ‘neighbourhood model’ that focuses on delivering services that meet the particular needs of local populations of 30-50,000 people.

**The big health challenges we face**

Although we have made significant steps already, there are still big challenges to address to improve our population’s health.

One is poor oral health, which can be a barometer for wider health issues. It has an impact on language development and school readiness in children, diabetes control in adults, and respiratory conditions in older adults. Seven of the 10 Greater Manchester localities are among the top 30 in England with the highest levels of dental decay in five-year-olds. We want everyone to enjoy good oral health, be able to speak and socialise without pain or discomfort, and to be able to easily access the dental care they need.

Although Greater Manchester has one of the fastest growing economies in the country, people here die younger than in other parts of England. Cardiovascular, respiratory illnesses and cancer contribute to this shortened life expectancy. The good news is that treatments are improving, and figures suggest there will be a 29% increase in the proportion of people aged over 65 in Greater Manchester by 2032 and the number of over-85s is expected to double. However, this could potentially increase our population’s need for more complex care.

Over 1 million of our residents live in areas among the 20% most deprived in England. Around one in three children each year start school not ready to learn and around 150,000 people are out of work due to health reasons.

The complexity of the challenges our communities face, combined with significant pressures on resources mean Greater Manchester cannot respond with the same thinking and same ways of working as we have always done.
The continuing contribution of primary care

There is still significant work to do. Although we are part way through the delivery of the existing primary care strategy, the LTP, the focus of neighbourhoods and place-based working provides opportunity to renew the primary care ambition, build on what has already been achieved and continue to address challenges.

Primary care will be more responsive to what people need, whether they require urgent care, have a long-term condition or complex needs requiring a focused package of care and support. People will experience more joined-up services and have greater involvement in decisions about their care. There will be better access to a wider range of professionals in the community, with different ways of accessing advice and treatment such as digital, telephone and physical services.

By removing silos of provision, health and care professionals will be able to work together with local communities to deliver changes to people’s life outcomes rather than services or programmes. This will also enable care and information to flow seamlessly across Greater Manchester. With an increased focus on prevention people will be able to take charge of their own health, enabling them to stay well for longer.

Collaboration in primary care will include sharing buildings, resources and expertise. This will help teams provide continuity of care between patients, their carers and their families in a resilient way, and share accountability.

This refreshed strategy provides the opportunity to redefine what we mean by primary care in the context of place-based systems. A move away from the traditional approach will enable people to access the most appropriate professional and service directly. This might include physiotherapy, midwifery, podiatry, work advisers or social care, as well as voluntary, community and social enterprise (VCSE) organisations. New and enhanced roles in primary care, such as pharmacists in General Practice, social prescribing link workers and physician associates, will further ensure that people are always seen by the most appropriate professional, and in the most appropriate setting.

The primary care workforce in Greater Manchester will be able to concentrate on what they do best i.e. to provide high quality and accessible care for patients. This will provide not just better care for our population but offer our workforce more satisfying work and improve their work-life balance.

To make these plans a reality, our new strategy focuses on:

- Developing a model of primary care based on a neighbourhood approach to provide care closer to home
- Supporting personalised care through trusted relationships developed over time
- Improving primary care quality across Greater Manchester, reducing unwarranted variation and supporting better health and wellbeing for everyone
- Making our system sustainable, so primary care provision can manage both current and future demand.

This strategy has been co-produced via a task and finish group including primary care commissioners and providers, population health and person and community centred approaches. It incorporates views of a range of stakeholders including patients and the public, providers of primary care, commissioners, local care organisations, the VCSE sector and acute trusts.
OUR MODEL OF CARE

Although access in the community is improving, too many of our residents are being treated in hospital when their needs could be better met elsewhere. 90% of health and wellbeing is determined by factors such as housing, income, education, relationships and behaviours. Care between teams is often not joined up effectively and is not always of a consistent quality.

In Greater Manchester we want to create a system that understands the relationship between health and the wider determinants of health. This will mean people can access support to identify and address their medical, social and emotional needs in one process, so they receive more timely and appropriate help from the professionals and services best placed to provide it. Primary care will embrace the opportunities for the VCSE sector to be partners in the delivery of health and wellbeing.

Thinking locally

Greater Manchester is working hard to break down the silos which exist between public services that can lead to isolated decision making and a narrow focus to service delivery. Services working more closely will reduce the number of people being passed from team to team without truly understanding what people and communities need.

As a devolved region, the Greater Manchester strategy goes beyond the improvement of NHS services. The vision is for a far-reaching improvement in our populations' health and wellbeing.

Our ‘place’ or neighbourhood approach recognises that people’s health, wellbeing and ability to live independently starts with living well day to day, supported by their families and wider community. So, we need to use and build on the strengths and resources (or ‘assets’) available to them. Greater Manchester will take a local approach to care, knowing that people want care as close to home as possible.

If people are supported to live well in their community, connected to family, friends and activities in an environment in which they feel safe and included, they are more likely to sustain a good quality of life and less likely to see a deterioration in their health and independence.

We aim to:

- Extend the original concept of integrated health and social care to recognise the important role of family, community and place in promoting the health and wellbeing of our population
- Develop good relationships between integrated neighbourhood teams, primary care, local care organisations and hospital teams to provide seamless care
- Improve and strengthen the links between general practice, community pharmacy, general dentistry and optometry, making best use of all of these professional groups

Each of Greater Manchester’s 10 localities now has an established Local Care Organisation (LCO) driving the integration of service provision, based on neighbourhoods of 30-50,000 people. LCOs aim to improve the health of local people, working as one team across traditional organisational boundaries. The
The formation of LCOs and neighbourhoods will enable conditions to be managed at home and in the community, provide alternatives to A&E, support effective discharge from hospital and help people to return home and stay well. General practice is central in LCO provision, coordinating much of the neighbourhood delivery. Practically, this means health and care teams (e.g. district nurses, social care and primary care) are co-located, working in integrated teams taking a joint approach to care.

LCOs are built on neighbourhoods, and it is through these neighbourhoods that health and care will connect with the full range of public services in Greater Manchester and the voluntary, community and social enterprise (VCSE) sector. For example, at a neighbourhood level dental practices could work more closely with local schools, pharmacies and care homes to achieve good oral health and facilitate access to dental care, particularly for children and vulnerable older people.

Primary care is ideally placed to help develop a truly community-based approach. It will mean aligning with the other local public services, such as housing and the police, to address the wider social determinants of physical and mental health. Neighbourhood working will retain the very best of how primary care operates, while finding improved ways to deliver care locally that can benefit residents, clinicians and primary care teams. Many people choose to access dental, pharmacy and optical services close to work or leisure. The neighbourhood model will reflect how people access health and care, ensuring that people can access care in the right place for them regardless of geographical boundaries. The neighbourhood approach will help ensure that teams work together around the needs of local people.

The three Greater Manchester Local Professional Networks (dental, eye health and pharmacy) are starting to work collaboratively to support the development of an integrated place-based system.

Primary Care Networks

Since 1 July 2019, GP practices across England have come together to form Primary Care Networks (PCNs). These PCNs are based on GP-registered lists, typically serving natural communities of around 30-50,000 – as described in our Greater Manchester neighbourhood model, they are small enough to provide the personal care valued by both patients and GPs, but large enough to have impact and economies of scale through better collaboration between practices and others in the local health and social care system. There are 67 newly formed Primary Care Networks across Greater Manchester.

These networks support groups of practices to come together locally, in partnership with community services, social care and other providers of health and care services. PCNs are intended to create more integrated services for the local population, improve quality of care and support the sustainability of general practice. Network agreements will enable PCNs to work more closely with community pharmacy, dentistry and community optometry.

We aim to:

- Support the development of Primary Care Networks as part of the GM neighbourhood model
- Facilitate the delivery of the national Primary Care Network Directed Enhanced Service alongside the GM commissioning-led model
- Work with commissioners and providers to develop shared outcomes and aligned incentives
- Use the opportunity devolution gives GM to go further and faster with wider primary care to deliver truly integrated care
Greater Manchester will embrace the evolution of PCNs, as an integral part of the GM model of integrated neighbourhood working. PCNs and the neighbourhood model present opportunities for integration with all of primary care and public sector services to create ‘one public service’. They also present opportunities for our workforce to operate differently – such as GPs, pharmacists and nurses working in rotating roles across general practice, community settings and the acute sector.

The NHS Long Term Plan highlights a number of key areas where PCNs can make a difference such as embedding new and enhanced roles, delivering additional access, improved crisis response and support to care homes.

The increased capacity and resource brought by the establishment of the PCNs will enable more personalised care, longer consultations and support early diagnosis. It is important to note that although PCNs are a national construct, each PCN and surrounding neighbourhood is individual and will need to develop models of care specific to their local needs. As the PCNs become more established they will be able to bring in specialists, for example paediatric consultants or drugs and alcohol workers, on a subcontracting arrangement to tackle the specific health inequalities in their local neighbourhood.

Greater Manchester will deliver the national ‘ask’ of PCNs as a minimum. However, our neighbourhoods will deliver a much wider vision in order to tackle the true determinants of health. Local Care Organisations, working closely with community services, Primary Care Networks, community pharmacy, general dentistry and optometry, are critical enablers to the delivery of the Greater Manchester neighbourhood model.

PCNs will be able to access national development resource to support the establishment of PCNs, organisational development support, change management, quality and culture, leadership development, population health, collaborative working and asset-based approaches. We will work with emerging leaders from community pharmacy, optometry and dentistry to develop similar support.

**Continuity of care**

Our neighbourhood model of care will ensure patients receive continuity of care. This covers both continuity in their relationships with providers through ongoing, holistic and trusted person-centred care, and continuity in how their care is managed, underpinned by effective information sharing and care planning across providers. Our multi-professional teams, enabled by technology, will work together across organisational boundaries to deliver care.

**We aim to:**

- Facilitate the sharing of patient owned records across providers who are providing direct care
- Enable the roll out of group consultations as a routine model for supporting people with long-term conditions

Greater Manchester has gained Local Health and Care Record Exemplar (LHCRE) status as part of its progress towards truly integrated care records. This will enable frontline staff to share a person’s health and care information safely and securely as someone moves between different parts of system.

Each professional involved in providing care will have the appropriate access to shared records. Providers will share data as necessary to improve the direct care people receive. People will be made aware of what information sharing means and give them choices about how their data is used.
Continuity of care becomes increasingly important as people age, develop multiple conditions, complex problems or become socially or psychologically vulnerable.

To support real continuity of care we want to make every contact someone has with public services count. Each contact a person makes is a potential opportunity for small conversations or interventions to inspire healthier, happier lifestyles. This means ensuring all our staff are able to understand the needs of the people they come into contact with, and to signpost them to the most appropriate service(s) for their specific needs.

**Group Consultations – supporting people with long term conditions**

Greater Manchester General Practice Nurses were among the first in the country to trial group consultations, these are an alternative way to deliver planned clinical care to people with long-term conditions that supports continuity and consistency of care and benefits both patients and professionals.

In the future Group Consultations could be the routine model for supporting people with long term conditions across primary care networks and neighbourhoods. It is our ambition to expand the workforce that delivers group consultations, so that these consultations can be delivered by a range of roles, including pharmacists and community paramedics.

In group consultations, clinicians can see up to 10 patients at a time in a supportive group setting, usually in one 40-60 minute session. Working this way not only doubles nurses’ capacity to deliver high-quality care, it systemises proactive follow-up care and is an opportunity to integrate primary care specialist and community services.

The approach gives patients more time to discuss their concerns, and eases the pressure on nurses, which helps with their own wellbeing. We hope this will support better retention among the practice nursing and wider workforce.

**Leigh Warblers**

There is a high prevalence of chronic obstructive pulmonary disease (COPD) in Leigh. The lead Practice Nurse in the area tested a model of ‘group-based consultations’ with the aim of empowering people to manage their long-term conditions and provide connections to wider support. Leigh Warblers, a singing group for people with breathing difficulties, was established with support from Wigan Council’s Community Investment Fund.

The fortnightly sessions led by a practice nurse and a breathing leader accredited through the British Lung Foundation was established. The sessions cover a variety of breathing exercises and songs designed to be enjoyable and stimulating and help with symptoms the people may be experiencing. The sessions provide a new approach to self-management through an asset-based approach, connecting individuals to wider community activities and support as well as sharing skills and expertise across Leigh GP practices.

**Digitally enabled primary care**

Digital technology is a part of our everyday lives, improving the way we socialise, shop and work. It also has the potential to transform the way we deliver health and care services. We will deliver consistent digital and online services to the population of Greater Manchester. People will be able to choose how they access services. Online services will help people to manage their health and wellbeing needs, backed up by face-to-face care when needed. We will develop digital solutions to promote healthy living and self-management.
We aim to:

• Support the workforce to embrace and utilise new technologies

• Roll out full population coverage of online consultations by April 2020 and video consultations by April 2021

• Improve utilisation of digital apps for transactional services such as appointment booking and repeat prescriptions

• Ensure Graphnet is integrated into all organisation electronic patient records with a single sign in by 2020

• Encourage people to access their personal health and care record

• Facilitate seamless care across primary, community and secondary care, enabled by technology

We want to go further, faster – providing online as well as face-to-face services via a computer or smartphone. Increased use of technology will promote wellness and encourage people to attend appointments and adhere to their medication. Technology will also be able to remind people to undertake routine appointments for screening and vaccinations such as flu or shingles. It will encourage people to keep moving throughout the day, offer health advice through push notifications and be key in supporting people to self-care.

Embracing digital technology will require a culture change for patients and our workforce. We will support our workforce to enable them to work with new technologies and innovations while continuing to provide quality services that are accessible to all. Digitally enabling primary care will free up frontline staff to focus on providing care navigation and active signposting.

Greater Manchester will continue to embed online consultations as part of the Greater Manchester Primary Care Reform Programme and support the roll out of video consultations. Most practices in Greater Manchester are already connected to the new NHS App, and we will help them to encourage people to use it to book and manage appointments, order repeat prescriptions, view their own care record and choose how their data is used. The NHS App also enables people to check their symptoms, offers advice, signposts them to urgent care and connect to professionals, including through telephone consultations and the roll out of video consultations. People using the NHS app (or similar apps) will be directed to the most convenient service for them. It also has the potential to be the ‘front door’ to a Greater Manchester primary care digital offer.

Community pharmacy now has access to the Summary Care Record, which has begun to bridge the gap between data sharing and the transfer of information. Greater Manchester will encourage the uptake of the electronic repeat dispensing service to improve practice workload and flow through community pharmacies.

By providing health and care teams with the right technology we will support them to complete administrative tasks more efficiently, freeing up time to spend with patients.

When asked about data sharing across public services, 79% of people thought that GP records being shared with hospital doctors when a patient is being admitted in an emergency was always acceptable.

Giving people easy access to their own records can be very empowering. More informed and engaged people tend to manage their health more effectively and get involved in joint decision-making about their care.

Proactive not reactive

A shift from reactively providing appointments to patients to proactively caring for people and communities is a major aspect of the vision for primary care. This means doing much more to
prevent ill health, diagnose it early and treat it quickly.

In particular, a priority will be to identify and address potentially serious conditions before they worsen. In Greater Manchester there are 356 premature cardiovascular disease (CVD) deaths each year. Greater Manchester spends £11.2m more on non-elective admissions associated with circulatory conditions compared to 10 similar clinical commissioning groups (CCGs). There are opportunities for dentists, optometrists and pharmacists to expand their contribution to the prevention agenda.

Prevention and early detection

Primary care providers play a very important role in prevention and early detection. Community pharmacy and GP practices already deliver many prevention services like flu immunisation and cancer screening programmes. Regular eye or dental checks can identify the initial indications of some health conditions such as diabetes, high blood pressure and cancer. The advice and support of pharmacists can help people at higher risk to self-care or better manage medicines to protect themselves. This could be extended to community pharmacist non-medical prescribers managing some stable long-term conditions in the community.

We aim to:

• Encourage peer support to enable people to manage their own long-term conditions

• Align our primary care health campaigns to the outcomes of the GM Population Health Plan

In Salford, Community Pharmacies have actively been managing care plans for people with long term and/or complex conditions. Being available without an appointment, being a familiar face and utilising their expertise around healthy living has proved to be a hugely beneficial service, actively improving the lifestyle of patients and their experience of the system. Going forward this could be expanded to other localities across Greater Manchester.

'Healthy Living' primary care providers will continue to proactively support and promote behaviour change across Greater Manchester to prevent ill health. They actively engage the local population in health campaigns aligned to the GM Population Health Plan and providing brief interventions on various topics such as oral health, obesity, cancer screening and smoking. The 2018 Oral Health Campaign took place during National Smile Month, with nearly 1000 interventions taking place within community pharmacies.

Dental disease costs Greater Manchester £220m annually, even though much of it is preventable. Every year around 3,438 children locally have to go into hospital to have teeth removed, which costs around £3.4m.

We will build on the success of our programme to prevent poor oral health among children under five by increasing coverage and uptake. As part of our supervised brushing scheme, children in Early Years settings and schools get help to clean their teeth with a fluoride toothbrush and toothpaste, developing good oral health habits that can continue at home.

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Health visitors provide oral health packs and advice to parents and carers, including important messages about weaning, healthy eating, cleaning teeth with fluoride toothpaste and visiting a dentist.

**Targeting those at risk**

Finding people who already have, or who are at risk of developing, disease and then successfully managing their condition(s) is crucial to prevent illnesses across Greater Manchester and to reduce mortality, morbidity and inequalities in health.

Prevention and early detection programmes are more effective when delivered at scale and with some targeted elements. So, there will be a targeted offer that will invite those at most risk for a face-to-face health check, in a range of settings and support those at less risk with advice and signposting to appropriate services.

**We aim to:**

- Increase early identification of a range of conditions through improving the uptake to the NHS health check
- Work with commissioners, providers and the VCSE sector to implement the GM Community Sight Loss Framework

The free NHS Health Check, offered to adults aged 40-74, is designed to spot the early signs of stroke, kidney disease, heart disease, type 2 diabetes and dementia. Unfortunately, around half of those invited for an NHS Health Check do not attend, and about 594,000 eligible adults in Greater Manchester have never had one.

Better use of data will help us actively find the thousands of local people with an as yet undiagnosed condition. Integrated patient information will make it easier to identify those with patterns of symptoms, or at particularly high risk of developing conditions, who will benefit from follow-up, lifestyle intervention or screening.

It is established that over 75,000 people in Greater Manchester are living with sight loss, with the number expected to rise to over 100,000 by 2030. Providing easily accessible and local provision of eye care giving early detection and treatment is paramount. As described in the Greater Manchester Community Sight Loss Framework, with intervention and support at the right time and with good services in place, the impact of sight loss can be lessened and managed effectively.

**Communities of interest**

'Communities of interest' describe groups of people who share an identity e.g. ethnicity or those that share an experience e.g. homelessness. People can identify with each other in a range of experiences such as values, social class, gender etc. In order for local providers of health and care to really engage with their residents. They need to understand how personal identities can influence behaviour.

**We aim to:**

- Develop communications and engagement strategies that better target communities of interest
- Create opportunities for peer support and social networking

Communications and engagement based solely on geographical neighbourhoods may not be meaningful for everyone. Not thinking of people in terms of where they live but through their 'communities of interest' can provide much richer engagement and encourage greater participation in local life. Communities of interest are able to support each other to do things better, quicker and more effective than if they worked alone.

**Encouraging self-care**
We want to encourage and enable everyone in Greater Manchester to take greater control of their own health and wellbeing.

Our ambition is to develop a whole-system approach to self-care that can be adopted across all 10 localities. This may entail changes in commissioning, organisational and clinical processes, workforce development and the support provided to individuals and communities. Greater Manchester is already committed to developing place-based integrated commissioning arrangements that enable community-based integrated health and care provision, particularly focused on the neighbourhood model. We want the people of Greater Manchester to feel empowered and experts in their own care.

More people will be able to design their own support, using integrated personal budgets – where their needs are more complex or round the clock – to ensure they are tailored to the individual.

Health and wellbeing support

The Healthy Living programme recognises the valuable role that primary care can play in self-care and supporting people to live healthy lives. Our framework is designed to meet local needs, improve the health and wellbeing of the local population, and help to reduce health inequalities. It will help to create a primary care system that more proactively supports people and communities to take charge of, and responsibility for, managing their own health and wellbeing, whether they are well or ill.

We aim to:

- Provide full population coverage of the Healthy Living programme across primary care

All Healthy Living practices have specially trained ‘health champions’. They are immediately identifiable and can provide people with health and wellbeing advice as well as signposting them to other community services.

We will continue to develop the role of Healthy Living champions across primary care, giving our non-clinical workforce additional skills in offering brief advice and interventions on a range of population health topics such as smoking and weight management.

The Healthy Living Framework is at the core of the Greater Manchester Health Care Academy. The Academy has also worked collaboratively with dental and optometry in this area and will be a key enabler in providing an environment for all primary care colleagues to interact and develop alongside one another and support integrated service delivery models going forward.

Helping People Lead Healthier Lives

Primary Care Health Champions have completed special training and are skilled at advising people on health and wellbeing.

Anne-Marie and Sharon, from Centre Pharmacy in Cheadle Hulme, are two of the Health Champions making a huge difference to people’s lives through their Healthy Living Pharmacy work. “One man said he’d had a bowel cancer screening kit in the post but didn’t fancy using it,” says Anne-Marie. “I explained it was free, only took two seconds and that I’d definitely do it if I got one because it could save my life. I convinced him and he went home and did it.”

“We don’t lecture people or tell them what to do,” Anne-Marie explains. “Most of us know we need to eat healthier or lose a bit of weight, but it’s not always easy to make a change. Our role is to listen to people and offer advice and information that will help them live a healthier, happier life.”
**Person and community centred approaches**

The Greater Manchester approach to care delivery is both person and community-centred. It allows the use of wider community assets, engage local people in non-traditional ways and settings, and adopt peer support and other techniques.

Across primary care we are developing health solutions that are much more than medicine and involve connecting people to non-medical care, support, information, advice and activities in the community. We want to see the consideration of issues that affect people’s health, such as employment, fuel poverty and social isolation, become as embedded in primary care provision as writing a prescription or making a referral to secondary care.

This asset-based approach recognises and builds on the strengths of our Greater Manchester communities and will also help develop and sustain a strong and vibrant local VCSE sector. It is noted that a clear commissioning and investment strategy will be necessary so that VCSE groups and organisations have the capacity to provide the support local people need.

**We aim to:**

- Make it easier for people to access non-clinical support that gives them the skills, knowledge and confidence to improve their health and wellbeing
- Train our health professionals to enable the provision of different types of primary care consultation, covering aspects of care such as health coaching and shared decision making.
- Develop relationships with the Voluntary, Community and Social Enterprise sector – making them partners in improving the health and wellbeing of our communities

Plans include expanding the primary care workforce to include health trainers and social prescribing link workers and developing the role of health champions through the Healthy Living Programme. This will provide a wider range of support for people in their own communities.

Social prescribing, for example, aims to provide support for all aspects of people’s emotional, social and physical wellbeing by connecting people with non-clinical community-based groups and activities such as befriending schemes, physical activities, social clubs, and housing and debt support.

People can be referred to a social prescribing link worker by a range of health, care and community-based people and teams. Social prescribers will have a face-to-face conversation with the individual to discuss their particular needs and what opportunities are available locally that could meet these, empowering the person to design their own personal solutions.

Social prescribing schemes are now in place in most parts of Greater Manchester. The adoption of social prescribing in the LTP brings additional resource to deliver the Greater Manchester ambition to make person and community centred approaches the standard approach to care in primary care.

As well as changing what primary care can offer, it should be easier for people to find out what is available and how to access it. Care navigation makes it easy for people to find the right help for them. This can be via digital access such as NHS 111, pharmacy health champions or a range of other groups and services.

Care navigation was introduced in Salford in 2018 and is now available at a number of local providers, including community pharmacies. The community pharmacy service focuses on a range of minor ailments, conditions and symptoms, such as acne, fever, hay fever, infantile colic and conjunctivitis. Care navigation
is also an important aspect of the Minor Eye Conditions Service pathway. Patients are referred by GP practice staff, NHS 111, pharmacies, ensuring they are seen in the right place for them and freeing up GP time. We will continue to upskill all our non-clinical primary care workforce to be effective care navigators.

New models of care

We know that seamless care across primary and secondary care could be improved to avoid unnecessary admission or readmission to hospital, for people whose care could be better managed in the community. Discharge from hospital needs to be faster with better care packages and ongoing management and support in place.

We aim to:

• Bridge the gap between primary, community and secondary care by supporting high risk patients through intensive proactive care

• Share the learning from new models of care such as Focused Care, High Impact Primary Care and Extensivist Care models being tested across GM

In Greater Manchester, areas such as the City of Manchester and Tameside and Glossop have been exploring innovative ways to provide care. ‘High Impact Primary Care’ or ‘Extensivist care’ focuses on self-management, wellbeing and preventing illness, by helping people to live as independently as possible.

The Tameside and Glossop extensivist model aims to help people with long term conditions, complex needs and those intensive users of the health and social care system. The service includes health and wellbeing support pulling together a range of community assets to ensure early Intervention. It has seen a 58% reduction in A&E attendances, among the targeted cohort.

The Manchester pilot has seen a 53% reduction in GP practice appointments for patients engaged with the service and a 25.8% reduction of admission length (bed days). Outcomes continue to improve in terms of measurable impact including a reduction in unplanned A&E admissions.

**High Impact Primary Care (HIPC) in Manchester**

A man with multiple health issues was referred by his GP Practice to the HIPC team. He had suffered multiple falls and was a regular attender at hospital. When the team first became involved, he did not get out of bed, and was very negative about his situation. The HIPC GP and Pharmacist reviewed his medication to improve pain management and his sleep, as these were major barriers for him in getting up and walking around his home. He was keen to increase his independence, to get out more and go on holiday. The HIPC Wellbeing Adviser built a relationship with him, and over a period of 5 months supported him to become more active, to think about his diet, sleep and stress management, and to become more engaged with others. His quality of life was greatly improved. In addition to now cooking meals for his wife and actively engaging in social activities, he is more physically active, less breathless, and the family have booked a holiday to Spain.

Focused Care aims to make invisible patients visible, reducing barriers to universal services. People are referred by general practice staff, community workers and in some cases the police. The Focused Care Practitioner then works with the individual and their household to understand their situation, assess their needs and works with local health and community contacts to bring stability to an often chaotic situation. Results found that families who had accessed focused care presented at A&E less often in the year following focused care support than in the year before it.
Focused Care in Practice

A 49 year old woman, with complex medical and mental health needs was referred jointly to Focused Care by the Police and her own GP – both due to inappropriate and frequent contacts. Living alone in a flat, she was regularly contacting the police concerned about her neighbours, whether or not there was an actual problem found. Since engaging with the Focused Care Practitioner, she has found a safe point of contact and support, which has meant that she is now in touch with the Police less. She is supported to her medical appointments with the Focused Care Practitioner and is more appropriately contacting health services. This is an ongoing case, for which there is no easy solution, but the help provided by a Focused Care Practitioner has enabled positive changes to be made.

Improved access to primary care

Providing great access to care is one of the biggest determinants to how the whole health and care system responds to people’s needs – and to how people perceive their interaction with health and care.

Nine out of 10 urgent care contacts occur in primary care. Greater Manchester primary care providers see around 10 times the urgent caseload of our A&E departments.

We aim to:

- Redesign pathways to ensure that every person who requires same day access to health advice receives it
- Ensure seamless provision of routine and urgent and emergency primary care
- Routinely offer general practice appointments during evenings and weekends
- Roll out the Community Pharmacist Consultation Service, connecting patients with minor illnesses to a community pharmacist
- Roll out of Greater Manchester Urgent Dental Telephony and Clinical service

The Greater Manchester ambition is to commission services from the most appropriate professionals. For example, this could include the GM Minor Eye Conditions and Red Eye services.

The roll of urgent treatment centres In Greater Manchester provide a locally accessible and convenient alternative to A&E. They also bridge the gap between traditional primary and secondary care services, while providing opportunities for the workforce to work in a variety of settings.

The role of primary care in providing high-quality urgent care is a key element of the Greater Manchester Urgent and Emergency Care Improvement Programme, launched in 2018. It focuses on keeping people well, encouraging them to get treatment close to home rather than going to hospital, improving patient flow, and supporting discharge and recovery. It aims to create the most comprehensive integrated model of care in England to better manage and reduce the need for urgent and emergency care.

Integrated urgent care will offer a single point of access for care and treatment in each locality, with strong links into neighbourhood teams. People in their own home and in care homes will be able to get help more easily through a community-based service that responds to 111 and some 999 calls, and includes social care, mental health and VCSE support. There will be a seamless link to secondary care advice, local out of hours services and urgent treatment centres, all with shared records. This will reduce potentially avoidable attendances at A&E and support people to stay well at home.
The new Greater Manchester Clinical Assessment Service (CAS) and community-based MDT urgent care response within each locality, will provide access to a wide range of health and care services. The CAS brings together NHS 111 and GP out of hours services, including direct booking from NHS 111 into other urgent care services.

Primary care is especially well placed to provide an early response to healthcare needs, that early intervention in illness that can stop many serious conditions from becoming worse, and even life threatening, as well as offering simple, timely, reassurance when that is appropriate.

Seeing the right health care professional, in the right place, and at the right time, is the most effective way of addressing peoples urgent needs.

This already exists in many areas through our well-established unscheduled dental, minor eye conditions and ‘Red Eye’ services. The Greater Manchester wide NHS Urgent Medicine Supply Advanced Service (NUMSAS) has positively impacted on GP out of hours services and A&E services. Between January and March 2019, community pharmacy received over 3000 referrals from NHS 111 to support patients with urgent repeat medication requests. We aim to make these services consistently available across Greater Manchester and easier for people to navigate. Urgent access may not always be face to face, with alternative methods such as online access and advice and telephone consultations available.

We want to provide access to local urgent and emergency primary care services spanning the whole of primary care to anyone who needs it. We are one of only three areas in the country to pilot the Digital Minor Illness Referral Service (DMIR) between general practices and community pharmacies in Bury so that patients are managed in the most appropriate place. From Autumn 2019, the new Community Pharmacy Consultation Service will replace the NUMSAS and DMIRS.

There are many additional primary care professionals that could be the first point of contact for appropriate problems in areas such as podiatry, audiology, physiotherapy, mental health, and debt and benefit advice. This will broaden our primary care urgent offer and enable all such primary care professionals to operate to the full extent of their professional licence.

**Estates**

Our primary care estate is an enabler to the sustainability and transformation of primary care and as such, needs to cope with increasing patient activity as more services are developed outside hospital. However, some of our estate is old, and would not meet the demands of a modern health and care service.

We want to make the most of existing community assets and other facilities. It is not just about creating new buildings – it is about targeting investment so that it has the greatest impact on improving the quality of primary care services and people’s ability to access them. Capital funding is limited so we need to be innovative and use our existing premises in a different way.

The primary care estate must be of good quality, energy efficient and fit for purpose to support our planned model of care and ensure primary care providers have the flexibility to meet local patients’ needs.

The Estates and Technology Transformation Fund (ETTF) has been able to support some improvements the Greater Manchester general practice estate. This includes new consultation and treatment rooms, improved reception and work areas and the development of new health centres providing a greater range of services.
We want to empower local primary care teams and stakeholders to develop estate solutions that enable delivery of ‘place-based’ services across a network of neighbourhood locations and make full use of buildings currently available. This would include patients’ own homes, local community centres, the VCSE sector, traditional primary care facilities and other public sector premises.

The established Strategic Estates Groups (SEGs) across Greater Manchester will enable wider and more targeted use of existing facilities and ensure neighbourhood provision is appropriate for patients and practical for staff. We will have up to date, accurate information about our existing and planned future estate to inform strategic planning across health and to utilise health data to inform strategic planning in other areas.

Public engagement

Engaging with and listening to what matters to people is a crucial aspect of the plans for primary care in Greater Manchester, and whether we can fully achieve them. On a practical level, we want to embed person-centred conversations in primary care provision. Individuals should have a care and support plan that takes a holistic approach to health and wellbeing, is based on their goals and motivations, and draws on support from their friends, family, carers and community, as well as health and care services.

People will also need to understand how the plans for primary care will affect them. Commissioners, providers and users of primary care services will need to be fully engaged with the plans for them to succeed. There must be meaningful two-way communication with everyone involved or affected, which means sending out the right messages, in the right way.

Greater Manchester Primary Care Citizen’s Network

The new Primary Care Citizen Network is a subgroup of the GM Primary Care Provider Board. The network is made up of members of the public from across all 10 Greater Manchester localities, who engage virtually with their own local networks and can ensure the public and patient voice shapes the strategic direction of primary care. So far, the network has provided input into the primary care digital offer, shortlisting for the GM Health and Care Awards and new roles in primary care.

The Citizen Network will support the development of messages for the public, so they understand that ‘primary care is changing’ and that this new approach means they will always see the professional that is right for them.
High-quality primary care services – including general medicine, general dentistry, pharmacy and optometry – have always had an essential role in supporting population health.

Quality means ensuring everyone gets equal access to consistently high standards of care, with services based on evidence of what benefits patients, and delivered in the best way possible by people with the right skills and experience. So, to keep improving the quality of primary care in Greater Manchester the issues of inconsistencies in care and health inequalities affecting sections of our population or specific localities or neighbourhoods need to be addressed.

We aim to:

- Optimise use of, reduce the need for and unintentional exposure to antibiotics as well as support the development of new antimicrobials
- Standardise primary care provision, ensuring people receive a consistent offer no matter where they are in Greater Manchester

Reducing inconsistency

High-quality primary care should be safe, effective, person-centred, accessible, inclusive and result in the best possible outcome for the individual. The quality of most primary care in Greater Manchester is good, but there can be wide and often unwarranted variation, for example in access to services.

We need to reduce this inconsistency. Patients, the public and professional colleagues across the health and social care system should be confident that all primary care in Greater Manchester is of the highest possible quality.

The general practice dashboard will benchmark practices and highlight challenges and unwarranted variation across primary care. We are also developing metrics to assure service quality across primary care dental, optometry and pharmacy services, focusing on experience, outcomes and safety. Working in networks and neighbourhoods will bring together a range of different skills and perspectives from across organisations and teams, enabling people to learn from each other, challenge and consider variation across providers and improve services for our population. Primary care providers will be able to assess how they are performing against other networks and neighbourhoods. This will make it easier to see the impact they are having on the system and to reduce unwarranted variation.

There are some specific areas of primary care quality and consistency we particularly want to address, such as prescribing and compliance with medication regimes. Although the number of antibiotic prescriptions dispensed in primary care has reduced by 13.2% in five years (between 2013 and 2017), further progress is required.

Medicine-related problems arising in primary care can lead to patients requiring acute and emergency care. Around 6.5% of hospital admissions in Greater Manchester are linked to adverse drug reactions. Significantly more result from people’s conditions getting worse because they are not using their medicines as recommended or are not getting the most from them, due to suboptimal prescribing that, for instance, does not follow local guidelines on
choice of medicine, dosage or frequency. If patients have access to a consultation with a pharmacist they should become more knowledgeable about their medicines and take them in order to achieve the outcomes they want but also clinical interventions by pharmacists will identify some medicines related issues before they cause harm. This can be achieved through improved referrals from primary care into other services for medicine reviews.

Tackling inequalities
Greater Manchester has lagged behind national and international comparators when it comes to key health outcomes for far too long. According to the Kings Fund\(^5\) (2018), poverty rates in low-middle income families have increased by a third since the mid-1990s. The proportion of adults in Greater Manchester with a long-term condition in employment is nearly 13% lower for the Greater Manchester adult population as a whole. Deeply embedded health inequalities, often between communities little more than a stone’s throw apart, have impacted individual lives and negatively affected our economy.

Improving child and adult mental health, narrowing their gap in life expectancy, and ensuring parity of esteem with physical health is fundamental to unlocking the power and potential of Greater Manchester communities. By 2020/21 there will be improved access to psychological therapies, many of which will be co-located in primary care.

We aim to:

- Provide full population coverage of Pride in Practice across primary care by 2022

- Embrace the GM Carers’ Charter ensuring carers are supported to stay healthy and socially connected

- Roll out the Enhanced Health in Care Homes framework and develop a consistent primary care offer for residential and care homes

- Embed the general practice support for carers framework of quality markers

Around 30,000 people are living with dementia in Greater Manchester. It affects one in six people aged 80 and over. Digital technology means that dementia diagnoses will be recorded electronically and shared with health and care professionals. When care plans are created with people with dementia and their carers, the plans will be made available electronically available. A ‘lasting power of attorney for health and welfare’ will also be included on the electronic record.

Across Greater Manchester we aim to identify and address the inequalities facing vulnerable and protected groups; this will in turn improve overall quality and outcomes, benefitting the wider population. One size does not fit all, including when it comes to primary care provision in neighbourhoods. Greater Manchester has a diverse population and it is important to recognise how this diversity is dispersed across our localities and neighbourhoods as this can lead to significant inequality.

In particular, our aim is for more of our dental practices to work with services that that provide care for currently under-represented vulnerable groups. These include people experiencing homelessness, substance misuse clients, refugees and asylum seekers. Consideration

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5 A vision for population health – Towards a healthier future
https://www.kingsfund.org.uk/sites/default/files/2018-
needs to be given to the additional access and inclusion requirements of certain other groups, such as disabled, deaf, lesbian, gay, bisexual and transgender (LGBT) people, young people, and people whose first language is not English.

For instance, steps are being taken to improve the primary care experience of LGBT people in Greater Manchester. Many have low expectations of how health professionals will treat them, especially concerning transition and adoption processes. The continued roll out Pride in Practice, a quality assurance support service created by the LGBT Foundation will help GP practices, dental, pharmacy and optometry teams confidently meet the needs of their LGBT patients. Since 2016, Pride in Practice has already offered ongoing advice and support to c25% of primary care providers across Greater Manchester, including training for clinicians, practice managers and other staff. The ambition is to have 100% coverage by 2022.

Compared to the national average, children growing up in Greater Manchester have a lower life expectancy, have worse health outcomes, there are more people living in poverty and a third start school not ready to learn. With greater collaboration, Greater Manchester can improve the quality of services for children and support the spread of innovation and best practice to ensure the best outcomes for children.

Greater Manchester will improve our support for veterans and their families, ensuring that veteran and reservists are recorded on practice systems as a minimum. As described in the NHS Long Term Plan, GP practices will undertake the Military Veterans Awareness Accreditation Scheme.

One in 10 people are known to be carers in Greater Manchester, yet there are many more who are unknown. Out of the 280,000 carers that we know about in Greater Manchester, 70,000 of them spend 50 hours per week as carers. We believe that carers should be respected, valued and supported equally in their caring role, as experts for those they care for and as individuals in their own right. We will support the Greater Manchester Carers Charter⁶, ensuring carers are identified as early as possible, have better access to annual health checks and supported to stay healthy and socially connected.

Across England, one in seven people aged 85 and over is living permanently in a care home. Building on the Enhanced Health in Care Homes Framework, will create a comprehensive primary care offer that is person centred, focuses on holistic needs, prevention and proactive care and continuity of care. There are several tried and tested programmes across Greater Manchester that support care homes. Greater Manchester can learn from the best, such as ‘Digital Health’ a nurse-led telemedicine service in Tameside and Glossop and scale up where possible.

Around 1% of the population die each year. In the past year there have been 23,866 deaths in Greater Manchester. In Greater Manchester 49.8% of deaths were in hospital, 23.5% in their own home, 18.7% in a care home, and 6.1% of deaths were in a hospice.

Many people die in hospital without any clinical need to be there. Surveys suggest that most people would not choose hospital as their preferred place to die. Primary care will play its part in the delivery of the Greater Manchester framework to improve palliative and end of life care.

Resilience and independent living

There is work ongoing across Greater Manchester to develop comprehensive and holistic approaches to addressing people’s psychological, social and biological needs.

The identification of clinical frailty in primary care is recognised in the ‘Strategy for an Age-friendly Greater Manchester 2017-2020’. Frailty can and should be identified in a range of different settings. Within primary medical care services, clinicians will use appropriate validation tools to identify patients who may be living with severe or moderate frailty. This will require clinicians to take a holistic view of the individual, including a complete clinical picture. An example from Stockport is at a ‘Birthday Review’ which uses motivational/aspirational interviewing and restorative conversations. Communication is also vital, particularly when a patient is admitted to hospital and when they are discharged back to primary care.

Primary care teams regularly encounter people who are at risk of or have sustained a fall. Community based falls prevention services are vitally important, with primary care making a significant contribution to identifying those at risk. Falls are very common in the older population, affecting one in three people over the age of 65 years and half of those aged over 80 years. There are many reasons why people fall in later life. It can be the result of dizziness caused by different medications, medical conditions, poorly fitting footwear natural deterioration of eyesight, muscle strength and much more. In many cases, it can be a combination of factors.

General practice care teams, have opportunities to identify people at risk of falls, ensuring they are navigated to local falls prevention services in order to reduce their risk. Across Greater Manchester, work is ongoing to increase uptake to routine sight tests. Research conducted by Age UK found that many people over 60 do not take advantage of the free sight test. Research also suggests that many people caring for older people are not aware that people aged over 60 are entitled to a free sight test, which can be performed at home if the person is unable to leave the house unaccompanied due to illness or disability. Regular pharmacy-led medicine reviews will also minimise the risk of medicine-related falls.

The Greater Manchester Mental Health and Wellbeing strategy was launched in February 2016 and describes the ambitious agenda to improve Mental Health outcomes for people in Greater Manchester. Primary care can contribute to improved outcomes in a number of ways including identifying and supporting people experiencing mental health problems during pregnancy and the first year after birth – something that affects up to one in five women and one in 10 men.

The Greater Manchester i-THRIVE Programme aims to support localities to improve mental health outcomes for children and young people in Greater Manchester. Children and young people make up a third of this population and in Greater Manchester the 0-15 year old cohort will be one of the fastest growing groups of all over the next five years. One in 10 young people need support with mental health problems and 75% of all adult mental health problems start by the age of 18 years.

The programme will support children and young people in a range of ways including signposting

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7 https://www.ageuk.org.uk/latest-press/archive/poor-vision-leads-to-falls-for-270000-over-60s/
and self-management, risk management and crisis response, focussed interventions and extensive treatment. It will increase the proportion of children and young people from Greater Manchester’s vulnerable groups accessing appropriate interventions through improved accessibility e.g. in primary care, community and schools.

**Support for primary care excellence**

There is an opportunity to expand the GP Excellence programme from its focus on general medical services to all primary care provision in Greater Manchester.

**We aim to:**

- **Continue to roll out the GP Excellence programme**
- **Develop a model for GM Primary Care Excellence**

The GP Excellence Programme, which we have offered in partnership with the Royal College of General Practitioners (RCGP) since 2017, currently supports general practices to become more sustainable, resilient and better placed to tackle the challenges they face now and into the future, and to secure continuing high-quality care for patients.

GP Excellence delivers a range of support to practices to help them through each stage of quality improvement, from ‘rescue’ to ‘excellence’. As well as information, resources and tools, it offers access to peer support and opportunities to share good practice and innovation. Over time the programme creates positive engagement across the Greater Manchester system and develops an ‘improvement culture’ among practices.

A future ambition of the programme is to develop more research and evaluation expertise to develop real world evaluations of innovations into working life.

We now plan to build on the principles of GP Excellence and the Greater Manchester Health Care Academy to create an extended ‘GM Primary Care Excellence’ programme that offers similar packages of support and development to all Greater Manchester dentistry, eye health and pharmacy providers and workforce by 2020.

**Using information for improvement**

Accessing and gathering data and intelligence about primary care services and the people who work in and use them, will enable that information to be used more effectively to support improvement.

All primary care providers will better understand what is happening to patients and where they might need to shape services to meet their needs going forward. The quality of data across primary care will improve.

**We aim to:**

- **Use near real-time data at a practice, neighbourhood, locality and GM level to make tactical decisions and deliver the highest quality patient care possible**
- **Develop an automated workforce data collection tool to understand our workforce and plan accordingly**
- **Take the learning from the Electronic Pharmacy Referral System pilot and scale up across Greater Manchester**

Working with data and technology will enable Greater Manchester and localities to understand the workforce and plan for future models of care. Primary care providers will be able to use data to undertake workforce planning, making use of population health and activity trends. This will provide an understanding of the skills and competencies needed to deliver current and future primary care, as well as establishing a baseline of the current workforce. It will highlight the gaps in workforce and the most appropriate methods to fill those gaps.
Seamless care

Between 30-70% of patients experience an error or unintended change to their medications when transferred across care settings. Issues often occur when patients are discharged from secondary care back to primary care. The Electronic Pharmacy Referral System will improve the transfer of information about medicines from a secondary care setting into the community. This will ensure that appropriate patients are signposted to supportive pharmacy services following their discharge from hospital. The referral system has the potential to improve medicine optimisation, reduce medication errors during transfers of care, reduce medication wastage, reduce non-elective admissions and improve efficiency.

Many optical practices have retinal imaging or scanning equipment, however if an abnormality is detected the patient is referred to secondary care to have repeat images and reviews from ophthalmologists. By enabling the transfer images between primary and secondary care would reduce false positive referrals and reduce the burden on secondary care with more people seen in the community.

Raising medical standards

Evidence based interventions, applied across primary care are essential to transform the health and wellbeing of the population.

We aim to:

- Review the implementation of the GM Primary Care Medical Standards and ensure the learning is shared
- Refresh the primary care standards ensuring they are outcomes based

Nine primary care medical standards were collectively developed in Greater Manchester, based on recognised evidence and reasoning. The roll-out of the refreshed standards (implementation commenced from April 2018) focused on quality improvement and the delivery of outcomes for the population, rather than processes. We believe this contributes to real health outcomes, drives workforce transformation, and ensures seldom-heard groups are included. The standards also encouraged the use of data and intelligence to drive improvement and facilitate collaborative working. Importantly, the standards allowed each of the localities to achieve the same outcomes through different routes, taking into account practices working together or working with other primary care professionals. This moved the emphasis away from process and focused on the patient outcomes that really matter.

The emergence of PCNs and neighbourhood working provides an opportunity to review and strengthen the GM standards, ensuring they are even more outcomes focused, able to be delivered by anyone in a neighbourhood, but able to identify and reduce individual provider variation in a neighbourhood.

The GM Primary Care Medical Standards:

1. Improving access and responsiveness in general practice
2. Improving health outcomes for patients with mental illness, dementia and learning disabilities and military veterans
3. Improving cancer survival rates and earlier diagnosis
4. Ensuring a proactive approach to health improvement and early detection of disease
5. Improving the health and wellbeing of carers
6. Improving outcomes for people with a long-term condition
7. Embedding a culture of safety
8. Improving outcomes in children, especially those with asthma
9. Proactive disease management to improve outcomes
SUSTAINABLE PRIMARY CARE

Primary care should be the best possible, most suitable, primary care for the 2.8 million population of Greater Manchester, ensuring it is adaptable and has underlying support to continue to be so for many years to come.

However, certain things are necessary to achieve this level of sustainability. First and foremost is having the right number and type of organisations and workforce to provide primary care. Primary care needs leaders who can develop systems and local responses fit for both current and future needs. It must have the infrastructure in place to meet the changing demands of primary care provision as it evolves over time. The Greater Manchester Primary Care Workforce Strategy describes in detail, the plans for workforce. The implementation will begin to address the Greater Manchester workforce challenges as well as prepare the workforce to adapt to new ways of working in the future.

We aim to:

- Implement the Greater Manchester Primary Care Workforce Strategy
- Take the learning from the NHS England Regional GP Retention and International GP Recruitment programmes to extend to other key roles and scale up across Greater Manchester
- Review the impact of the implementation of the GM Primary Care Reform Programme and share the learning

Environmental Sustainability

The Greater Manchester Health and Social Care Partnership (GMHSCP) recognises that climate change and environmental degradation are unprecedented threats to our health and wellbeing. To ensure the system is able to meet the primary care needs of the population, we recognise that Greater Manchester must be a healthy place to live and work and addressing these wider environmental issues is necessary to achieve this goal. Greater Manchester is working hard to tackle air pollution, which contributes to 1200 deaths a year in Greater Manchester and a wide range of health conditions. Greater Manchester has also outlined ambitions for carbon neutrality and other environmental goals that will impact service delivery as the NHS reduces our carbon footprint.

We know that addressing environmental issues represents our greatest opportunity to improve population health and primary care will play a crucial role in these efforts. For example, primary care professionals can make recommendations to individuals for changes in behaviour that have environmental co-benefits. e.g. they can recommend increasing physical activity by shifting from motorised to active transport, healthier diets with low environmental impact including little or no red meat and high fruit and vegetable intake, and family planning. Changes in health care provision models can also have significant impacts on the environment. Engagement with patients using the new NICE guidelines on inhaler usage can have significant impacts on the release of greenhouse gases and the adoption of digital technology and the development of co-ordinated services bringing care closer to home will make efficient use of resources as well as reduce duplication of effort and travelling time. Primary care providers will also be key in the care or increased preparedness for vulnerable populations during
the extreme weather events we are experiencing as a result of climate change.

**Workforce**

Primary care will not achieve its plans for transformation without a sustainable workforce. Consideration will be given to the shape of primary care teams and whether these are still appropriate for the population. It is likely that primary care will look very different in the future, which is already evident with the emergence of multidisciplinary, neighbourhood working. The Greater Manchester Primary Care Workforce Strategy will tackle workforce challenges and develop a workforce that is fit for the future.

**We aim to:**

- Establish an integrated training academy in each locality
- Continuously engage with local primary care clinicians
- Embed a number of new roles including Nurse Associates, Physician Associates and primary care apprenticeships
- Explore the opportunity for pharmacy technician led services to free up the pharmacists’ time
- Continue to maximise the opportunities in general practice through ‘return to practice’, ‘retire and return’ programmes, and greater utilisation of the General Practice Nurse Resource Pack

Recruitment and retention continue to be a challenge in a number of key roles including GPs, Practice Nurses and Dental Practice Nurses. Across Greater Manchester we will explore ways to increase capacity in primary care by utilising the vast range of skills of the wider primary care workforce in the community, meaning general practice does not always need to be the first point of contact.

Being part of the Greater Manchester primary care workforce will be seen as the ‘career of choice’ and the planned changes will help to attract and retain the best talent by providing flexible, multidisciplinary work options and opportunities for development and career progression.

In the future, care may be delivered in non-traditional settings, with blurred boundaries between primary care, community services, secondary care and the VCSE sector. Roles such as general practitioners and pharmacists are already working in care home settings and emergency departments improving patient experience.

The primary care workforce will be much broader in terms of skills and roles, crossing traditional boundaries of primary, community and secondary care.

We would like to see Integrated Training Hubs, spanning the breadth of primary care, in all 10 localities. This could be through the existing Enhanced Training Hubs, GP Federation or the Academy model and would provide the career and skills development of all staff, reducing the burden on individual practices or providers. These training hubs will provide an opportunity, working closely with Health Education England, to meet the educational and training needs of the multidisciplinary primary care workforce, working closely with PCNs and neighbourhoods to enable regular training rotations through primary care. These training hubs would also work closely with providers to facilitate consistent mandatory training and be supported by the Greater Manchester Training Hub.

Plans for the future will focus on developing talent and leadership across Greater Manchester primary care. This will involve investing in training and development, apprenticeships and addressing skills gaps through more flexible and integrated ways of working.
Where possible, development of the care workforce will happen in partnership with other Greater Manchester public services, and also take advantage of the resources larger organisations have for organisational development.

**Heywood, Middleton and Rochdale (HMR) Primary Care Academy**

Heywood, Middleton and Rochdale (HMR) has a diverse population which is growing in complexity. Alongside this, practices are faced with increased workload, funding pressures and difficulty in recruitment.

HMR CCG commissioned the HMR Primary Care Academy delivered by the One Rochdale Local Care Organisation and Rochdale Health Alliance (the local GP Federation).

One solution included promoting Rochdale as the employment destination of choice, highlighting the opportunities that exist within the borough.

- Liaising with local education providers
- Influencing educational programmes
- Promoting HMR as the destination of choice

As a result, the locality has a greater understanding of the issues that attract and deter people from coming to HMR.

**Improved relationships**

Good person-centred care requires close collaboration between a range of multidisciplinary professionals to ensure care is co-ordinated, appropriate, timely, avoids duplication or unnecessary interventions, and is cost effective. This is especially important across organisational and professional boundaries where technical, cultural and financial barriers that hinder effective communication.

There are not many opportunities for health and care professionals from different organisations, such as GPs and consultants, to meet. This reduces the potential for building understanding of each other’s roles in order to share perspectives and problem solve.

**We aim to:**

- Create opportunities to improve inter-professional relationships between the primary, community and secondary care workforce

With highly skilled staff and effective technology, holistic health and care can be provided in the community in ways that are easier for people to access. In order to reduce demand on acute hospital services health and care services will need to be much better integrated and co-ordinated, ensuring care is received in the right place at the right time.

**Strengthening system leadership**

Primary care leaders in Greater Manchester will need specific expertise required to lead a ‘place’ across organisational and professional boundaries, and a system in which people take priority over process.

**We aim to:**

- Facilitate organisational development and leadership development across the whole of primary care

Greater Manchester is developing programmes that supports emerging primary care system leaders to develop the skills and knowledge they will need. For instance, they will focus more on approaches that draw on local strengths.

The changing shape of primary care in Greater Manchester will present challenges to existing provider organisation models. This means we need to pay particular attention to our providers, their views and future development.

Given the breadth of providers and volume of service delivery in primary care, we will build effective engagement mechanisms so that primary care has a consistent representative voice.
The Primary Care Provider Board will continue to be integral in ensuring that primary care is front and centre in considering the opportunities and implications of strategic change. The discipline-specific boards for general practice, pharmacy, optometry and dental, will continue to facilitate wider engagement (in conjunction with local professional networks). The Greater Manchester Local Leaders Network will also continue to support primary care network and neighbourhood clinical leads.

Engagement with the workforce to support them through this period of culture change, will be essential in order to provide the necessary tools and competencies to enable new ways of working.

**Care closer to home**

Increasingly primary care providers are expanding their services to accommodate the needs of patients who would previously have been treated in hospital.

Over 90% of dental activity already takes place outside the hospital setting. Delivery of dental services in the community, where possible and appropriate, is supported through the demand management approach of Greater Manchester dental referral management and embedding clinical pathway models delivered by the Greater Manchester dental managed clinical networks.

Population-level services are both cost effective and make a real difference to local people. Primary care providers have the necessary skills and competencies to deliver a range of services in the community which may have traditionally been provided in hospital.

Provision of minor conditions, glaucoma repeat measures and pre and post cataract referrals will become commonplace in the community, as will ‘eye tests made easy’ for people with a moderate or severe learning disability who would benefit from adjustments such as an advance visit, easy read paperwork and longer appointments with a specially trained optician. Other services such as dermatology, endoscopy, chemotherapy and musculoskeletal clinics will also be more accessible in the community. These are just a few examples of where secondary, community and primary care can work collectively to deliver services closer to home.

Greater Manchester will support more of the workforce including nurses, pharmacists, physiotherapists and optometrists to become independent prescribers. This will improve people’s access to treatment, making it easier for them to access medication.

**Infrastructure**

Developing and modernising the infrastructure across the whole of primary care will enable the improvement of local communities.

For primary care to succeed, it will need to have the infrastructure to support new forms of provision and services, including suitable locations and premises (our estate), funded by targeted investment, training to develop the primary care workforce, and technology to enable planned changes. However, we do note that national capital funding for estates development is limited and currently only for general practice and not for primary care dental, optometry or pharmacy services.

**Space for staff and training**

The expansion of the primary care workforce into new professions places a huge burden on the general practice estate, which was built when training was restricted to a few disciplines on a one-on-one basis.

For example, there are advanced practice-based attachments throughout Medical Schools, Foundation years and in the Specialist Trainee
years. Alongside the GP training, practices now contribute to the community development of nursing and pharmacy prescribers, practice-based paramedics, physiotherapy first, community navigators, physician associates and nurse assistants. Even at a neighbourhood level, this requires more physical space.

The nature of our interactions with patients have also changed over time so we need to think differently about how we utilise our estate and local assets. There is a lack of provision of such as space for link workers, voluntary sector and social care provision to work beside health and changes to health delivery such as group consultations.
HOW WE WILL DELIVER THE STRATEGY

Implementing the vision means people will be able to access a greater range of health services locally, including specialist consultation, diagnostics, urgent care and non-medical care. We will have a digitally-led primary care service developed as part of the refreshed strategy. The Greater Manchester primary care workforce will experience greater resilience and improved work-life balance. Across Greater Manchester there will be a wider range of services delivered in the community.

The implementation of this strategy will be locality driven. However, it may make more sense that some initiatives are delivered once at a Greater Manchester level. The design and delivery of the strategy will happen at a system wide level.

The primary care team of the Greater Manchester Health and Social Care Partnership will work with stakeholders to deliver the ambition to transform primary care.

A 3-5 year implementation plan has been co-produced with the Greater Manchester system (including both commissioners and providers). A series of measures and outcomes have been developed in order to quantify the benefits that result from the transformation of primary care.
GET IN TOUCH

England.primarycaretransformation@nhs.net
www.gmhsc.org.uk

@GM_HSC
@GMHSCPpartnership
@GMHSCPpartnership
GM PRIMARY CARE STRATEGY

Implementation Plan
## VERSION CONTROL

<table>
<thead>
<tr>
<th>Version</th>
<th>Description</th>
<th>Date</th>
<th>By</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>V0.1</td>
<td>Document creation</td>
<td>25.10.19</td>
<td>A. Osei</td>
<td></td>
</tr>
<tr>
<td>V0.2</td>
<td>Alignment with co-production workshop. Inclusion of programme governance and funding streams</td>
<td>31.10.19</td>
<td>C. Wildgoose</td>
<td>Full implementation plan review</td>
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<tr>
<td>V0.3</td>
<td>Update to programmes and projects</td>
<td>01.11.19</td>
<td>A. Osei</td>
<td>Inclusion of outcomes framework and metrics</td>
</tr>
<tr>
<td>V0.4</td>
<td>Amendment to project slides</td>
<td>04.11.19</td>
<td>C. Wildgoose</td>
<td>Incorporation of feedback from LCO Chief Officers Group</td>
</tr>
<tr>
<td>V0.5</td>
<td>Inclusion of we aim to statements</td>
<td>05.11.19</td>
<td>C. Wildgoose</td>
<td>Full implementation plan review</td>
</tr>
<tr>
<td>V0.6</td>
<td>Update to programmes and project</td>
<td>07.11.19</td>
<td>A. Osei</td>
<td>Inclusion of programme reporting, meeting demand and research projects</td>
</tr>
<tr>
<td>V0.7</td>
<td>Inclusion of contents, title slides, minor amendments</td>
<td>07.11.19</td>
<td>C. Wildgoose</td>
<td>Full implementation plan review</td>
</tr>
<tr>
<td>V0.8</td>
<td>Inclusion of children’s dental management slide</td>
<td>08.11.19</td>
<td>C. Wildgoose</td>
<td>Full implementation plan review</td>
</tr>
<tr>
<td>V0.9</td>
<td>Inclusion of “Ask of GM”, “Ask of Localities”</td>
<td>12.11.19</td>
<td>C. Wildgoose</td>
<td>Full implementation plan review</td>
</tr>
<tr>
<td>V1.0</td>
<td>Removal of milestones pre-November 2019</td>
<td>13.11.19</td>
<td>C. Wildgoose</td>
<td>Full implementation plan review</td>
</tr>
<tr>
<td>V1.1</td>
<td>Inclusion of further pharmacy projects and revised metrics</td>
<td>02.12.2019</td>
<td>C. Wildgoose / A. Osei</td>
<td>Full implementation plan review</td>
</tr>
<tr>
<td>V1.2</td>
<td>Refinement of milestones and inclusion of additional project</td>
<td>08.01.20</td>
<td>A. Osei</td>
<td>Inclusion of additional content</td>
</tr>
<tr>
<td>CONTENTS</td>
<td>Greater Manchester Health and Social Care Partnership</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------</td>
<td>-------------------------------------------------------</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

# CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Purpose</td>
<td>4</td>
</tr>
<tr>
<td>Vision</td>
<td>5</td>
</tr>
<tr>
<td>Scope</td>
<td>6</td>
</tr>
<tr>
<td>Programme Overview</td>
<td>7</td>
</tr>
<tr>
<td>Primary Care Delivery Programme: Integrated Neighbourhood Working</td>
<td>22</td>
</tr>
<tr>
<td>Primary Care Delivery Programme: Person and Community Centred Approaches</td>
<td>27</td>
</tr>
<tr>
<td>Primary Care Delivery Programme: Digitally Enabled Primary Care</td>
<td>30</td>
</tr>
<tr>
<td>Primary Care Delivery Programme: Improved Access to Primary Care</td>
<td>39</td>
</tr>
<tr>
<td>Primary Care Delivery Programme: Population Health</td>
<td>46</td>
</tr>
<tr>
<td>Primary Care Delivery Programme: Tackling Health Inequalities</td>
<td>51</td>
</tr>
<tr>
<td>Primary Care Delivery Programme: Improving Quality in Primary Care</td>
<td>60</td>
</tr>
<tr>
<td>Primary Care Delivery Programme: Information for Improvement</td>
<td>64</td>
</tr>
<tr>
<td>Primary Care Delivery Programme: Workforce Development</td>
<td>67</td>
</tr>
<tr>
<td>Primary Care Delivery Programme: Outcomes Framework</td>
<td>70</td>
</tr>
</tbody>
</table>
The purpose of the implementation plan is to provide a structure and framework for the delivery of the primary care strategy.

It describes the scope, programme governance, risks, and high level timescales.
Across Greater Manchester (GM) we aim to deliver the fastest and greatest improvement in the health and wellbeing of our whole population, creating a strong, safe and sustainable health and care system that is fit for the future.

The GM prospectus looks at where further improvement over the next few years might take us and what fresh relationships we’ll need to develop. We hope it will be a starting point for discussions with those potential partners. It particularly explores how the Greater Manchester model can make rapid progress in improving population health, creating a sustainable health and care system, and contribute to achieving the region’s economic potential.
SCOPE

In Scope

- General practice developments
- General dentistry developments
- Community optometry developments
- Community pharmacy developments
- Alignment of primary care and PCNs with the GM neighbourhood model

Out of Scope

- Community services redesign
- Acute services transformation
- Locality commissioning intentions
- Contract changes
- GM programmes and workstreams where primary care contributes but does not lead, e.g. frailty, mental health

Note: Although community services redesign and acute services transformation is out of scope of the implementation plan, primary care will collaborate with the wider system where changes are being agreed and primary care would be impacted and / or required to deliver services.

No financial commitments have been made in the strategy or implementation plan on behalf of localities. Where there is a commissioning request, this has been detailed in the ‘ask’ of localities and will progress through the usual GM governance arrangements for approval/agreement.
PROGRAMME REPORTING AND CONTROLS

- Proposed programme governance (page 9)

- Bi-monthly highlight reports will be provided

GM Primary Care Strategy Task and Finish Group will oversee the implementation of the GM primary care strategy

- Briefing updates provided to Joint Commissioning Board and Primary Care Provider Board on an agreed reporting basis

- Application of the use of agreed project methodology including risk and issues management

- Change management process will be in place for delayed or deferred projects
**PROGRAMME LEADERSHIP (GM)**

**Programme Sponsor** - Responsible for authorising the programme and resolving cross programme issues.

**Programme Director** - Responsible for ongoing management on behalf of the SRO ensuring desired programme outcomes and objectives are delivered.

**Business Change Manager**
Responsible for assessing progress and achieving measured improvements in business operations.

**Chief Officer, GMHSCP**

**Executive Lead for Population Health and Commissioning**

**Deputy Director of Commissioning (Primary Care)**

**Head of Primary Care Operations**

**Head of Primary Care Transformation**

**Primary Care Programme Management Office**

**Senior Responsible Officer (SRO)**
Accountable for the programme, ensuring that it meets its objectives and realises expected benefits.

**Programme Manager**
Responsible for planning and governance for overseeing the successful delivery of the programmes’ outputs.

**PMO**
Responsible for setting up programme processes, planning, tracking and reporting on outputs and outcomes.
Note: the GM enabler workstreams (digital, workforce, estates) also have their own governance structures.
<table>
<thead>
<tr>
<th>PROGRAMME</th>
<th>LEAD</th>
<th>FUNDING</th>
<th>SOURCE</th>
<th>RECURRENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCN Development</td>
<td>Locality/GM</td>
<td>£2.3m 19/20 £2.6m 20/21</td>
<td>NHS England (national)</td>
<td>Yes</td>
</tr>
<tr>
<td>Leadership and OD (wider primary care)</td>
<td>Locality/ GM</td>
<td>£200k 19/20</td>
<td>GM Transformation Fund (PC Reform Programme)</td>
<td>TBA</td>
</tr>
<tr>
<td>Estates</td>
<td>GM</td>
<td>ETTF - £1,914k (19/20 &amp; 20/21) BAU - £3,340k (19/20 &amp; 20/21)</td>
<td>NHS England (national) – BAU and ETTF</td>
<td>Yes (BAU only)</td>
</tr>
<tr>
<td>Social Prescribing</td>
<td>Locality</td>
<td>N/A</td>
<td>Locality funded / PCN DES (new roles)</td>
<td>TBA</td>
</tr>
<tr>
<td>Group Consultations</td>
<td>GM</td>
<td>£150k</td>
<td>GM Transformation Fund (PC Reform Programme)</td>
<td>N/A</td>
</tr>
<tr>
<td>Use of GP Online Services</td>
<td>Locality</td>
<td>N/A</td>
<td>GM Transformation Fund (PC Reform Programme)</td>
<td>N/A</td>
</tr>
<tr>
<td>Direct Booking</td>
<td>GM</td>
<td>Cost implication is TBA. Awaiting further information from NHS Digital</td>
<td>TBA</td>
<td>N/A</td>
</tr>
<tr>
<td>IM&amp;T</td>
<td>GM</td>
<td>ETTF - £2.286k (19/20 &amp; 20/21) BAU- £3,082k (19/20 &amp; 20/21)</td>
<td>NHS England (national) – BAU and ETTF</td>
<td>Yes (BAU only)</td>
</tr>
<tr>
<td>Primary Care Platform</td>
<td>GM</td>
<td>£22k 19/20 / £15k 20/21</td>
<td>NHS England (GP Retention)</td>
<td>Yes – year 2 onwards</td>
</tr>
<tr>
<td>Online Consultations</td>
<td>Locality</td>
<td>£890k (19/20)</td>
<td>GM Transformation Fund (PC Reform Programme)</td>
<td>No</td>
</tr>
<tr>
<td>Seamless Care</td>
<td>GM</td>
<td>TBA</td>
<td>GMHSCP (Direct Commissioning)</td>
<td>TBA</td>
</tr>
<tr>
<td>Eye Health IT Enabler</td>
<td>GM / LOCs</td>
<td>£685k (19/20)</td>
<td>GMHSCP (Direct Commissioning)</td>
<td>No</td>
</tr>
<tr>
<td>Improving Access to General Practice</td>
<td>Locality</td>
<td>£9.8m</td>
<td>GM Transformation Fund (PC Reform Programme)</td>
<td>CCG baselines from 2020</td>
</tr>
<tr>
<td>Primary IT Care Service Framework</td>
<td>GM</td>
<td>N/A</td>
<td>Locality commissioned (subject to approval)</td>
<td>TBA</td>
</tr>
<tr>
<td>Healthy Living Framework</td>
<td>GM</td>
<td>N/A</td>
<td>GMHSCP (Direct Commissioning)</td>
<td>N/A</td>
</tr>
<tr>
<td>Primary Care Health Campaigns</td>
<td>GM</td>
<td>£2600 for 19/20</td>
<td>GMHSCP (Direct Commissioning)</td>
<td>TBA</td>
</tr>
<tr>
<td>Increased uptake to sight tests</td>
<td>GM</td>
<td>N/A for LEHN project Sight tests funding included overall optometry direct commissioning budget</td>
<td>N/A GMHSCP (Direct Commissioning)</td>
<td>TBA</td>
</tr>
<tr>
<td>Sight Loss Framework</td>
<td>GM</td>
<td>TBA</td>
<td>Locality commissioned (subject to approval)</td>
<td>TBA</td>
</tr>
<tr>
<td>Pride in practice</td>
<td>GM</td>
<td>£100k 19/20, £65k 20/21</td>
<td>GMHSCP (Direct Commissioning)</td>
<td>TBA</td>
</tr>
<tr>
<td>Transgender Health Service</td>
<td>GM</td>
<td>£61k 19/20 / £61k 20/21</td>
<td>Localities (Agreed by DOCs)</td>
<td>National procurement underway</td>
</tr>
<tr>
<td>Primary care in care homes</td>
<td>GM</td>
<td>TBA</td>
<td>Locality commissioning (subject to approval)</td>
<td>TBA</td>
</tr>
<tr>
<td>Oral Health in Older People</td>
<td>GM</td>
<td>£96k (2018/19)</td>
<td>GMHSCP (Direct Commissioning)/ HEE</td>
<td>No</td>
</tr>
<tr>
<td>GM Excellence</td>
<td>GM</td>
<td>£636k 19/20 / £694k 20/21</td>
<td>GM Transformation Fund (PC Reform Programme)</td>
<td>TBA</td>
</tr>
<tr>
<td>Primary Care Standards</td>
<td>GM</td>
<td>N/A</td>
<td>Locality commissioned</td>
<td>TBA</td>
</tr>
<tr>
<td>Primary Care Dashboard</td>
<td>GM</td>
<td>N/A</td>
<td>GM Transformation Fund</td>
<td>TBA</td>
</tr>
<tr>
<td>GP Workforce Visualisation Tool</td>
<td>GM</td>
<td>£200k</td>
<td>GM Transformation Fund (PC Reform Programme)</td>
<td>No</td>
</tr>
<tr>
<td>General Practice Retention</td>
<td>GM</td>
<td>£600k</td>
<td>NHS England (regional)</td>
<td>Yes</td>
</tr>
<tr>
<td>Developing expanded primary care team</td>
<td>GM</td>
<td>£720k</td>
<td>NHS England/HEE (various roles)</td>
<td>TBA</td>
</tr>
</tbody>
</table>
DISCOVERY TO DELIVERY - DEFINITION

Each project has been mapped to a ‘stage’ within the internal delivery and assurance framework (based on a 5-stage design methodology):

<table>
<thead>
<tr>
<th>Stage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discover</td>
<td>Case for change, high level plan</td>
</tr>
<tr>
<td>Define</td>
<td>Project Initiation Document, outline business case (if applicable)</td>
</tr>
<tr>
<td>Design &amp; Develop</td>
<td>Cost benefit analysis (if applicable), detailed</td>
</tr>
<tr>
<td></td>
<td>project/implementation plan</td>
</tr>
<tr>
<td>Deliver</td>
<td>Continuous monitoring, operational handover, sustainability plan</td>
</tr>
<tr>
<td>Evaluate</td>
<td>Benefits realisation, post project review, lessons learnt</td>
</tr>
</tbody>
</table>
Projects

- PCN development
- Leadership and OD
- Communication and engagement
- Estates
- Social prescribing
- Group consultations
- Digital First Primary Care
- Use of GP online services
- Direct booking
- Information management & technology
- Primary care platform
- Online and video consultations
- Seamless care
- Eye health IT enabler projects
- Meeting demand
- Community Pharmacist Consultation Service
- 7 day access to general practice
- Primary eye care service framework
- Proactive children’s dental management
- Contraceptive services in community pharmacy
- Healthy Living Framework
- Primary care health campaigns
- Environmental sustainability
- MenACWY vaccinations
- Increased uptake of sight tests
- Sight loss framework
- Pride in Practice
- Transgender health service
- Primary care contribution to adult social care
- Oral health in older people
- Hypertension and AF find and treat
- Asthma review in community pharmacy
- GM Excellence
- Primary care standards
- Research in primary care
- Primary care dashboard
- GP workforce visualisation
- Retention
- Developing an expanded primary care team

Programmes

- Integrated Neighbourhood Working
- Person and Community Centred Approaches
- Digitally Enabled Primary Care
- Improved Access to Primary Care
- Population Health
- Tackling Health Inequalities
- Improving Quality in Primary Care
- Information for Improvement
- Workforce Development

Themes

- Model of Care
- Quality
- Sustainability

Primary Care Strategy
WE AIM TO: MODELS OF CARE

The GM Primary Care Strategy details a number of aims that will be undertaken in order to achieve the ambition for primary care. These statements have been mapped against the programmes of work within the implementation plan.

<table>
<thead>
<tr>
<th>“We aim to” statement</th>
<th>Programme: Project</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extend the original concept of integrated health and social care to recognise the important role of family, community and place in promoting the health and wellbeing of our population</td>
<td>Integrated Neighbourhood Working</td>
</tr>
<tr>
<td>Develop good relationships between integrated neighbourhood teams, primary care, local care organisations and hospital teams to provide seamless care</td>
<td>Integrated Neighbourhood Working</td>
</tr>
<tr>
<td>Improve and strengthen the links between general practice, community pharmacy, general dentistry and optometry, making best use of all of these professional groups</td>
<td>Integrated Neighbourhood Working</td>
</tr>
<tr>
<td>Support the development of Primary Care Networks as part of the GM neighbourhood model</td>
<td>Integrated Neighbourhood Working: Primary Care Network development</td>
</tr>
<tr>
<td>Facilitate the delivery of the national Primary Care Network Directed Enhanced Service alongside the GM commissioning-led model</td>
<td>Integrated Neighbourhood Working: Primary Care Network development</td>
</tr>
<tr>
<td>Work with commissioners and providers to develop shared outcome and aligned incentives</td>
<td>Integrated Neighbourhood Working: Primary Care Network development</td>
</tr>
<tr>
<td>Use the opportunity devolution gives GM to go further and faster with wider primary care to deliver truly integrated care</td>
<td>Integrated Neighbourhood Working: Primary Care Network development</td>
</tr>
<tr>
<td>Facilitate the sharing of patient owned records across providers who are providing direct care</td>
<td>Digitally Enabled Primary Care</td>
</tr>
<tr>
<td>Enable the roll out of group consultations as a routine model for supporting people with long-term conditions</td>
<td>Person and Community Centred Approaches: Group consultations</td>
</tr>
<tr>
<td>Support the workforce to embrace and utilise new technologies</td>
<td>Digitally Enabled Primary Care</td>
</tr>
<tr>
<td>Roll out full population coverage of online consultations by April 2020 and video consultations by April 2021</td>
<td>Digitally Enabled Primary Care: online consultations</td>
</tr>
<tr>
<td>Improve utilisation of digital apps for transactional services such as appointment booking and repeat prescriptions</td>
<td>Digitally Enabled Primary Care: GP online services</td>
</tr>
</tbody>
</table>
## WE AIM TO: MODELS OF CARE

<table>
<thead>
<tr>
<th>“We aim to” statement</th>
<th>Programme: Project</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensure Graphnet is integrated into all organisation electronic patient records with a single sign in by 2020</td>
<td>Digitally Enabled Primary Care</td>
</tr>
<tr>
<td>Encourage people to access their personal health record</td>
<td>Digitally Enabled Primary Care</td>
</tr>
<tr>
<td>Facilitate seamless care across primary, community and secondary care, enabled by technology</td>
<td>Digitally Enabled Primary Care: Seamless care</td>
</tr>
<tr>
<td>Encourage peer support to enable people to manage their own long-term conditions</td>
<td>Person and Community Centred Approaches: Group consultations</td>
</tr>
<tr>
<td>Increase the number of professionals that are able to support people to manage their long-term conditions in the community</td>
<td>Population Health: Healthy Living Framework</td>
</tr>
<tr>
<td>Align our primary care health campaigns to the outcomes of the GM Population Health Plan</td>
<td>Population Health: Healthy Living Framework</td>
</tr>
<tr>
<td>Increase early identification of a range of conditions through improving the uptake to the NHS health check</td>
<td>Tackling Health Inequalities</td>
</tr>
<tr>
<td>Work with commissioners, providers and the Voluntary, Community and Social Enterprise sector to implement the GM Community Sight Loss Framework</td>
<td>Tackling Health Inequalities: Sight loss framework</td>
</tr>
<tr>
<td>Provide full population coverage of the Healthy Living programme across primary care</td>
<td>Population Health: Healthy Living Framework</td>
</tr>
<tr>
<td>Make it easier for people to access non-clinical support that gives them the skills, knowledge and confidence to improve their health and wellbeing</td>
<td>Person and Community Centred Approaches: Social Prescribing</td>
</tr>
<tr>
<td>Train our health professionals to enable the provision of different types of primary care consultation, covering aspects of care such as health coaching and shared decision making.</td>
<td>Person and Community Centred Approaches: Group consultations</td>
</tr>
<tr>
<td>Develop relationships with the Voluntary, Community and Social Enterprise sector – making them partners in improving the health and wellbeing of our communities</td>
<td>Person and Community Centred Approaches: Social Prescribing</td>
</tr>
<tr>
<td>Bridge the gap between primary, community and secondary care by supporting high risk patients through intensive proactive care</td>
<td>Tackling Health Inequalities</td>
</tr>
</tbody>
</table>
**WE AIM TO: MODELS OF CARE**

<table>
<thead>
<tr>
<th>“We aim to” statement</th>
<th>Programme: Project</th>
</tr>
</thead>
<tbody>
<tr>
<td>Share the learning from new models of care including focused care, High Impact Primary Care and Extensivist Care models being tested across GM</td>
<td>Integrated Neighbourhood Working</td>
</tr>
<tr>
<td>Redesign pathways to ensure that every person who requires same day access to health advice receives it</td>
<td>Improved Access to Primary Care</td>
</tr>
<tr>
<td>Ensure seamless provision of routine and urgent and emergency primary care</td>
<td>Improved Access to Primary Care: Extended access</td>
</tr>
<tr>
<td>Routinely offer general practice appointments during evenings and weekends</td>
<td>Improved Access to Primary Care: Extended access</td>
</tr>
<tr>
<td>Roll out the Community Pharmacist Consultation Service, connecting patients with minor illnesses to a community pharmacist</td>
<td>Improved Access to Primary Care</td>
</tr>
<tr>
<td>Roll out of Greater Manchester Urgent Dental Telephony and Clinical service</td>
<td>Improved Access to Primary Care</td>
</tr>
</tbody>
</table>
## WE AIM TO: QUALITY

<table>
<thead>
<tr>
<th>&quot;We aim to&quot; statement</th>
<th>Programme: Project</th>
</tr>
</thead>
<tbody>
<tr>
<td>Optimise use, reduce the need for and unintentional exposure to antibiotics as well as support the development of new antimicrobials</td>
<td>Improving Quality in Primary Care</td>
</tr>
<tr>
<td>Standardise primary care provision, ensuring people receive a consistent offer no matter where they are in GM</td>
<td>Improved Access to Primary Care</td>
</tr>
<tr>
<td>Provide full population coverage of Pride in Practice across primary care by 2022</td>
<td>Tackling Health Inequalities: Pride in practice</td>
</tr>
<tr>
<td>Embrace the GM Carers’ Charter ensuring carers are supported to stay healthy and socially connected</td>
<td>Tackling Health Inequalities: Primary care contribution to adult social care</td>
</tr>
<tr>
<td>Roll out the Enhanced Health in Care Homes framework and develop a consistent primary care offer for residential and care homes</td>
<td>Tackling Health Inequalities: Primary care contribution to adult social care</td>
</tr>
<tr>
<td>Embed the general practice support for carers framework of quality markers</td>
<td>Tackling Health Inequalities: Primary care contribution to adult social care</td>
</tr>
<tr>
<td>Develop communications and engagement strategies that better target communities of Interest</td>
<td>Integrated Neighbourhood Working: Communications and engagement</td>
</tr>
<tr>
<td>Create opportunities for peer support and social networking</td>
<td>Integrated Neighbourhood Working: Communications and engagement</td>
</tr>
<tr>
<td>Continue to roll out the GP Excellence programme</td>
<td>Improving Quality in Primary Care: Primary care excellence</td>
</tr>
<tr>
<td>Develop a model for GM Primary Care Excellence</td>
<td>Improving Quality in Primary Care: Primary care excellence</td>
</tr>
<tr>
<td>Use near real-time data at a practice, neighbourhood, locality and GM level to make tactical decisions and deliver the highest quality patient care possible</td>
<td>Information for Improvement: Primary care dashboard</td>
</tr>
<tr>
<td>Develop an automated workforce data collection tool to understand our workforce and plan accordingly</td>
<td>Information for Improvement: General practice workforce visualisation tool</td>
</tr>
<tr>
<td>Take the learning from the Electronic Pharmacy Referral System pilot and scale up across Greater Manchester</td>
<td>Digitally Enabled Primary Care: Seamless care</td>
</tr>
<tr>
<td>Review the implementation of the GM Primary Care Medical Standards and ensure the learning is shared</td>
<td>Improving Quality in Primary Care: Primary Care Medical Standards</td>
</tr>
<tr>
<td>Develop the primary care standards ensuring that they are outcomes based</td>
<td>Improving Quality in Primary Care: Primary Care Standards</td>
</tr>
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</table>
## WE AIM TO: SUSTAINABILITY

<table>
<thead>
<tr>
<th>“We aim to” statement</th>
<th>Programme: Project</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implement the Greater Manchester Primary Care Workforce Strategy</td>
<td>Workforce Development</td>
</tr>
<tr>
<td>Take the learning from the NHS England Regional GP Retention and International GP Recruitment programmes to extend to other key roles and scale up across Greater Manchester</td>
<td>Workforce Development: Retention</td>
</tr>
<tr>
<td>Review the impact of the implementation of the GM Primary Care Reform Programme and share the learning</td>
<td>Improved Access to Primary Care</td>
</tr>
<tr>
<td>Establish an integrated training hub in each locality</td>
<td>Workforce Development</td>
</tr>
<tr>
<td>Continuously engage with grass roots primary care clinicians</td>
<td>Workforce Development</td>
</tr>
<tr>
<td>Embed a number of new roles including Nurse Associates, Physician Associates and apprenticeships</td>
<td>Workforce Development</td>
</tr>
<tr>
<td>Explore the opportunity for pharmacy technician led services to free up the pharmacists’ time</td>
<td>Workforce Development</td>
</tr>
<tr>
<td>Continue to maximise the opportunities in general practice through ‘return to practice’, ‘retire and return’ programmes, and greater utilisation of the General Practice Nurse Resource Pack</td>
<td>Workforce Development</td>
</tr>
<tr>
<td>Create opportunities to improve interprofessional relationships between primary, community and secondary care workforce</td>
<td>Workforce Development</td>
</tr>
<tr>
<td>Facilitate organisational development and leadership development across the whole of primary care</td>
<td>Integrated Neighbourhood Working: Leadership and organisational development</td>
</tr>
</tbody>
</table>
The implementation plan captures the entirety of the primary care programme. However, the following projects and programmes were prioritised during the implementation plan workshop:

- **Integrated neighbourhood working** – including PCN development, comms and engagement, OD and leadership and estates

- **Digitally enabled primary care** – including online and video consultations and seamless care between secondary, community and primary care

- **Workforce development** – recruitment and retention across all primary care

- **Improving access to primary care** – including urgent and emergency care and extended 7-day access
### GMHSCP Priorities

<table>
<thead>
<tr>
<th>Priority</th>
<th>Additional Comment</th>
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</thead>
<tbody>
<tr>
<td>Leadership and OD</td>
<td>Development of support at GM level that mirrors PCN development support</td>
</tr>
<tr>
<td>Direct Booking</td>
<td>National direction, GM led, locality implementation</td>
</tr>
<tr>
<td>Primary Care Platform</td>
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<tr>
<td>Seamless Care</td>
<td>Led by GM Local Professional Network</td>
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<tr>
<td>Eye Health IT Enabler</td>
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<tr>
<td>Proactive Children’s Dental Management</td>
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<tr>
<td>Healthy Living Framework</td>
<td>Led by GM Local Professional Network</td>
</tr>
<tr>
<td>Primary Care Health Campaigns</td>
<td>Led by GM Local Professional Network</td>
</tr>
<tr>
<td>Environmental Sustainability</td>
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<tr>
<td>Pride in Practice</td>
<td>Led by GM Local Professional Network</td>
</tr>
<tr>
<td>Transgender Health Service</td>
<td>National pilot</td>
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<tr>
<td>Increased Uptake to Sight Tests</td>
<td>Led by GM Local Professional Network</td>
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<tr>
<td>Primary Care in Care Homes</td>
<td></td>
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<tr>
<td>Oral Health in Older People</td>
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<tr>
<td>GM Excellence</td>
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<td>GM Standards</td>
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<tr>
<td>Research in primary care</td>
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<tr>
<td>Primary Care Dashboard</td>
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<tr>
<td>GP Workforce Visualisation</td>
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<td>Retention</td>
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<tr>
<td>International Recruitment</td>
<td>National programme</td>
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</table>

### Locality Priorities

<table>
<thead>
<tr>
<th>Priority</th>
<th>Additional Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCN Development</td>
<td>Funding split between GM and localities but locality led</td>
</tr>
<tr>
<td>Estates</td>
<td>Capital funding is held at GM but spend is determined by localities</td>
</tr>
<tr>
<td>Social Prescribing</td>
<td>Locality funded and locality driven</td>
</tr>
<tr>
<td>Group Consultations</td>
<td>Locality developed schemes</td>
</tr>
<tr>
<td>GP Online Services</td>
<td>National direction, locality implementation</td>
</tr>
<tr>
<td>Online Consultations</td>
<td>GM funded, locality implemented</td>
</tr>
<tr>
<td>Meeting Demand</td>
<td></td>
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<tr>
<td>7 Day Access</td>
<td>GM funded (until Mar 2020), locality developed</td>
</tr>
<tr>
<td>Primary Eye Care Service Framework</td>
<td>Delegated to localities once approved</td>
</tr>
<tr>
<td>Embedding new roles</td>
<td>Via PCN DES</td>
</tr>
<tr>
<td>Increased Uptake to Sight Tests</td>
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<td>National programme</td>
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</tbody>
</table>
GM is working hard to break down the silos which exist between public services that can lead to isolated decision making and a narrow focus to service delivery. Teams working more closely will reduce the number of people being passed from service to service without the services truly understanding what people and communities really need.

**Primary care projects include:**

- Primary Care Network Development
- Leadership and Organisational Development
- Communications and Engagement
- Estates
### Aims, Objectives

The aim of this programme is to ensure that primary care is firmly embedded into the GM neighbourhood model, working alongside LCOs, community and secondary care to deliver the best outcomes for local communities. This includes:

- Supporting the development and evolution of the 67 PCNs
- Facilitating the delivery of the national PCN DES alongside a GM led commissioning model
- Using the opportunity that devolution gives GM to go further and faster with wider primary care to deliver truly integrated care

### Expected outcomes

- The development of PCNs is intended to provide stability to general practice
- New roles and opportunities for development will improve skill mix
- PCNs will dissolve the divide between primary care and community care and improved links between primary and secondary care
- There will be provision of more proactive, co-ordinated care and improved outcomes for patients and the wider population
- This will lead to better health and reduced health inequalities

### Benefits / Rationale

- More sustainable and satisfying roles for the workforce
- Development of multi-professional teams working across traditional boundaries
- Reduced pressure on General Practice and a more balanced workload
- Better utilisation of all primary care
- Reflection of the priorities of local people including better urgent care access and improved digital services

### Delivery Activities (to date)

- A quarterly GM Local Leaders Network has been established. The clinically led network provides a safe space for PCN Clinical Directors and Neighbourhood Clinical Leads and an opportunity for peer support and development.
- A task and finish group has been established to agree a collective approach to the roll out of PCN development funding
- Each locality has submitted details of their local PCN development plans
- Agreement and allocation of development funding to PCNs
- Agreement and development of GM support to PCNs

### Milestones / commitments

- Development of assurance framework for locality PCN development – **January 2019**
- Local leaders network event – **January 2020**
- Broaden Local Leaders Network membership to wider primary care – **March 2020**
- Receipt of locality assurance re PCN development fund – **April 2020**

### Risks

- PCNs are new entities and many clinical directors are new to system leadership
- Engagement of PCNs and the neighbourhoods may not be sufficient to deliver the GM neighbourhood model
- PCN capacity to engage at a GM level when already doing so at locality level

### Lead(s)

- Locality led
- GM GP Excellence Programme, GM Health and Social Care Partnership
Leadership and Organisational Development (Wider Primary Care)

Ask of GM: Development of leadership opportunities for wider primary care, which is aligned to the PCN support

Ask of Localities: Identification of local leaders in dentistry, pharmacy and optometry, facilitation of engagement with clinical directors and neighbourhood leads

Some of the most wide-ranging changes are occurring in primary care. To meet the needs of a changing population, adopt vital innovations, redesign for greater sustainability and support increasing personalised and integrated care, primary care teams will need to evolve the way they work. These are leadership challenges of unprecedented scale and complexity which require that primary care professionals are inspired, equipped and supported in leadership roles.

<table>
<thead>
<tr>
<th>Aims, Objectives</th>
<th>This project aims to:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Facilitate organisational development and leadership across the whole of primary care</td>
</tr>
<tr>
<td></td>
<td>• Understand the needs of emerging leaders across dental, optometry and pharmacy</td>
</tr>
<tr>
<td></td>
<td>• Create development opportunities in line with PCN and ‘one public service’ development</td>
</tr>
</tbody>
</table>

| Expected outcomes | |
|-------------------|• The emergence of identifiable system leads in dentistry, optometry and pharmacy |
|                   |• Primary care leaders have the skills and expertise required to lead a ‘place’ across organisational and professional boundaries |

| Benefits / Rationale | |
|----------------------|• Primary care leaders better able to facilitate and implement change, influence others and build resilience |

| Delivery Activities (to date) | |
|------------------------------|• Identification of funding to support the development of leadership in wider primary care |
|                              |• Initial enquiries with the North West Leadership Academy |

| Milestones / commitments | |
|--------------------------|• Development of a leadership offer for wider primary care – January 2020 |
|                          |• Roll out of leadership offer pilot – February-March – 2020 |
|                          |• Evaluation of leadership development and agreement of next steps – May 2020 |

| Risks | |
|-------|• There is no resource in place for emerging pharmacy, dentistry and optometry leaders in 19/20. However, in 20/21 the PCN Development Fund will cover the breadth of primary care. |

| Lead(s) | |
|---------|• GM Local Professional Network Chairs (dental, eye health, pharmacy) |
**COMMUNICATIONS AND ENGAGEMENT**

<table>
<thead>
<tr>
<th>Discovery</th>
<th>Define</th>
<th>Design &amp; Develop</th>
<th>Deliver</th>
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</table>

**Ask of GM:** Support to the GM Citizens Network, promotion of primary care developments and achievements

**Ask of Localities:** Identification and sharing of primary care developments and achievements with stakeholders and local governance groups, e.g. Primary Care Commissioning Committees.

*For our plans to succeed, all commissioners, providers and users of primary care need to be fully engaged as we work towards our aim of achieving properly integrated public services. Our communications and engagement activities must clearly show patients, the public and our workforce the benefits of transforming the way that services are currently delivered. This means sending out the right messages, in the right way, to develop meaningful dialogue with all our stakeholders.*

### Aims, Objectives

The aim of the communications and engagement plan is to support the implementation of the primary care strategy through strong stakeholder relationships and effective two-way communications. This will be achieved by the following objectives:

- The development and maintenance of a comprehensive stakeholder database
- The establishment of appropriate methods of communication to ensure the sharing of best practice and primary care developments
- Ensuring effective means of communication between the primary care and stakeholders
- Establishment and ongoing support of a GM Citizens’ Network to build an active network of stakeholders committed to improving health and wellbeing in GM localities and communities.

### Expected outcomes

- Improved engagement with stakeholders in relation to primary care development
- Inclusion of a patient and public voice to influence emerging plans for primary care services across GM to improve services and the health of residents.
- Alignment of local plans with GM messages.

### Benefits / Rationale

- Improved communications ensuring stakeholders have accurate information
- High quality and diverse two-way communications system meaning we can reach a wider range of stakeholders
- Creation of a shared purpose that stakeholders are fully engaged with

### Delivery Activities (to date)

- A new GM Citizen’s Network has been established to make a valuable contribution to the work of the Primary Care Provider Board in improving health and social care services across Greater Manchester. The network is comprised of enthusiastic volunteers and patients from across the 10 boroughs of Greater Manchester who engage virtually with their own local networks and can ensure the public and patient voice shapes the strategic direction of primary care.
- The 7th Greater Manchester Primary Care Summit, highlighting the theme ‘Primary Care is Changing’, was held on 11th April 2019, bringing together a range of health and care colleagues from across Greater Manchester and beyond.
- Development of primary care delivery programme newsletter and reporting mechanism.
- Development of a 2018/19 Primary Care Delivery Programme Annual Report

### Milestones / commitments

- Presentation of the refreshed GM Primary Care Strategy and implementation plan to the GM Health and Care Board – **January 2020**
- Establishment of online engagement/feedback mechanism with citizens network members – **March 2020**
- Publication of Primary Care Delivery Programme end of strategy report – **April 2020**
- Development of online stakeholder engagement mechanism – **April 2020**
- To develop clear governance mechanisms to steer feedback through appropriate channels – **April 2020**
- Continue to promote and raise profile of Citizens’ Network to other teams for meaningful engagement – **Ongoing**
- To broaden membership of the Citizens’ Network and be inclusive of all communities and localities across GM – **April 2020 / Ongoing**

### Risks

- Lack of engagement with stakeholders could adversely impact on the delivery of the primary care delivery programme.
- Poor communication will risk staff and patient/public confidence in the primary care delivery programme.
- Poor staff engagement could hinder patient/public adopting new ways of working and therefore delay the delivery of the primary care strategy.

### Lead(s)

- Primary Care, GM Health and Social Care Partnership
- Locality communications and engagement teams
We know that a significant number of our GP practices are in buildings not fit for purpose and this often presents a predicament for GPs who have invested in these premises. We are therefore exploring the ‘art of the possible’ which includes: streamlining processes and barriers, reviewing all premises to understand how we can better utilise public sector estate, development of a toolkit for practices to consider their options.

Aims, Objectives
- Development of clear capital programme and pipeline to ensure schemes are properly prioritised, areas receive the appropriate allocations and new builds can evidence how it delivers more efficient primary and community services.
- This programme aims to support new ways of working by:
  - Facilitating utilisation of BAU capital
  - Facilitation utilisation of ETTF primary care capital
  - Supporting the development of ‘hub based working’ in localities
  - Transforming premises to support Integrated working

Expected outcomes
- Improved GP facilities across GM which offer fit for purpose premises for patients and staff
- Improved integration of services at one site, offering patients a more streamlined joined up service
- Increased utilisation of public sector estate across GM were possible and rationalisation of estates where premises are no longer fit for purpose.

Benefits / Rationale
- Rationalisation of surplus estate
- Use property as a catalyst for service transformation and integration
- Efficient management and utilisation of primary care estate
- Support improved health and social care outcomes

Delivery Activities (to date)
- Facilitation of BAU and ETTF capital process
- Collation of hub locations from localities and completion of some 6 facet surveys
- Mapping of GP practices (including condition of estate) completed by New Economy
- Establishment of estates task and finish group
- Establishment of Strategic Estates Group (SEG) Chairs forum to share best practice
- A further £790k has been committed to improve GP premises across GM.
- The system has already submitted plans for learning disability schemes for 2020/21 and these are currently under review.
- Report of neighbourhood asset reviews

Milestones / commitments
- Fully utilise the ETTF and BAU capital allocations - March 2020
- 2 pre-committed schemes progressing this year (Unsworth & Horwich scheme in Bolton) - awaiting further costings before they can progress to the next stage – March 2020
- Further approved ETTF schemes are expected to commence (Cordialhurst in Wigan and Kearsley scheme in Bolton) – March 2020
- 2 pre-committed large BAU schemes are progressing well (Royton in Oldham and Pennygate in Wigan) – March 2020.
- Three learning disability schemes expected to complete this year in Manchester, Bury and Trafford – March 2020

Risks
- LD schemes have been given priority but delays in finding adequate premises may result in capital slippage later in the year.
- Procurement of building contractors and planning permission for large scheme could result in delays, this would increase underspends on the capital allocations.

Lead(s)
- Primary Care, GM Health and Social Care Partnership
PERSON AND COMMUNITY CENTRED APPROACHES

Primary care is working with the GM system to develop health solutions that are much more than medicine and involve connecting people to non-medical care, support, information, advice and activities in the community. The consideration of issues that affect people’s health, such as employment, fuel poverty and social isolation, will become as embedded in primary care provision as writing a prescription or making a referral to secondary care.

Primary care projects include:

• Social Prescribing
• Group Consultations
### Social Prescribing

#### Aims, Objectives
- Social prescribing aims to support people who frequently attend primary or secondary health care to access non medical support which is more suited to their needs.
- Existing social prescribing schemes and new PCN social prescribing link workers will work with patients to:
  - Assess and evaluate whether health and wellbeing needs can be met by services and other opportunities in the community
  - Co-produce a simple personalised care and support plan to address the patient’s health and wellbeing needs by introducing or reconnecting people to community groups and statutory services;
  - Provide personalised support to individuals, their families and carers to take control of their health and wellbeing, live independently and improve their health outcomes;
  - Develop trusting relationships by giving people time and focus on ‘what matters to them’; and take a holistic approach, based on the person’s priorities, and the wider determinants of health.

#### Expected Outcomes
- Reduced pressure on clinicians and public sector services
- Improved timely access to health services and strengthening of community resilience
- Better ability to meet the needs of diverse and multi-cultural communities
- Sustainability of social prescribing and community investment within placed-based integration and PCN

#### Benefits / Rationale
- Improved quality of life and emotional wellbeing
- Improved ability to manage practical issues, such as debt, housing and mobility
- Better connections to others, including less social isolation
- Improved ability to manage their own health and wellbeing

#### Delivery Activities (to date)
- Local models for social prescribing have been established across GM. E.g. Wigan Borough Community Link Workers are in place, working as part of the Integrated Teams supporting practices and patients within the place. These link workers work directly with practices, and give the opportunity for patients to be referred to them, picking up the wider needs (non medical) that can support an individual to be in control of their health and care.
- A GM Social Prescribing Network has also been established.
- From the 1st July, PCNs have been able to begin the recruitment of a pharmacist and social prescribing link worker, which will constitute the first elements of an extended primary care workforce.

#### Milestones / Commitments
- In 2019/20 social prescribing link workers will take referrals from the PCN members, expanding from 2020/21 to take referrals from a wide range of agencies, to support the health and wellbeing of patients.
- 13,000 referrals by **March 2020**
- Social Prescribing IT platform to record & track activity/outcomes – **March 2020**
- GM Toolkit for Social Prescribing – **March 2020**

#### Risks
- There is a risk that social prescribing will increasingly be viewed as a quick and easy fix to several of the major issues currently facing the NHS (e.g. rising demand and inadequate funding).
- There is a risk that established social prescribing schemes in localities may become destabilised.
- Increased utilisation of VCSE services, without suitable investment may destabilise the sector

#### Lead(s)
- General Practice via Primary Care Networks
- VCSE sector
**GROUP CONSULTATIONS**

<table>
<thead>
<tr>
<th>Discovery</th>
<th>Define</th>
<th>Design &amp; Develop</th>
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</table>

**Ask of GM:** Support identification of funding to facilitate GM wide coverage of group consultations  
**Ask of Localities:** Develop the group consultation model and embed as routine model of long term conditions management

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**Aims, Objectives**

To enable patients:
- to spend longer with a clinician who knows them because they gain confidence from this regular connection; feel better supported and more confident to self-care when they regularly see a clinician whom they know and trust.
- to receive proactive routine follow up and review because this helps them to take control; reassures them; reduces their anxiety and prevents then “falling through the net”
- To set goals together with practice clinicians both around what they can do to help themselves and what the clinical team can do to help them
- To review these goals regularly (a robust, proactive care planning approach)
- To connect with people with the same condition because it gives them confidence, hope and inspires them to change and take control.

In the future we would like to:
- see group consultations as the routine model for supporting people with long term conditions across primary care networks and neighbourhoods.
- expand the workforce that delivers group consultations, so that these consultations can be delivered by a range of roles, including pharmacists and community paramedics

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**Expected outcomes**

- Enhanced patient experience
- Improved clinical outcomes
- Reduction in hospital admissions
- Reduction in A&E attendance

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**Benefits / Rationale**

Research has found that group consultations:
- Create efficiency and time savings
- Improve access to continuity of care and increase perceived time spent with clinicians
- Improve access to routine care for people with long term health issues
- Systematise care planning follow up and review
- Seed and build peer connection and peer led support groups: people connect with the rest of the group.
- Activate confident self-management in those who need to build confidence and self esteem
- Reduce or streamline GP appointments
- Improve person and family care experience and satisfaction.

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**Delivery Activities (to date)**

- Greater Manchester General Practice Nurses were among the first in the country to trial group consultations, these are an alternative way to deliver planned clinical care to people with long-term conditions that supports continuity and consistency of care and benefits both patients and professionals.
- Identified funding for roll out

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**Milestones / commitments**

- Scoping work includes:
  - Design and share options appraisal - **January 2020**
  - CCG to determine preferred approach and detail implementation plan - **February 2020**
  - Funding released - **March 2020**
  - Monitoring of uptake across GM - **2020/21**

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**Risks**

- There is a risk that there will not be adequate funding for training in group consultations for enable this model to be rolled out across GM.

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**Lead(s)**

- GM Primary Care Workforce Programme
- Locality Workforce Leads
DIGITALLY ENABLED PRIMARY CARE

Digital technology has the potential to transform the way we deliver health and care services. Online services will help people to manage their health and wellbeing needs, backed up by face-to-face care when needed. We will develop digital solutions to promote healthy living and self-management. Most importantly, people will be able to choose how they access services.

**Primary care projects include:**
- Increased Use of Online services
- Direct Booking
- Information Management and Technology
- Primary Care Platform
- Online and video consultations
- Seamless Care
- Eye Health IT Enabler
INCREASING THE USE OF GP ONLINE SERVICES

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Ask of GM: Monitoring of uptake and usage across GM
Ask of Localities: Commissioners and providers to work together to increase sign up and usage of online services. Providers to proactively promote online services to patients.

GP online services is an NHS England programme designed to support general practices to confidently offer these online services to patients, increasing choice and convenience for patients and responding to their needs. These services include:
- booking and cancelling of appointments
- ordering of repeat prescriptions
- viewing of their GP record (which includes coded information about allergies, immunisations, diagnoses, medication and test results).

Aims, Objectives

- Enable patients to go online to book appointments, order repeat prescriptions and view their own health records within their GP practice.
- Allocate 25% of a practice’s current appointments to provide an alternative route for patients to access the booking of appointments.

Expected outcomes

- Evidence shows that patients who are informed and involved in their own care have better outcomes and are less likely to be hospitalised.
- Releasing appointments for online booking as part of the book on the day allocation may reduce the pressure on telephone lines and reduce work for receptionists.

Benefits / Rationale

**Benefits to GP practices:**
- Receiving repeat prescription requests online rather than via the telephone may be easier for staff because it avoids opportunities for error when taking down information over the phone.
- Fewer phone calls and face-to-face transactions with patients which releases time for reception and administration staff to be deployed on other tasks.
- Free up phone lines for patients who still wish to contact the practice using the telephone.
- Easier for patients to cancel or re-book appointments, resulting in reduced “did not attends” (DNAs).

**Benefits to patients:**
- Anywhere, anytime access – 24 hours a day, 7 days a week.
- Reduces visits and phone calls to the practice.
- Able to give permission to an authorised proxy to manage their appointments and prescription ordering.
- Able to check which medication they should be taking and when and verify that the medication they are taking regularly is put on repeat prescription.

- A number of apps are available, including the new NHS App, that will help GP practices meet their targets for registering patients to GP online services as set out in the GP contract. The apps don’t change the online services that are already available; it is a new way of accessing them that can encourage uptake.

Delivery Activities (to date)

- 95 practices across GM are reporting that over 30% of their registered patients are enabled to use one or more GP online service (July 2019)
- All EMIS and TPP practices are connected to the NHS App. NHS App has been rolled out to 86% of GM GP practices.
- Testing continues with Vision. Time frames for connection to this supplier system has not yet been confirmed.

Milestones / commitments

- As a default, all practices will be offering and promoting electronic ordering of repeat prescriptions and using electronic repeat dispensing for all patients for whom it is clinically appropriate.
- All practices will ensure at least 25% of appointments are available for online booking.

Risks

- There are c200 practices across GM that are reporting that less than 20% of their registered patients are enabled to use one or more GP online service (July 2019). This means that there is not a consistent offer for patients for online GP services across GM.
- There is a risk that there will not be enough appointments allocated to online booking and patients will continue to book appointments via more traditional methods – in person, telephone – thus not releasing receptionist time.

Lead(s)

- GM locality commissioners
- GM GP Provider Board
**DIRECT BOOKING**

<table>
<thead>
<tr>
<th>Discovery</th>
<th>Define</th>
<th>Design &amp; Develop</th>
<th>Deliver</th>
<th>Evaluate</th>
</tr>
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</table>

**Ask of GM:** Facilitate discussions between NHS Digital and localities

**Ask of Localities:** Commissioners to work with eligible practices and extended access providers to facilitate direct booking via NHS 111 and other local urgent care services.

**Aims, Objectives**
- Make unscheduled primary care services easier to use and better for patients.
- Get patients to the right care more quickly – reducing unnecessary steps.
- Make using the NHS for unscheduled primary care less complex and confusing.
- Support NHS 111 with IT that helps the sharing of patient records, referrals and booking of appointments as part of an integrated system.

**Expected outcomes**
- **Right care, right place from people with the right skills:** Improve access to unplanned primary care so the right care is in place for a patients’ needs.
- **Help people to recover from episodes of ill-health or following an injury:** NHS 111 responds to a patient’s immediate need in a timely fashion and arranges for any follow-up care and support required in one go.
- **Ensure people have a positive experience of care:** Patients get information and options for self-care and are supported to manage an acute or long-term physical or mental condition.

**Benefit/Rationale**
- There are many benefits connected with Direct Booking for the patient, the GP Practice, NHS 111 and the wider healthcare economy:
  - Patients are more likely to adhere to the advice given by NHS 111 and attend the most appropriate service when they have a booked appointment.
  - Provides a seamless ‘patient-friendly’ experience – one call, not multiples to book appointment.
  - Supports access to, and the delivery of, relevant clinical care.
  - Patients are given appointments in their own surgery.
  - Improved use of GP Practice reception time – due to less calls to book appointments.
  - A timely appointment in line with clinical dispositions – with flexibility to move to most appropriate clinician, as necessary.
  - Reduces footfall into EDs, Urgent Treatment Centres and calls into a GP practice improving the wider healthcare economy.

**Delivery Activities (to date)**
- Direct booking from 111 into extended access hubs is currently taking place in **Oldham** and **Manchester**.
- Within GM, **2 practices** have enabled direct booking to date.
- CCGs have a list of all their eligible practices and all the guidance for getting started with GP Connect. CCGs have been asked to:
  - Contact their practices highlighting the contractual and technical requirements around GP Connect.
  - Support their practices in getting started by completing a web based GP Connect enquiry form to put them in touch with the GP Connect team.

**Milestones / commitments**
- Practices are required to make available 1 appointment per 3,000 patients per day for NHS 111 to book directly into practice appointments. This is provided that the functionality and governance exist.
- CCGs should by **March 2020** be able to direct appointments via 111 to an extended access service when that clinical path is identified for **100%** of its population.

**Risks**
- General practice may not fulfil new contract requirements in relation to taking same-day bookings direct from NHS 111 when clinically appropriate.

**Lead(s)**
- NHS Digital
- Primary Care Team, GM Health and Social Care Partnership
- Local commissioners and providers
Embracing advances in technology will enable us to deliver primary care in new ways. We want to use digital technology to improve how people access care, particularly to their GP, while making best use of resources. Digital technology will also mean records can be shared across care providers. If we can get the fundamentals of interoperability right, we will have the foundations in place to deliver our ambitions both to become ‘paper-free’ at the point of care and to strengthen primary care to create easier access to services that fit around the patient’s family and work life.

<table>
<thead>
<tr>
<th>Aims, Objectives</th>
<th>This programme aims to facilitate a common approach to information and technology for all of primary care. Including</th>
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<tr>
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<td>• Supporting the development of the right information governance ensuring the appropriate legal/ethical framework for sharing information</td>
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<td></td>
<td>• Supporting the development of interoperability across organisations and geographical boundaries</td>
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| Expected outcomes | • Improving patients’ lives by using digital technology to give patients the access to their information and their health and care. |
|                  | • To increase the toolkit for health and care professionals to better manage workloads |
|                  | • To use digital technology to analyse information and provide better evidence for clinical and commissioning decisions |

**Benefits / Rationale**

- Co-ordinated approach to IM&T developments
- Improve patient self-management and access to primary care services
- Create multi-modal opportunities for care; increasing the clinical toolkit.
- Delivering improvements aligned to the Long Term Plan.

**Delivery Activities (to date)**

- Agreed GPIT priorities for 2019/20
- Digital fund assurance panel took place to review submitted bids – **August 2019**
- Facilitation of the ETTF and Digital Fund
- £790k of pre-committed technology schemes have been supported this year through ETTF with a further £1.5m of schemes approved in 2019/20
- Pre-commitments of £2m GPIT have been supported this year with a further £0.5m recently approved.

**Milestones / commitments**

- GM are fully committed to utilise the whole of their capital allocations in 2019/20 across GPIT/IT.

**Risks**

- Low adoption which could lead to difficulties in delivery.
- Technology increasingly has a revenue annual cost; and this needs to be recognised in funding.
- Deprivation can cause challenges with adopting technology where the technology is not available to hard-to-reach groups

**Lead(s)**

Primary Care Transformation Team, GM Health and Social Care Partnership
The development and ongoing promotion of an online Greater Manchester Primary Care Platform, which brings together general practice, dentistry, optometry and pharmacy. This website would help to address the recruitment and retention challenges we are experiencing across all primary care sectors in GM.

### Aims, Objectives
This online portal is intended to be the first port of call for workforce-related matters across all primary care sectors and would be used to:
- Offer an additional recruitment method for primary care sites and an alternative search mechanism for jobseekers, which is GM-specific (at no cost to either audience).
- Provide a single point of access for users looking for careers/workforce-related information.
- Host information for all role disciplines within primary care.
- Provide guidance around schemes and initiatives (e.g. GP Retention Scheme, I&R Scheme, GP Career Support Pack) which are not currently hosted anywhere at a GM-level.
- Clearly signpost users to related GM websites which may already host the information they require.
- Allow stakeholders such as CCGs to have their own section and promote their area of GM accordingly.
- Offer a ‘Contact us’ function, allowing users to communicate with the GM workforce team in order to ask questions and/or request support.
- Through marketing of the platform, communicate new national, regional and local initiatives, in addition to content updates, which support recruitment and retention within GM. Promotion would also encourage both employers and job-seekers to make use of the vacancy functionality.

### Expected outcomes
- Improve the recruitment and retention of key roles and skills across primary care
- Ensure staff are aware of opportunities for development in Greater Manchester
- Help to ensure that primary care is seen as the ‘career of choice’ and GM is the ‘region of choice’.

### Benefits / Rationale
- The platform is intended to help address recruitment and retention challenges across the whole of primary care in GM. Primary care staff both within and outside of GM will be able to access GM vacancies and find out more about what a career within GM can offer. They will be signposted quickly and easily to partner websites where necessary. If staff feel informed and engaged with, and they can easily access information pertaining to their career development, this would encourage them to continue working in GM as opposed to seeking opportunities elsewhere.

### Delivery Activities (to date)
- Project agreed by the GM Primary Care Core Steering Group and Primary Care Oversight and Delivery Group.

### Milestones / commitments
- Development of primary care platform: specification developed – January 2020
- Development of primary care platform: launch – March 2020

### Risks
- There is a risk that promotion to jobseekers will be difficult, especially to anyone outside of GM, unless there is a comprehensive comms and marketing plan. If practices do not receive applicants quickly, they may be reluctant to use the platform again, thus continuous engagement is key.
- As the vacancy section is expected to be ‘self-service’ for employers, there is a risk that the content and presentation of job advertisements could vary greatly, so templates and guidance may be required. However there is likely to be a feed from NHS jobs so this will provide some standardisation and will mitigate some of the risk.

### Lead(s)
- Primary Care Workforce Managers, GM Health and Social Care Partnership
Recent years have seen rapid development of a number of online consultation systems for patients to connect with their general practice. Using a mobile app or online portal, patients can tell the practice about their query or problem, and receive a reply, prescription, call back or other kind of appointment. They can also access information about symptoms and treatment, supporting greater use of self care.

### Aims, Objectives

Through GM Primary Care Reform Programme funding, roll out an online consultation solution to all practices across GM, ensuring that the chosen systems has the following features:

- Connection via web browser, mobile app or both. Apps should be accessible to patients without payment.
- Functionality to allow the patient to enter a query, symptoms or other information and for this to be transmitted securely to their registered GP practice.
- Information provided by patients used for clinical purposes must be capable of being imported back into the GP practice system with minimal manual intervention.
- Optionally, the system may provide functionality to provide or signpost the patient to information relating to their query or symptoms. This may include information about conditions and treatment or about local health, care and support services.

### Expected outcomes

- Reduction in face-to-face contacts and free up GP time
- Improving access for patients.

### Benefits / Rationale

- These systems are proving to be popular with patients of all ages. Many enable the patient to access information about symptoms, conditions and treatments, and connect to self help options. They free up time for GPs, allowing them to spend more time managing complex needs. Some issues are resolved by the patient themselves, or by another member of the practice team. Others are managed by the GP entirely remotely, with about a third of online consultations being followed up with a face to face consultation.

### Delivery Activities (to date)

- The service in Wigan is delivered through the GP Alliance at a borough-wide level which is available to all patients, rather than an individual practice model. The CCG is also working with individual practices to look at how practice level online consultations can also improve patient access.
- Nine out of ten localities in GM have identified a provider for their online consultation solution.
- 132 general practices across GM are offering online consultations to their patients.

### Milestones / commitments

- NHS App integration with online service providers will be completed by January 2020.
- CCGs are expected to work with their practices to ensure that by March 2020, 100% of practices are offering online consultations to their patients.
- Delivery of an online consultation offer in each practice by April 2020
- Delivery of video consultation offer in each practice by April 2021

### Risks

- There is a risk that procured online consultation software will not be compatible with the new NHS App and other software.
- There is a risk that the functionality of solutions that have been commissioned do not meet expectations.

### Lead(s)

- GM locality commissioners
- GM GP Provider Board
### Aims, Objectives

This project will:
- Identify the benefits and requirements of an electronic referral system.
- Develop a specification for procurement initially focusing on referral between hospital and mental health trusts and community pharmacies but with the capability for further development to include pharmacy teams working in general practices.
- Manage the implementation of the electronic referral system across GM

### Expected outcomes

- Improved medicines optimisation and hence safety (reduction of harm)
- A direct improvement in the transition of care between secondary and primary care.
- Reduced medicines wastage
- Reduce non-elective hospital re-admissions for medicines related issues following discharge.
- Improved patient and carer experience of care and increased patient empowerment.
- Cost savings to the GM health economy through reduced hospital readmission, delayed discharge and medicines wastage.

### Benefits / Rationale

- Between 30-70% of patients experience an error or unintended change to their medications when transferred across care settings. Issues often occur when patients are discharged from secondary care back to primary care.

### Delivery Activities (to date)

- The GMHSC Partnership pharmacy contracts team commissioned Healthwatch to work with patients who had been discharged from hospital in the last two years to understand their experience of their medicines whilst in hospital and when they were discharged. Healthwatch undertook online patient surveys and 7 focus groups in 18 locations across Greater Manchester. 256 respondents participated in the survey and 85 people participated in the interviews and workshops.
- A pilot has commenced in Salford where an electronic referral system about medicines has been implemented. From the commencement of the pilot in February through to the end of April, 237 referrals have been made by Salford Royal Hospital pharmacy to community pharmacies.

### Milestones / commitments

- Discussions with Tameside and Glossop, Stockport and Bolton continue and these localities are expected to go live from **January 2020**

### Risks

- There is a risk that GM will become an outlier if this project is not implemented as it has been identified as a priority area for other Academic Health Science Networks (AHSNs) in England.

### Lead(s)

- Local Pharmacy Network
- Health Innovation Manchester
- GMLPC
## EYE HEALTH IT ENABLER PROJECT

<table>
<thead>
<tr>
<th>Discovery</th>
<th>Define</th>
<th>Design &amp; Develop</th>
<th>Deliver</th>
<th>Evaluate</th>
</tr>
</thead>
</table>

**Ask of GM:** Lead and management of project, identification of funding, facilitation of discussions with general practice and acute providers regarding roll out across GM  
**Ask of Localities:** General practice and acute providers to work with GM team and optometry practices to streamline eye health referrals

The IT Connectivity project for Optometry practices in Greater Manchester aims to enable optometrists to access services, such as the Summary Care Record (SCR) and enable referrals to and from GP practices through the NHS Spine. The project also includes the development of a solution to allow for information / clinic letters to be sent electronically to GPs.

### Aims, Objectives

The GM Connectivity project is of 3 years duration (commencing in early 2018) and was agreed to deliver the following objectives:

- Improve clarity and quality of referrals (i.e. reduce unwarranted variation)
- Enable ability to identify referral trends and ability for workforce development
- Enable secure methods of communication
- Reduce duplication
- Introduce use of standard NHS identifier of patients (NHS number)
- Enable access to elements of wider GP patient record(s) to support care in optical practice and quality of care and referrals
- Enable integration/interoperability with ophthalmology and other GM IM&T systems

### Expected outcomes

- Improved clarity and quality of referrals
- Increased number of optical practices making referrals via ERS
- Improved patient journey and access to services by streamlining and digitalising patient referrals and enable optometrists to access patient summary care records.

### Benefits / Rationale

The project will:

- enable electronic referral of patients directly into GP workflows and directly to ophthalmology services. It will also ensure timely flow of clinical information back to the referring optometrist and access patient summary care records supporting more holistic patient care.
- support the harmonisation and standardisation of referral process and access to patient records across the whole of GM.
- Support community optometry services to play a stronger role and be more integrated in community-based services.
- support better integrated care by breaking down national system barriers and enable the delivery of key GM IT strategies.

### Delivery Activities (to date)

- The technical development has been completed for the patient referral module, enabling direct electronic referrals from optometry practices to GP practices and secondary care ophthalmology services. The developed IT platform will also enable optometrists to access services such as Summary Care Records via the NHS Spine to enhance patient care.
- The referral module is live and being rolled out in a phased approach across GM localities.
- A significant level of stakeholder engagement and coordination with secondary care ophthalmology departments and ophthalmology service commissioners across GM has been undertaken to establish referral pathways.

### Milestones / commitments

- Roll out of NHS Mail to optical practices — **January 2020**
- Scope additional IT infrastructure / integration for community orthoptists and third sector — **March 2020**

### Risks

- Potential delay in NHS mail roll owing to complexities of co-ordinating 315 optometry practices and optometrist performers across GM
- Obtaining 100% uptake in optometry practices utilising the Electronic Referral Platform and wider engagement with the multiple optometry practices.

### Lead(s)

- GM Eye Health Network
- Primary Care, GM Health and Social Care Partnership
Providing great urgent care is one of the biggest determinants to how the whole health and care system responds to people’s needs – and to how people perceive their interaction with health and care. Primary care is especially well placed to provide an early response to healthcare needs, and early intervention in illness that can stop many serious conditions from becoming worse, and even life threatening, as well as offering simple, timely, reassurance when that is appropriate.

**Primary care projects include:**
- Meeting demand
- NHS Community Pharmacist Consultation Service (CPCS)
- 7 day access to general practice
- Primary Eye Care Service Framework
- Proactive children’s dental management
- Contraceptive services in community pharmacy
The 10 GM localities are developing plans to streamline urgent and emergency care services. This is intended to create seamless provision between routine and urgent and emergency care, as well as reduce the burden on A&E departments. GM has an established UEC Improvement and Transformation Programme which aims to:

- Develop and deliver GM standards of care for the whole urgent and emergency care pathway,
- Provide an equitable and fully integrated UEC service,
- Harness technology and collaborative working and information sharing and year on year,
- reduce in A&E attendances and length of stay.

This programme aims to support people to stay well and to provide the highest quality urgent and emergency care that is safe, co-ordinated and person centred. This will be delivered by:

- Locality development and implementation of integrated urgent care models
- Roll out of primary care led urgent treatment centres
- Implementation of co-designed GM Clinical Assessment Service and community based MDT response

- Reduction in duplication across localities and rationalisation of services where possible
- Reduction in A&E attendances
- Better utilisation of 7 day additional General Practice services

- Better utilisation of workforce
- When people need access to urgent or emergency care that the right care can be accessed at home or as close to home as possible
- Reduction in the requirement for urgent and emergency escalation, improving outcomes for patients and the GM system

- A 90 day test of change was run in 7 localities to provide a proof of concept for the ‘pushing’ an agreed set of Category 3 and 4 999 codes out to a single Clinical Assessment Service (CAS) that is integrated with an urgent care response in the locality

- Completion of CAS cost benefit analysis – January 2020
- Roll out of urgent treatment centres by Autumn 2020
- GM commissioning intentions for future CAS delivery – March 2020
- Exploration of inclusion of Community Pharmacist Consultation service into GM CAS service – May 2020

- There is a risk that localities will not commission service

- Led by localities
**NHS COMMUNITY PHARMACIST CONSULTATION SERVICE (CPCS)**

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<thead>
<tr>
<th>Discovery</th>
<th>Define</th>
<th>Design &amp; Develop</th>
<th>Deliver</th>
<th>Evaluate</th>
</tr>
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**Ask of GM:** Ensure locality models utilise the breadth of primary care

**Ask of Localities:** Providers to deliver the CPCS within localities and participate in local pilots where appropriate and ensure service is included in any local directory of services

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### Aims, Objectives

- To expand the scope of the nationally commissioned Community Pharmacist Consultation Service in GM to better support the provision of urgent care across the system
- To include referral from GP practices to pharmacies across GM
- To include referral from Clinical Assessment Service (CAS) to pharmacies
- To enable communication across the GM system about the Community Pharmacist Consultation Service

### Expected outcomes

- Reduced demand on integrated urgent care services, urgent treatment centres, Emergency Departments, walk in centres, other primary care urgent care services and GP Out of Hours (OOH) services, and free up capacity for the treatment of patients with higher acuity conditions within these settings
- To increase patient awareness of the role of community pharmacy as the ‘first port of call’ for low acuity conditions and for medicines access and advice
- To be cost effective for the NHS when supporting patients with low acuity conditions
- To reduce the use of primary medical services for the referral of low acuity conditions from NHS 111 and the need to generate urgent prescriptions

### Benefits / Rationale

- The CPCS aims to relieve pressure on the wider NHS by connecting patients with community pharmacy, which should be their first port of call and can deliver a swift, convenient and effective service to meet their needs.
- The CPCS provides the opportunity for community pharmacy to play a bigger role than ever within the urgent care system.
- As a devolved health economy, GM has the ability to commission services from community pharmacies and not to have to wait for nationally commissioned services
- Following success in local pilots of GP referrals, it is anticipated that a GM rollout would significantly reduce winter pressures on the GM system

### Delivery Activities (to date)

- Nationally commissioned service live on 29th October 2019 – 580 of 692 pharmacies signed up (84%) with 1151 urgent medicine referrals and 586 minor illness referrals in the first 3 weeks of service
- Local pilot for GP referrals live on 2nd July 2019 – 3 of 6 GP practices live, with 6 of 8 pharmacies live in Radcliffe, 62 referrals to date
- GM is also piloting NHS 111 referrals

### Milestones

- Scope the GM GP referral plan and GM CAS plan and highlight where community pharmacies can make a contribution.
- Engagement and communications across the system
- Source funding
- Project signed off and implementation commences

### Risks

- There is a risk that appropriate funding will not be identified to roll out the service further following the conclusion of the pilots.

### Lead(s)

- Primary Care, GM Health and Social Care Partnership
- GM & Bolton Local Pharmaceutical Committees

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The NHS Community Pharmacist Consultation Service (CPCS) launched on 29th October 2019 as an Advanced Service. The service, which replaced the NHS Urgent Medicines Supply Advanced service (NUMSAS) and the Digital Minor Illness Referral Service (DMIRS) pilots, connects patients who have a minor illness or need an urgent supply of a medicine with a community pharmacy.

The CPCS takes referrals to community pharmacy from NHS 111, but there are plans for referrals to be taken from other parts of the NHS in time.
IMPROVING ACCESS TO GENERAL PRACTICE (EXTENDED ACCESS)

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<thead>
<tr>
<th>Discovery</th>
<th>Define</th>
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<th>Deliver</th>
<th>Evaluate</th>
</tr>
</thead>
</table>

Ask of GM: funding via Primary Care Reform Programme
Ask of Localities: Localities are required to meet the 7 national core requirements and ensure that it is embedded in the neighbourhood model.

Aims, Objectives

Localities were required to meet seven core requirements for improving access:

- Weekday provision of access to pre-bookable and same day appointments to general practice services in evenings (after 6:30pm) and at weekends
- Provide robust evidence, based on utilisation rates, for the proposed disposition of services throughout the week.
- A minimum additional 30 minutes consultation capacity per 1000 population
- Ensure practices are measuring appointment activity by all participating practices, both in-hours and in extended hours. This will enable improvements in matching capacity to times of high demand.
- Ensure services are advertised to patients so that it is clear to patients how they can access these appointments and associated service.
- Ensure all practice receptionists able to direct patients to the service and offer appointments to extended hours service on the same basis as appointments to non-extended hours services
- Ensure patients are offered a choice of evening or weekend appointments on an equal footing to core hours appointments.
- Use of digital approaches to support new models of care in general practice
- Issues of inequalities in patients’ experience of accessing general practice identified by local evidence and actions to resolve in place.

Expected outcomes

- Improved and more convenient access for patients
- Alleviate pressures in core general practice
- Enable target interventions
- Reduction in A&E attendances
- Support admissions avoidance/discharge at evenings and weekends

Benefits / Rationale

Benefits of GP extended access services include:

- appointments at more convenient times
- additional appointments per week for patients
- greater scope to provide a wider range of services outside of traditional daytime hours.

Delivery Activities (to date)

People can now access general practice for routine appointment as well as urgent contact any day of the week, with all Greater Manchester localities offering full population coverage during evening and weekends. This means general practice is providing an additional 1,500 hours of time from GPs, nurses, health care assistants and pharmacists during evenings and weekends.

Milestones / commitments

- Provision of extended hours access appointments are a requirement of the Network Contract DES. These hours are separate from the CCG commissioned extended access services in 2019/20.
- By April 2021, the funding for the existing Extended Hours Access DES and for the wider CCG commissioned extended access service will fund a single, combined access offer as an integral part of the Network Contract DES, delivered to 100% of patients including through digital services like the NHS App.

Risks

- There is a risk that these services will be under-utilised if they are not appropriately offered to patients and well advertised.
- There is a risk regarding cost effectiveness and utilisation of workforce where there is less demand, e.g. Sundays / Christmas Day

Lead(s)

- GM locality commissioners
- GM GP Provider Board
The Local Eye Health Network transformation plan – ‘Delivering improved Eye Health across Greater Manchester’ – describes the approach to transforming the eye health of the population of Greater Manchester. This project aims to standardise extended primary care and community services by developing single operating model/pathways for primary care and community services; developing Primary Eye Care Service Framework for GM and developing GM Optometry Standards.

**Aims, Objectives**

- Provision of safe and effective care by appropriately trained and competent professionals.
- Delivery of high quality clinical services that ensure patient safety and a positive patient experience.
- Ongoing development of the current and future workforce supported by receipt of feedback to the practitioner following referral.
- Reconfiguration of patient flows to make best use of available resources and skills.
- Provision of clinical services in a setting closer to home or work.
- Reduction of referrals to HES to reduce waiting times for outpatient appointments and/or enable greater capacity for the care of higher risk patients.
- Empowerment of patients through education and self-care.
- Elimination of postcode lottery and resolution of boundary issues.

**Stakeholder Engagement**

- The Optometry Advisory Group meets on a regular basis and aims to provide overarching system leadership for optometry and eye health improvement as a part of the wider Local Eye Health Network and provide a unified voice for primary eye care in Greater Manchester (GM).
- Primary Eye Care Service Framework shared with all Ophthalmology trusts and commissioners.

**Benefits / Rationale**

The primary eye care service in its totality, including the clinical elements, public health contributions and participation in enabling projects will together transform eye health and service across Greater Manchester. The key outcomes from the Primary Eye Care service are:

- Improved access and choice.
- Services delivered consistently across an area and integrated with the rest of the pathway.
- Less duplication and waste (fewer inappropriate and low-quality referrals, and more patients with relatively low risk conditions managed in Primary Care).

**Delivery Activities (to date)**

- Development of the framework with the incorporation of non-commissioned services – Healthy Living Optical Framework, optometry standards, compliance with IT project.
- Development of optometry standards.

**Milestones / commitments**

- Decision on framework from Directors of Commissioning – **March 2020**
- Implementation of Primary Eye Care Service Framework from **1st April 2020**

**Risks**

- There is a risk that the framework will not be commissioned: there are a number of other projects that are dependent on the agreement and implementation of the framework – it is a critical enabler for the whole eye health transformation plan.

**Lead(s)**

- GM Eye Health Network
- Primary Care, GM Health and Social Care Partnership
- Locality commissioners
The proactive dental management of young children is a multifaceted programme including the work of the Paediatric Managed Clinical Network, Baby Teeth DO Matter, oral health improvement and reduction in children’s GAs and the implementation of Dental Checks by One. This project overview focuses on Baby Teeth DO Matter and Dental Checks by One.

Ask of GM: Lead and development of programme
Ask of Localities: Ensure programme is embedded as part of local neighbourhood model, with particular focus on oral health in early years

Aims, Objectives

- The aim of the Baby Teeth DO Matter Programme is to ensure all young children in GM have access to proactive general dental care by
  - Increasing the proportion of children below the age of 5 years who regularly attend a general dental practice
  - Increase proportion of children under 5 receiving ‘DBOH advice’ using benchmarking and feedback on BSA indicator
  - Increase proportion of children under 5 receiving Fluoride varnish using benchmarking and feedback on BSA indicator
- The Dental Checks by One (DCby1) is a national programme that aims to get parents of babies to bring them to the dentist before their first birthday. This is to provide preventive dental advice, prevent dental problems early and establish a longer term relationship with dental care.

Expected outcomes

- Increase in proportion of children under 5 years old attending a dentist
- Increase in proportion of children receiving preventative interventions (e.g. fluoride varnish)
- Reduction in children requiring specialist dental services, e.g. GAs
- Improved quality of life, reduced pain and infection, leading to improved school readiness

Benefits / Rationale

- Improved children’s oral health across GM.
- Consistent quality of care, including increased access to prevention such as fluoride varnish.
- Reduced general anaesthetic activity for the extraction of children’s teeth.
- Facilitates greater engagement with community colleagues / neighbourhood working.
- Contributes to the improvement of school readiness and reduces number of school days missed (toothache/treatment).

Delivery Activities (to date)

- Access to primary dental care for children has improved in the four priority localities. The application of fluoride varnish has also increased.
- The introduction of the Oral Health Improvement Team has increased engagement with dental practices being commissioned.
- Discussions are taking place to agree a future model of commissioning prevention initiatives in primary dental care (flexible commissioning arrangements).

Milestones / commitments

- Agree dental commissioning intentions for secondary care – January 2020
- Agree future model of commissioning prevention initiatives in primary dental care – March 2020
- Introduction of child friendly practice model across all 10 localities in GM – April 2020
- Review and agree provision of specialist community dental service – October 2020

Risk

- Further to the strategic decision for Pennine Care FT to focus on mental health provision and divest of other services, there is a requirement to safely transfer specialist community dental services to an alternative provider in advance of planned GM-wide procurement. There is a risk that no access to dental care for vulnerable patient groups presents additional pressures across wider specialist services already under considerable pressure.

Lead(s)

- Primary Care, GM Health and Social Care Partnership
## Aims, Objectives

- To scope, secure funding and implement a quick start contraceptive service across GM where pharmacists supplying EHC can also initiate a regular contraceptive with a client.
- To scope, secure funding and implement a complete contraceptive service from community pharmacy which includes:
  - Contraceptive choices consultation
  - Provision of oral contraception, including repeat supplies
  - Provision of LARC contraception including depo and implant, including repeat and removal

## Expected outcomes

- Increase the uptake of regular contraception by women across GM due to increased accessibility of community pharmacy
- Increase uptake of regular contraception following a supply of EHC
- Increase accessibility for women to contraceptive services
- Reduce unintended pregnancies
- Increase and publicise the role of community pharmacy in contraceptive services

## Benefits / Rationale

- Pharmacists are already commissioned to supply Emergency Hormonal Contraception (EHC) under Patient Group Direction (PGD) in all GM localities but are not able to complete an effective consultation by initiating regular contraception
- Over 81,000 people visit Greater Manchester community pharmacies each day and over 90% of interactions with an NHS health professional are in a community pharmacy. Across Greater Manchester, pharmacies are open between 6am and midnight and currently 70% of pharmacies are open on a Saturday or a Sunday.

## Delivery Activities (to date)

- Initial discussions have taken place at Sexual Health Steering Group meeting.

## Milestones / commitments

- Funding to be secured
- Project planning and mobilisation including:
  - Commissioning arrangements
  - Data collection to be identified & arranged
  - Service specification / Service level agreement to be defined and created
  - Training

## Risk

- Contraceptive implant fitting and removal in community pharmacy setting needs further investigation.
- There is a risk that appropriate funding will not be identified to roll out a designed service.

## Lead(s)

- GM & Bolton Local Pharmaceutical Committees
- CPGM Healthcare (CHL)
A shift from reactively providing appointments to patients to proactively caring for people and communities is a major aspect of the vision for primary care. This means doing much more to prevent ill health, diagnose it early and treat it quickly. Primary care providers play a very important role in prevention and early detection.

**Primary care projects include:**
- Roll out of Healthy Living Framework and Dementia Friendly Primary Care
- Primary Care Health Campaigns
- Environmental sustainability
- MenACWY catch up vaccinations
HEALTHY LIVING FRAMEWORK & DEMENTIA FRIENDLY PRIMARY CARE

Ask of GM: Lead and management of programme

Ask of Localities: Primary care providers to undertake Healthy Living accreditation and dementia friendly training, Healthy Living providers to be included in any local directory of services/social prescribing schemes. Other local providers to signpost to health living providers.

Aims, Objectives

• Develop and upskill a sustainable primary care workforce with a focus on wellbeing, prevention and restorative health.
• Empower patients, carers and communities to take greater responsibility for their health and wellbeing.
• Increase early detection of disease and find the thousands of local people with a condition that has not yet been diagnosed.

Expected outcomes

• Empowered patients more able to self care and take responsibility for their own health
• Upskilled staff leading to increased staff motivation and retention and greater engagement with patients
• Improved wellbeing of individuals
• Increased access to a range of health promotion services in locations that are convenient to the patient.
• People affected by dementia feel understood and included and empowered to still do the things they have always done such as shopping or travelling.

Benefits / Rationale

• This approach will mean people will better understand how they contribute to their own health and wellbeing and can make the most of available services. They will have the information they need to prevent ill health, manage any conditions and access the right support (including screening, wellness and prevention services) in their local neighbourhood when they need it. Every contact people have with health and care professionals will be an opportunity to promote good health and prevention.

Delivery Activities (to date)

• 95% of community pharmacies in Greater Manchester have achieved Healthy Living Pharmacy Level 1.
• 37 dental practices have been accredited under the Healthy Living Dentistry programme with further training to increase this planned in 2019/20.
• Nearly 99% of community pharmacies have trained patient-facing staff to be dementia friendly – an estimated 2500 dementia friends.
• Over 400 dementia friends trained with 112 dental practices signed up to the dementia friendly dentistry scheme.
• The Healthy Living Optical Practice Framework and dementia friendly optical practices are elements of the GM Primary Eye Care Service Framework.

Milestones / commitments

• All pharmacies required to be accredited Level 1 Healthy Living Pharmacies by April 2020.
• Ambition for all primary care providers to be ‘dementia friendly’ by 2021.
• Healthy Living Framework for optical and dental practices to be fully embedded by 2022.

Risks

• The Healthy Living Optical Practice (HLOP) framework is an element of the GM Primary Eye Care Service Framework. The service framework makes a request for eye care services to be commissioned collaboratively across GM and should this request not be supported, the implementation of the HLOP Framework may stall.

Lead(s)

• Primary Care, Greater Manchester Health & Social Care Partnership
• GM Local Professional Networks for Pharmacy, Eye Health and Dental
Ask of GM: Development and roll out of resources, facilitate agreement of health campaigns calendar

Ask of Localities: Primary Care providers to undertake health campaigns locally. Other local providers to signpost to health living providers.

Primary care providers will pro-actively take part in and contribute to national/local campaigns for patients and the general public during the campaign period, including giving advice to people on the campaign issues. This advice may be supplemented by provision of written information and in-store displays. This activity aims to:

- To increase patient and public knowledge and understanding of key healthy lifestyle and public health messages so they are empowered to take actions which will improve their health.
- To target the ‘hard to reach’ sectors of the population who are not frequently exposed to health promotion activities in other parts of the health or social care sector.

Expected outcomes:
- Empowered patients more able to self care and take responsibility for their own health
- Upskilled staff leading to increased staff motivation and retention and greater engagement with patients
- Improved wellbeing of individuals
- Aligned campaigns across all four disciplines of primary care with same key messages & training/supporting information

Benefits / Rationale:
- As part of the Community Pharmacy Contractual Framework, each year pharmacies are required to participate in six mandated campaigns at the request of NHS England.
- Active participation in these campaigns by primary care providers can help maintain and improve the local population’s physical and mental health and wellbeing, especially those living with a long-term condition.

Delivery Activities (to date):
- In 2018, health campaigns focussed on bowel cancer screening, dementia awareness, oral health, physical health, Stoptober with 7500 personal interactions recorded for these campaigns with patients being offered support around stopping smoking and discussing the importance of physical activity, screening programmes and oral health with pharmacy staff, give staff to engage in webinars, evening training and share best practices with dental teams in the collaborative oral health campaign.
- In 2019 to date, over 10,800 health conversations have been recorded covering cervical cancer, bowel cancer, oral health, breast cancer and Stoptober. Following an intervention, over 50% of patients agreed to participate in cancer screening programmes or attempt to stop smoking.
- Planning for the GM 2020 calendar has commenced.

Milestones / commitments:
- Develop 2020 campaigns calendar and align primary care health campaigns to the outcomes of the GM Population Health Plan – December 2019
- Roll out health campaigns calendar across all primary care contractor groups – April 2020

Risks:
- There is a risk that people who initially agree to participate in a cancer screening programme or attempt to stop smoking during the health conversation may not follow it up in the future.

Lead(s):
- Primary Care, Greater Manchester Health & Social Care Partnership
- GM Local Professional Networks for Pharmacy, Eye Health and Dental

Healthy Living Framework providers will continue to proactively support and promote behaviour change across Greater Manchester to prevent ill health. They actively engage the local population in health campaigns aligned to the GM Population Health Plan and providing brief interventions on various topics such as Oral health, obesity Cancer screening and smoking.
### Aims, Objectives

This project aims to increase awareness of environmental sustainability across the whole of primary care, by:

- Ensuring providers and commissioners of primary care have undertaken Carbon Literacy training
- Development of environmental impact assessment
- Embedding environmental impact into the primary care transformation programme

### Expected outcomes

- Improved carbon literacy among commissioners and providers of primary care
- System engagement of GM environmental issues – challenges and benefits

### Benefits / Rationale

There are significant population health benefits from environmental action including:

- More active lifestyles and healthier eating
- Healthier children and reduced inequalities
- Sustainable economies

### Delivery Activities (to date)

- Commissioning, population health and adult social care GM teams undertaken carbon literacy training – **November 2019**

### Milestones

- Development of project plan – **March 2020**
- Carbon Literacy session at Local Leaders network – **June 2020**
- Development of environmental impact assessment – **September 2020**
- Environmental impact fully embedded into primary care programme – **March 2021**

### Risks

- Primary care not prepared/equipped to support vulnerable populations

### Lead(s)

- TBA
MENACWY CATCH UP VACCINATIONS

Ask of GM: Lead and manage the project through CPGM Healthcare and the LPCs
Ask of Localities: Providers to participate in local pilots where appropriate

Aim to increase uptake of MenACWY vaccine in the 18 – 24-year-old catch up cohort (currently nationally commissioned through GP practices)
- Increase opportunistic access for 18 – 24-year-olds by community pharmacy delivering the service
- Access for 18 – 24-year olds attending university and 18 – 24-year-olds who are not attending university

Expected outcomes
- Increase the number of contractors offering the service across GM
- Increase in number of patients in the target age group vaccinated
- Increase the uptake of associated services e.g. chlamydia screening, emergency hormonal contraception

Benefits / Rationale
- Up to 10% of patient who contract invasive meningococcal disease (IMD) die
- Up to 20% of survivors of meningococcal meningitis suffer long term consequences
- Adolescents and young adults (16-24 years old) show the highest asymptomatic carriage rates with up to 25% of 19-year-olds carrying the bacteria at any one time
- For GM, there are 112,677 eligible patients in the target age group cohort, assuming 39% coverage, this gives a target of 69,068 patients in the gap. The table below shows the status of GP coverage in GM.

Delivery Activities (to date)
- This project is still in the early scoping stage.
- This service has been delivered in London and GM will be using the learning from their experience to support project development and agree outcomes.

Milestones / commitments
- Funding to be secured
- Project planning and mobilisation including:
  - Commissioning arrangements
  - Data collection to be identified and arranged
  - Service specification / Service level agreement to be defined & created
  - Training

Risks
- As Immform stock is currently only available to GP practices and school age vaccination providers, discussions will need to take place regarding the availability of stock for community pharmacies using the learning from London.

Lead(s)
- GM & Bolton Local Pharmaceutical Committees
- CPGM Healthcare (CHL)

Meningococcal disease (meningitis and septicaemia) is a rare but life-threatening disease caused by meningococcal bacteria.
- Older teenagers and new university students are at higher risk of infection because many of them mix closely with lots of new people, some of whom may unknowingly carry the meningococcal bacteria at the back of their noses and throats.
- Anyone who is eligible for the MenACWY vaccine should have it, even if they’ve previously had the MenC vaccine.
- The MenACWY vaccine is highly effective in preventing illness caused by the 4 meningococcal strains, including the highly virulent MenW strain.
TACKLING HEALTH INEQUALITIES

In order for local providers of health and care to really engage with their residents. They need to understand how personal identities can influence behaviour. ‘One size does not fit all’, including when it comes to primary care provision in neighbourhoods. Greater Manchester has a diverse population and it is important to recognise how this diversity is dispersed across our localities and neighbourhoods as this can lead to significant inequality.

Primary care projects include:

- Increased Uptake of Sight Tests
- Community Sight Loss Framework
- Pride in Practice
- Transgender Health Service
- Primary Care Contribution to Adult Social Care
- Oral Health in Older People
- Hypertension and Atrial Fibrillation (AF) Find and Treat
- Asthma Review in Community Pharmacy
INCREASED UPTAKE OF SIGHT TESTS

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<th>Discovery</th>
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<th>Design &amp; Develop</th>
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**Ask of GM:** Lead the programme on behalf of GM

**Ask of Localities:** Local optical committees to roll out See More, Learn More, Go Further. Localities to embed within the local neighbourhood model and signpost to local optical practices.

The Local Eye Health Network transformation plan – “Delivering improved Eye Health across Greater Manchester” – describes the approach to transforming the eye health of the population of Greater Manchester. It also describes the potential for primary care optometrists and other eye health professionals to influence the wider determinants of health and is critical to enabling improvement in health and wellbeing. This project aims to increase the uptake of sight tests amongst identified population groups across Greater Manchester.

**Aims, Objectives**

- Develop and embed an awareness programme within schools to increase awareness of eye care and encourage referral of children who may be suffering from vision difficulties for sight tests.
- Develop and embed an awareness programme with GM employers (including the NHS) to increase awareness of eye care in working age population.
- Link with school screening system and community orthoptic services to reinforce the message of regular sight tests starting at an early age and ensure access to and uptake of sight tests for children in special education needs (SEN) schools.
- Improve uptake of sight tests for hard to reach groups such as those with learning disabilities and people who are homeless.
- Share the signs and symptoms of sight problems with social care services to promote timely access to sight tests for at risk groups.

**Expected outcomes**

- Reduction in preventable sight loss
- Improved update of sight tests in different population groups
- Improved eye health of children, working age population and those in social care.
- Increase in educational attainment
- Early detection of eye conditions such as glaucoma and cataracts

**Benefits / Rationale**

The Greater Manchester area has a level of sight testing comparable with other areas in the North West overall; however, detailed analysis identifies a lower uptake of sight tests in children and those of working age compared to other similar parts of England. This project aims to:

- Increase the uptake of sight tests in children, in the working population, for patients with learning disabilities and for patients with dementia.
- Increase support for eye health for people in social care services e.g. care homes; and
- Improve eye health of children, working age population and those in social care.

**Delivery Activities (to date)**

- Development of a (draft) ‘Framework for Transforming Eye Health Services for People with Learning Disabilities. This report outlines the reasons why targeted eye care needs to be in place for people with a learning disability from birth to older age, how it fits into the wider Greater Manchester health and social care strategy and the positive financial and social impact.
- Across GM, enhanced sight tests for people with learning disabilities have been rolled out. This means that accredited community optical practices can offer longer or split appointments and people with learning disabilities know where they can go and get onward referral and treatment if needed.
- The roll out of the “See More, Learn More, Go Further” project to raise awareness of the importance of good eye health and regular sight tests amongst children in GM. To continue to build on the early success of the project and reinforce the initial messages, a step by step guide to has been produced to support the local implementation of the project resources.

**Milestones / commitments**

- Agree contractual delivery of homeless service – December 2019
- Scoping of current service provision in special educational schools across GM – December 2019
- Development of materials for the Department of Work and Pensions – March 2020
- Commissioning of homeless service – April 2020

**Risks**

- There is a risk that more serious eye conditions are not detected early leading to damage to the eye and / or loss of vision.

**Lead(s)**

- GM Eye Health Network
- Primary Care, GM Health and Social Care Partnership
**GM COMMUNITY SIGHT LOSS SERVICE**

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Ask of GM: worked with stakeholders to develop the sight loss service

Ask of Localities: Commission and implement GM Community Sight Loss Service locally and embed within local neighbourhood model to ensure signposting to appropriate services.

In order to provide coordinated and holistic care for patients with sight loss, as outlined in the Eye Health Transformation Plan – ‘Delivering Improved Eye Health across Greater Manchester’, to increase “care closer to home” and to harmonise pathways, the Greater Manchester Eye Health Network recommends the implementation of a GM Community Sight Loss framework.

### Aims, Objectives
- The primary aim of the GM Community Sight Loss framework is to set out the standards for commissioners of services to enable people with sight loss to regain or maintain as much independence and autonomy as possible in their community. Sight loss services achieve this through a wide range of services, focusing on individual needs, including; rehabilitation, visual aids, digital aids and emotional support and advice.
- The implementation of the Community Sight Loss Framework will recognise the potential to transform the landscape of eye health care in primary and community care. It is recognised that the third sector is an equal partner in the care and support of people living with sight loss as they provide coordinated and holistic care for patients with sight loss as outlined in the GM Eye Health Transformation Plan.

### Expected outcomes
- Improved mental health and wellbeing of individuals experiencing sight loss.
- Reduction in falls
- Increased independence

### Benefits / Rationale
- Sight Loss affects every aspect of someone’s life, from the ability to prepare food to recognising friends’ faces. Approximately half of the population with sight loss experience problems outside the home and are three times more likely to have difficulty accessing health care services. People with sight loss are also less likely than the rest of the working age population to be in employment, all of which significantly affects their independence and wellbeing.
- Many people with sight loss never go out because the social care system does not meet their needs. Cost of transport and access difficulties reduces mobility. Public buildings are often not designed to be accessible, leading to the isolation and social exclusion of blind and partially sighted people.
- Sight loss services in Greater Manchester are fractured and uncoordinated. At a time when all resources are stretched and strained, there has never been more willingness for organisations to collaborate rather than compete to ensure better outcomes for visually impaired people.

### Delivery Activities (to date)
- Mapped existing sight loss services
- Patient and practitioner engagement undertaken
- Identified workforce issues in rehabilitation services – scoping of potential new role with HEE underway.
- Development of a (draft) GM Sight Loss Service Framework: Supporting Independence in Adults with Sight Loss; the implementation of which will provide co-ordinated and holistic care for patients with sight loss, to increase care closer to home and to harmonise pathways.

### Milestones / commitments
- Framework to progress through GM governance – **January 2020**
- Implementation of sight loss service framework – **April 2020**

### Risks
- If the framework is not supported by locality commissioners:
  - There is a risk that people who experience sight loss will not receive the necessary support and assistance they require and will continue to experience difficulties accessing health care services.
  - Unwarranted variation across GM localities will continue.

### Lead(s)
- GM Eye Health Network
- Primary Care Team, GM Health and Social Care Partnership
**PRIDE IN PRACTICE**

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**Ask of GM:** Facilitation of roll out to primary care providers

**Ask of Localities:** Primary care providers to undertake pride in practice accreditation. Pride in practice providers to be included in local directories of service/social prescribing models. Other local providers to signpost to health living providers.

- **Pride in Practice** is a quality assurance and social prescribing programme for primary care services and lesbian, gay, bisexual and trans (LGBT) communities. It develops and strengthens relationships between clinicians and patients and enables primary care services to link with community assets and utilise strength based approaches to community healthcare delivery.
- **Pride in Practice** is endorsed by the Royal College of General Practitioners, Greater Manchester Local Pharmaceutical Committee, the Northern Optometric Society and is part of the Healthy Living Dentistry Framework.

### Aims, Objectives

Ensure that all lesbian, gay, bisexual and trans people have access to primary care services that are LGBT inclusive and understand the needs of our communities and this will be achieved by:

- Access to training around LGBT inclusion, Sexual Orientation and Trans Status Monitoring and myth-busting
- Access to a Pride in Practice compendium, which includes a wealth of information on high prevalence areas and referral pathways for LGBT people
- An accreditation award, including a wall plaque and Pride in Practice logos for letterheads and websites
- Support to deliver effective active signposting and social prescribing for LGBT communities, linking services with a range of LGBT-affirmative local community assets to facilitate holistic approaches to care
- Access to posters, rainbow lanyards and a suite of LGBT information resources for display in primary care services
- LGBT patient insight so that services can be proactive about meeting LGBT patients’ needs
- Support reviewing Equality & Diversity policies and inclusivity statements
- Practical support, guidance and confidence-building for staff members on how to implement the Sexual Orientation Monitoring Information Standard
- Celebration of awarded primary care services within LGBT communities

### Expected outcomes

- Increase in LGBT people accessing primary care services
- Increased confidence of primary care staff when working with LGBT communities.

### Benefits / Rationale

Lesbian, gay, bisexual and trans (LGBT) people consistently experience poorer health outcomes and worse health care than heterosexual people. It is reported that barriers are often experienced by LGBT people in their use of universal public services and many have low expectations about how they are going to be treated by health care workers. The majority of LGBT people who experience worse health care feel unable to challenge or report it because they feel too vulnerable or afraid to do so.

### Delivery Activities (to date)

- Since 2016, Pride in Practice has empowered GM’s primary care workforce to support LGBT communities. It has been rolled out across 445 primary care services (348 GP practices, 47 dental practices, 17 optical practices and 33 pharmacies), reaching 2 million patients across GM.
- To date, over 5,100 health professionals have been trained and can evidence improvements within their service as a result of Pride in Practice.
- According to 2018 GP patient survey, 100% of transgender patients at PiP-accredited general practices felt their GP was supportive of their gender identity and medical transition.

### Milestones / commitments

- All 2000 primary care providers will have achieved Pride in Practice status by **2022**.

### Risks

- There is a risk that poorer health outcomes for lesbian, gay, bisexual and trans (LGBT) people will continue.

### Lead(s)

- Primary Care Team, GM Health and Social Care Partnership
- GM Primary Care Provider Board
Ask of GM: Development and implementation of transgender health service pilot on behalf of GM
Ask of Localities: Provided funding to maintain existing services. Ensure people are being referred into the service once rolled out

Expected outcomes
- Improved patient care, experience and outcomes for individuals.
- Reducing waiting times.
- Reduced variation: there are inconsistent and inequitable approaches to commissioning and delivery of services.
- Equity of access and quality of care
- Improved access to initiation of Hormone Replacement Therapy for Trans and Gender Diverse people, impacting the drive to self medicating (buying hormones online) and reducing the associated medical risks.

Benefits / Rationale
- A GM primary care gender identity service will aim to offer patients local and prompt access to assessment and non-surgical packages of care, reducing unnecessary barriers in accessing services, specifically hormone therapies and improving health outcomes in the primary care setting. The service will also provide management of aftercare following gender identify clinics discharge as well as direct referral onto specialist gender identify clinics for consideration of surgical packages.

Delivery Activities (to date)
- Successful stakeholder engagement events have been held with the local trans and non-binary population that have informed the design of the GM Transgender Health Service
- GM Transgender Working Group established to oversee the design/development, representation from the VCSE sector, Primary Care, Commissioners and those with lived experience; an exemplar of co-design.
- Prior Information Notice (PIN) published for the GM Trans Health Service to seek formal expressions of interest (informal market testing has demonstrated that there is significant interest within GM).
- Agreement reached by GM commissioners to funding the continuation of local Trans services delivered by LGBT Foundation (previously due to end in October 2019)

Milestones / commitments
- Procurement and mobilisation of provider for GM Primary Care led THS service in conjunction with NHS England – Q2 2020/21
- Service commencement – Q2/Q3 2020/21 pending procurement

Risks
- A risk has been identified relating to managing expectations because the timeframe to procure has been delayed by NHS England.

Lead(s)
- Primary Care, GM Health and Social Care Partnership
- NHS England – Specialised Commissioning Team
There is currently no standard offer from primary care to support people living in care homes, living well at home, carers and people with learning disabilities. Although localities provide some provision, it is not standardised across GM. There are some nationally provided primary care services (e.g. seasonal flu) but they are not specific to adult social care services. This project aims to provide some consistency.

### Aims, Objectives

This project aims to provide a consistent primary care offer for people living in care homes, living well at home, carers and people with learning disabilities

- Map and establish a baseline of current primary care input into adult social care services
- Development of a costed best practice model for the primary care offer to care homes, living well at home, carers and learning disabilities
- Analysis of localities trajectory from present state to delivery of model

### Expected outcomes

- Consistent and co-ordinated primary care input into adult social care
- Reduction in unplanned admissions
- Improved care planning
- Greater opportunities for people to be involved in decisions about their care

### Benefits / Rationale

- Improved quality of life
- Improved use of local resources

### Delivery Activities (to date)

- Initial meeting held to develop joint project with development of T&F group terms of reference
- Engagement with Care homes/living well at home delivery group
- Establishment of task and finish group to develop the model

### Milestones / commitments

- Completion of mapping/baselining exercise – December 2019
- Development of best practice model and cost benefit analysis – March 2020
- Engagement and ratification via joint commissioning board – May 2020
- Commencement of roll out (subject to JCB approval) – October 2020

### Risks

- Alignment with Enhanced Health in Care Homes framework, which is general practice only
- Any provision over and above core primary care contracts would need to be commissioned separately
- Agreement from commissioners to roll out a consistent service

### Lead(s)

- Primary Care, GM Health and Social Care Partnership
- Adult Social Care, GM Health and Social Care Partnership
ORAL HEALTH IN OLDER PEOPLE PROGRAMME

Aims, Objectives

- Information and support for older people and their carers to maintain their oral health.
- Better training, guidance and resources to help carers provide good mouth care, keeping people independent for longer.
- Better access to appropriate dental care - prevention and treatment.
- Strategic dental and oral health contribution to adult social care and wider neighbourhood developments.
- Training and support for dental teams on care planning of vulnerable older people.

Expected outcomes

- Quality compliance with CQC and NICE guidance
- Mouth Care Matters toolkit implemented by dental teams in delivery of care to vulnerable older people
- Improvement in oral health care regimes in care homes
- Improvement in overall general health and dignity
- Reduced demand on health and care services resulting from poor oral health (including inappropriate referrals into secondary care)

Benefits / Rationale

- The programme is demonstrating impact on quality of care and peoples’ lives and is making a difference to local people by enabling improvements in quality of life and function whilst presenting indicative cost savings.

Delivery Activities (to date)

- The Dental foundation training pilot has increased confidence of young dentists and dental nurses in providing care for vulnerable older people and increased access.
- A GM training resource on mouthcare for care homes and agencies has been developed and tested.
- Mouthcare Matters training and improvements in nursing care has commenced in all acute trusts.
- The Dental foundation training pilot has increased confidence of young dentists and dental nurses in providing care for vulnerable older people and increased access.
- Health Education England and Local Authorities have commissioned local training for care staff to improve mouthcare for vulnerable older people.

Milestones / commitments

- Further milestones for this programme will be agreed once the new Consultant in Dental Public Health is in post in January 2020.
- The dental foundation care link programme evaluation has been completed and Health Education England funding has been secured to roll it out in 2019/20 – March 2020

Risks

- There is a risk that there will not be appropriate resources and funding available for the delivery of this programme across GM, however flexible commissioning arrangements are currently being explored that may mitigate this risk in the coming months.

Lead(s)

Local Dental Network supported by:
- Primary Care, GM Health and Social Care Partnership
- Health Education England
- Consultant in Dental Public Health, Public Health England

Dental care pathways for older people must span the whole ‘patient journey’, supporting good daily mouth care, enabling patients to benefit from prevention and early detection, and ensuring timely access to clinical care where required. Therefore, work is in development to explore a care delivery model which links general dental practices with adult social care providers to improve daily home care, increase access to evidence-based daily prevention and facilitate timely access to general and specialist dental care where necessary.
Early detection and prevention of long-term conditions is a key feature of the NHS Long Term Plan, Public Health England’s five-year strategy and Community Pharmacy’s Contractual Framework. There is good evidence at national level that detecting atrial fibrillation and hypertension early and initiating treatment reduces complications and saves money.

**Aims, Objectives**
- To find and support the treatment of undiagnosed AF and hypertensive people in community pharmacies.
- Eligible patients walking in to the pharmacy will be screened for hypertension and AF.
- Lifestyle support and goal setting will be given to patients with borderline hypertension with a view to supporting a reduction in blood pressure.
- Those patients whose blood pressure is resistant to lifestyle intervention, or whose blood pressure is over 180/110, or who have an irregular pulse indicating AF, will be referred to their GP for diagnosis and treatment initiation.
- Once treatment has been initiated by the GP, patients will be supported and followed up by the community pharmacy to ensure medicines are optimised, patients are concordant with prescribed regimes and conditions are appropriately controlled.

**Expected outcomes**
- Support QoF targets to close the prevalence gap.
- Improve health and delay complications through supporting concordance to prescribed medication.
- Improve health through proactive lifestyle interventions.
- Improve awareness of hypertension and AF.

**Benefits / Rationale**
- Public Health England stated in 2014 that over 5 million people in England are unaware they have high blood pressure and that by reducing the blood pressure of the nation as a whole, £850 million of NHS and social care spend could be avoided over 10 years and if 15% more people were diagnosed, £120 million of NHS and social care spend could be avoided over 10 years.

**Delivery Activities (to date)**
- Initial pilot ‘finding’ patients with AF and hypertension in Bury in one pharmacy.
- Second 18 month pilot with ‘finding & treating’ patients with hypertension including post diagnosis pathway and ‘finding’ patients with AF commenced in 8 pharmacies in North Manchester in September 2019.
- Health Innovation Manchester momentum fund bid submitted in November 2019 to support the full roll out of find and treat for both hypertension and AF.

**Milestones / commitments**
- Decision on momentum fund - **February 2020**
- North Manchester pilot runs to **April 2021**
- Evaluation – **July 2021**

**Risks**
- There is a risk that appropriate funding will not be identified to roll out the service further following the conclusion of the pilots.

**Lead(s)**
- CPGM Healthcare (CHL)
ASTHMA REVIEW IN COMMUNITY PHARMACY

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<th>Discovery</th>
<th>Define</th>
<th>Design &amp; Develop</th>
<th>Deliver</th>
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**Ask of GM:** Lead and manage the project through CPGM Healthcare

**Ask of localities:** Providers to participate in pilots as appropriate.

**Aims, Objectives**
- To undertake a proof of value pilot in one or two localities that will identify hard to reach patients who do not have an asthma review with their GP practice or have had a hospital admission or ED attendance due to asthma in previous 12 months and undertake a review within a community pharmacy setting.
- To review the use of metered dose inhalers (MDIs) versus dry powder inhalers (DPIs) and the recycling of inhalers.
- Demonstrate whether a new pathway of asthma care can be delivered within community pharmacy.
- Demonstrate community pharmacy’s value in supporting patients with long term conditions.
- Demonstrate interoperability between pharmacy and GP systems for the output of clinical consultations with patients.

**Expected outcomes**
- Improved standard of asthma care in the identified patient cohort resulting in an improvement in asthma control.
- Reduced hospital admissions and A&E visits.
- Improved quality of life for patients with asthma.

**Benefits / Rationale**
- 2017/18 QoF data shows that approximately 24.4% of patients with asthma do not attend an annual review within General Practice.
- Greater Manchester has some of the worst asthma outcomes in the country with asthma emergency admissions above the average for the North of England.
- Patients may not visit their GP practice for an asthma review due to working pattern, or as prescriptions are generated and sent electronically, but they do have to visit the pharmacy to collect their medication – patients who do not have their review at the practice can be opportunistically targeted for a review in the pharmacy when collecting their prescription.
- Opportunity to have their asthma medication optimised potentially leading to better asthma control and outcomes.
- Opportunity to have an asthma review at a more convenient time and/or place.
- The potential for reduced healthcare utilisation due to asthma including primary and secondary care.
- Increased number of annual asthma QoF reviews, including the difficult to reach patients who are usually exception coded.
- Opportunity to raise the profile of community pharmacy and the role they can play in delivering asthma care.

**Delivery Activities (to date)**
- Funding for proof of value secured in Joint Working Agreement between Health Innovation Manchester and GSK.
- CHL secured to deliver the pharmacy mobilisation and support.
- Potential localities to pilot project have been identified.
- GMHSCP IT team support secured to complete interoperability outcome.
- GMHSCP team support secured to commission service from pharmacies and provide PharmOutcomes licence for data & reporting.
- Initial project plan created and Project Steering Group in place and meeting regularly (weekly calls and monthly meetings).

**Milestones / commitments**
- Joint Working Agreement between Health Innovation Manchester and GSK to be signed – **December 2019**
- Transfer of funding following Joint Working Agreement being signed.
- Work to commence on mobilisation following funds transfer.
- Service go live – **February 2020**

**Risks**
- There may be a risk relating to the timescales for completing the interoperability element of the project.
- There is a risk that the identified patients do not attend their asthma review in community pharmacy.

**Lead(s)**
- CPGM Healthcare (CHL)
- Health Innovation Manchester
- GSK
- IT Team, GM Health and Social Care Partnership
The emergence of PCNs and neighbourhood working provides an opportunity to review and strengthen the existing GM Primary Care Medical Standards, ensuring they are more outcomes focused, but able to identify and reduce individual practice unwarranted variation across a neighbourhood. At the same time, GM Excellence will build on the principles of GP Excellence and the GM Health Care Academy to offer support and development for the whole of primary care.

**Primary Care Projects include:**

- GM Excellence Programme
- Primary Care Standards
- Increasing Research in Primary Care
The GM Excellence Programme will support primary care providers through the delivery of a wide menu of support that will help primary care to become more sustainable and resilient, better placed to tackle the challenges they face now and into the future, and securing continuing high quality care for patients. This programme supplements existing mechanisms of support to Primary Care and will work with localities to ensure alignment with existing quality improvement initiatives. The model has already been tried and tested across General Practice. The next phase of the programme will be to expand the model to all of primary care.

Aims, Objectives

This programme aims to support primary care through every stage of quality improvement, from ‘Rescue’ to sustained quality ‘Excellence’ by
- Identifying best practice and areas of excellence from elsewhere, supporting primary care to develop these models locally
- Offering a coherent and consistent offer in terms of rescue, resilience and improvement.
- Providing a systematic response at a locality level however must also be responsive to individual provider requirements and crisis response
- Embracing the excellent practice which is taking place across Greater Manchester, ensuring mechanisms to share best practice
- Adopting a proactive approach to identifying improvements earlier rather than in the reactive sense, e.g. following CQC inspection
- Having an understanding of the needs of providers in order to be able to respond
- Fostering a sharing and learning environment across GM which will include a repository or portal of best practice, case studies and standard documentation that providers and commissioners can access
- Developing clinical leaders to enable them to offer peer support or more formal arrangements to support primary care
- Driving excellence across GM which will be enabled by business intelligence in order to facilitate peer to peer discussions, comparative analysis, identification of best practice and the development of quality pathways

Expected outcomes
- To ensure sustainability of all primary care by building capacity and capability through continues Quality Improvement

Benefits / Rationale
- The programme will help primary care to become more sustainable and resilient, better placed to tackle the challenges they face now and into the future, and secure continuing high quality care for patients and the public

Delivery Activities (to date)
- The first phase of the programme (GP Excellence), in partnership with the Royal College of General Practitioners (RCGP), is supporting general practice in important areas such as rescue, resilience, improvement and excellence. To date this has included helping GP practices with their Care Quality Commission (CQC) compliance, delivering organisational resilience, development and GP management training and courses on ‘working at scale’. At least 160 practice managers are supported in management development and education through diploma courses.
- In September 2018, the GP Excellence Programme launched a brand new website to host a range of information, resources, case studies, learning opportunities and tools designed for improvement and development of GP Practices across Greater Manchester
- The first GP Excellence Conference was held on 6th February 2019 with the aim of supporting practice managers to build Resilience in General Practice, Encourage Wellbeing and Leading Successful Teams. This event was attended by circa 200 practice managers across GM

Milestones / commitments
- Further training opportunities for general practice staff throughout the remainder of 2019/20
- Second GM practice manager conference – February 2020
- Support ongoing development of PCNs and Clinical Directors – ongoing
- Expansion of programme to all primary care – 2021

Risks
- There is a risk that the GP Excellence programme (phase 1) will not deliver the expected benefits. There is increasing pressure on primary care, with a number of GP practices struggling to deliver business as usual.
- There is a risk that there may not be sufficient to support the roll out to wider primary care (phase 2)

Lead(s)
- Primary Care, GM Health and Social Care Partnership
- GM GP Excellence Programme (RCGP)
A suite of **GM primary care medical standards** were developed that aimed to transform the delivery of primary care to reduce unwarranted variation, adopt a more pro-active approach to health improvement and early detection in order to improve health outcomes for our patient population.

A refresh of the standards is now required, making them more outcomes focused and able to be delivered at a GM level.

### Aims, Objectives
- Review the GM Primary Care Medical Standards to ascertain what has been implemented across GM
- Identify what learning and possible outcomes have been generated from the implementation of the standards and how can this be shared
- Agree how localities will hold themselves to account on this agreed work now that the AGG has ceased.
- Develop outcomes based standards that are deliverable at a neighbourhood level and better tackle inequalities e.g. mental health and children

### Expected outcomes
- Reduction in variation in primary care provision in GM
- Improved standards of delivery in general practice

### Benefits / Rationale
- The implementation of the primary care standards will ensure that patients are seen by the right people for their needs.
- They will help to release capacity in General Practice and potentially contribute to the reduction in A&E attendances and unplanned admissions.
- Through the delivery of these standards, patients will be consistently and proactively managed, leading to a reduction in unwarranted variation and contributing to a reduction in premature mortality and increased prevalence.

### Delivery Activities (to date)
- A task and finish group, chaired by Dr Alan Dow, comprising of CCG commissioners (clinical and managerial), public health colleagues, GP Quality Lead, RCGP representative and GP provider representatives was established to review the original standards developed in 2015. The group reviewed each of the standards and key deliverables and made a number of recommendations together with a set of principles which underpinned the standards.
- Presentation to GM Directors of Commissioning providing a summary of the development of the GM Primary Care Medical Standards and progress to date across the 10 GM localities.

### Milestones / commitments
- Detailed review of implementation of the standards - **March 2020**
- Refresh of GM standards – **July 2020**
- Ratification from Joint Commissioning Board – **October 2020**

### Risks
- There is a risk that differing levels of investment agreed at locality level may result in continued unwarranted variation in quality and care and increased health inequalities.

### Lead(s)
- Primary Care, GM Health and Social Care Partnership
- Locality commissioners
**INCREASING RESEARCH IN PRIMARY CARE**

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<thead>
<tr>
<th>Discovery</th>
<th>Define</th>
<th>Design &amp; Develop</th>
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<th>Evaluate</th>
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**Ask of GM:** Identification and sharing of research opportunities and sharing of best practice

**Ask of Localities:** TBA

This project will look to understand what research is currently being undertaken in localities. It will also seek to explore opportunities to bring more academic research into primary care. Working with Health Innovation Manchester and local academic institutions, will enable primary care to explore the opportunities offered through academic research and industry partnership.

### Aims, Objectives

This project aims to bring more research, innovation and sharing of good practice into primary care by:

- Understanding what research is currently taking place in primary care
- Developing relationships with Health Innovation Manchester and academic institutes
- Facilitating opportunities to bring more research into primary care
- Seeking and utilising primary care clinicians with an interest in research and innovation
- Development of a mechanism for sharing best practice

### Expected outcomes

- Localities enabled to ‘do things once’ where appropriate
- Creation of a learning culture across all primary care

### Benefits / Rationale

- Improved patient outcomes (Downing et al, 2017; Boaz et al, 2015)
- Lower patient mortality (Ozdemir et al, 2015)
- Long term financial returns (Glover et al, 2018)
- Higher levels of staff satisfaction (Royal College of Physicians, 2016)

### Delivery Activities (to date)

- Supported applications from localities to The Health Foundation
- Commissioned academic research from GM CLAHRC to evaluate the GM Demonstrator pilot
- Commissioned academic research from the University of Salford to evaluate the asset based approaches training pilot
- Commissioned academic research from GM CLAHRC to evaluate the roll out of extended access and exploration of primary care workforce
- Invited Health Innovation Manchester to the General Practice Board to generate discussions regarding research

### Milestones / commitments

- Project scoping and initiation – **September 2020**

### Risks

- General practice may not fulfil new contract requirements (#8. supporting research and testing future contract changes)

### Lead(s)

- TBA
Building on existing data from a variety of sources will provide a comprehensive picture of primary care. Data and technology will also enable system-wide workforce planning, making use of population health and activity trends, provide an understanding of the skills and competencies needed to deliver current and future primary care, enable a baseline of the current workforce to be established, and highlight the gaps in workforce and the most appropriate methods to fill those gaps.

**Primary Care Projects include:**

- Primary care dashboard
- General Practice Workforce Visualisation Tool
**PRIMARY CARE DASHBOARD**

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<tr>
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**Ask of GM:** Leading the development and roll out

**Ask of Localities:** Utilisation across individual providers, PCNs / neighbourhoods and localities. Feedback to GM as prototype is tested.

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**Aims, Objectives**

- To make available information relating to quality and delivery of primary care services across Greater Manchester.
- Use data at a practice, neighbourhood, locality and GM-level to make tactical decisions and deliver the highest quality patient care possible.
- Embed tool in neighbourhood model, peer reference, use by GP / GM Excellence Programme, working with BI and Quality Leads to ensure that this compliments local systems.

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**Expected Outcomes**

- Benchmarking to drive provider and neighbourhood improvements of care for local populations
- Increase awareness and understanding across GM of wider primary care provision
- Use of primary care data for tactical commissioning and development of integrated service provision across neighbourhoods and localities (e.g. by PCNs incorporating community pharmacy, dentistry and optometry)

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**Benefits / Rationale**

- Support reduction in inequalities
- Identification and use of consistent datasets across primary care and GM
- Consideration of wider primary care contribution to neighbourhood delivery

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**Delivery Activities (to date)**

- Datasets and design have been developed to present initial dashboard. There has been engagement of BI leads and PC Leads in concept and design of initial dashboards.
- Scoping exercise of available datasets has been undertaken.
- Pharmacy, dental and optometry quality metrics have been agreed.
- Primary Care Sprint version 1

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**Milestones / commitments**

- Design and testing of GM Dashboard v1 – **January 2019**
- Quality metric dashboard development for Pharmacy, Optometry and Dentistry - **March 2020**
- Locality reporting of service delivery across GM - **September 2020**

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**Risks**

- There is a risk that the BI tool will duplicate local systems.
- There is a risk that there is a lack of wider primary care data available and / or being used via the tool.

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**Lead(s)**

- GP Team, Primary Care, GM Health and Social Care Partnership

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To make primary care indicators available online across GM, by Tableau, to support quality and improvement.
**GENERAL PRACTICE WORKFORCE VISUALISATION**

### Aims, Objectives

- Utilise infrastructure, resource and learning from the VWIS project to provide a tool which will provide baseline intelligence, support workforce planning and support real time workforce management
  - To provide general practice and PCNs with information to better inform workforce planning
  - To provide simple process for practices to collate workforce data to avoid duplication while meeting local and national requirements
  - To work with general practice to develop the tableau visualisation tool to support strategic decision making and inform workforce planning

### Expected outcomes

- Reduction in duplication in efforts to both satisfy mandatory collections which are required from national and regional teams whilst supporting the local requirement of the GM system
- Raised profile of the importance of understanding workforce data
- Creation of a suite of views (visualizations) within Tableau, accessible by designated parties which display practice and local system activity data
- Within a secure environment, practices will have the ability to view their workforce data and through information governance agreements will have an opportunity to view partners within a local system

### Benefits / Rationale

- Increase in quality of data inputted into the General Practice NWRS promoting more realistic picture of the GP workforce to NHS Digital
- Clear, robust visualisation of the primary care workforce across Greater Manchester which falls into primary care networks, allowing for clinical leaders, practices and decision makers to understand the workforce
- A readily available workforce report which can be utilised by practices, networks and providers when asked to report on the workforce
- A tool owned by general practice and led by the GP board with robust information governance arrangements which promotes trust and understanding between providers and commissioners

### Delivery Activities (to date)

- Engagement with general practice providers via the GM General Practice Board (and subsequent engagement with CCG Accountable Officers)
- Development of Project Initiation Document

### Milestones / commitments

- System wide engagement, pilot localities mapped, IG in place, commencement of development of tool - **Jan-Mar 2020**
- Testing and creation of standard operating model, development of ‘onboarding pack and readiness assessment, agree go live dates - **Apr-Jun 2020**
- Locality submissions, data validation and visualisation - **Jul-Sep 2020**
- Development of continuation and sustainability plan, final submissions received - **Oct-Dec 2020**

### Risks

- Agreement of a common dataset across 10 localities/67 PCNs/ 450 providers
- Technical developments may present unpredictable challenges, causing delays and requiring workarounds
- Alignment with other ongoing workforce developments

### Lead(s)

- Greater Manchester General Practice Board
- Programme Manager (Workforce Intelligence), GMHSCP
- Primary Care Transformation Team, GM Health and Social Care Partnership

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An expansion of the current scope and reach of the Virtual Workforce Information System project to develop a web-based tool which can be utilised within general practice to support workforce visualisation, planning and HR management.
Primary care will not achieve its plans for transformation without a sustainable workforce. Consideration will be given to the shape of primary care teams and whether these are still appropriate for the population. A detailed 5 year primary care workforce strategy accompanies this strategy and describes how together, GM will tackle workforce challenges and develop a workforce that is fit for the future.

**Primary Care Projects include:**

- Retention
- Developing an expanded primary care team
Research shows that a complex combination of factors are leading to poor job satisfaction within general practice including workload, remuneration, perceived lack of recognition, increasing bureaucracy and lack of peer support. This is leading to an increase in the rate at which general practitioners are choosing to leave the workforce, or work on a more part-time basis. National funding only supports the retention of GPs. However, learning will be taken and shares/replicated across all of primary care.

<table>
<thead>
<tr>
<th>Discovery</th>
<th>Define</th>
<th>Design &amp; Develop</th>
<th>Deliver</th>
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<tbody>
<tr>
<td>Ask of GM: Facilitation of GM retention programme and assurance regarding funding</td>
<td>Ask of Localities: Identification of retention initiatives, roll out of initiatives, provision of monitoring information, sharing of learning</td>
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**Aims, Objectives**

- Support the establishment of local schemes and initiatives that enable local GPs to stay in the workforce, through promoting new ways of working and offering additional support.
- For 2019/2020, £12 million is being made available to STPs to support GP retention, with similar funding to follow in 2020/21. The GM share for 2019/2020 is £640,000. This funding supports local systems to develop innovative local retention initiatives for:
  - GPs who are newly qualified or within their first five years of practice
  - GPs who are seriously considering leaving general practice or are considering changing their role or working hours.
  - GPs who are no longer clinically practicing in the NHS in England but remain on the National Medical Performers List

**Expected outcomes**

A sustainable workforce across primary care through:

- the creation of satisfying roles for staff,
- development of multi-professional teams
- more balanced workload for all.

**Benefits / Rationale**

- GP retention is a key issue affecting many GPs and practices, and must be seen as a priority. The requirement for a well developed GP retention action plan is expected to feature prominently in all local primary care workforce strategies.

**Delivery Activities (to date)**

- In 2018/2019, NHS England invested £18 million to support GP retention, which was 80% more than originally planned. GMHSCP secured £516,750 of this funding, which was used to facilitate initiatives to enable GPs to stay in the workforce, through promoting new ways of working and providing a more flexible offer that will create a sustainable model within general practice.
- The majority of localities chose to appoint a GP Clinical Lead and a Nurse Clinical Lead, and to conduct focus groups to understand how clinicians could be supported on a local level. However some areas invested in innovative projects such as Wigan that chose to support educational Primary Care Podcasts, which are being produced by two GP Fellows.
- Funding released to localities for local retention schemes

**Milestones / commitments**

STP-level initiatives for 2019/2020 include:

- a GM Primary Care Platform (central online repository for vacancies and careers information (page 34)
- Encourage uptake of tier 2 license holders - March 2020
- a rolling engagement program for GP Trainees ongoing
- Group Consultations (page 29)

CCG Local Retention (LGPR) initiative scheme milestones:

- Scheme issued to CCG’s and Stakeholders - September 2019
- Scheme bids to be submitted, approved and MoU’s issued - November 2019
- Monitoring of schemes - quarterly monitoring in line with MoU commencing Q4 2019/20

**Risks**

- GM localities are at differing levels of maturity around workforce and may not have the capacity to get some of the retention schemes off the ground quickly, however the GM Primary Care Workforce Managers are supporting localities as much as possible, and are putting an MOU in place to agree deliverables/accountability.
- There is a risk that national data does not reflect skill mix in practice as it currently only captures GPs in post and GP vacancies.

**Lead(s)**

- Primary Care Workforce, GM Health and Social Care Partnership
- Workforce Leads in GM Localities
**DEVELOPING AN EXPANDED PRIMARY CARE TEAM**

### Ask of GM
Leading the IGPR programme on behalf of GM, facilitation of relationships with GM Training Hub and Higher Education Institutes to facilitate change.

### Ask of Localities
Facilitation of roll out of new roles across primary care.

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### Aims, Objectives

To increase capacity and improve the skill mix in primary care. This will be achieved by:

- Increasing the number of new roles in general practice through the implementation of the PCN DES
- Supporting family doctors who work in European Economic Area (EEA) countries to work in GM and streamlining application routes for GPs from Australia, Canada, New Zealand and South Africa
- Rolling out a Trainee Nurse Associate Pilot in primary care

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### Expected outcomes

- Creation of a more sustainable workforce
- Increased capacity in primary care through the introduction of new roles
- Increased number of GPs and nurses

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### Benefits / Rationale

- Over the coming years, PCNs will be supported in developing an expanded primary care team, with member practices also working alongside other organisations such as community trusts and the voluntary sector, to help alleviate workload pressures on practices and allow GPs to concentrate on the most complex patients.
- While GP training places are increasing year-on-year and many GPs are returning to practise, some practices continue to face recruitment issues and newly qualified GPs are often working temporally at a practice (known as a locum) rather than joining as a permanent GP. Some older GPs are also leaving the profession early. This is leaving a gap between the number of GPs that practices want, and the numbers they are successfully recruiting and retaining.

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### Delivery Activities (to date)

- 7 candidates have been interviewed and offered a placement within GM under the International GP Recruitment programme, with 2 GPs having relocated to GM and started the scheme, 1 relocating in January 2020 and 2 others considering the offer. An additional 4 GPs are completing an English language programme with a view to starting the interview process in January 2020.
- 5 clinical pharmacy pilot sites have transferred their employed clinical pharmacists to the PCNs within their locality.

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### Milestones / commitments

- **From April 2020/21**, each PCN will be allocated a single combined maximum sum under the Additional Roles Reimbursement Scheme. This sum will be calculated on a weighted capitation basis (to be confirmed during 2019).
- PCNs will be able to recruit from within the five roles as they require to support delivery of the Network Contract DES requirements as follows:
  - from **April 2020** - clinical pharmacists, social prescribing link workers, physician associates and physiotherapists; and
  - from **April 2021** – additionally paramedics.
- **International GP recruitment scheme had been extended until 2023/24.**
- **Trainee Nurse Associate pilot to commence – March 2020**

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### Risks

- To date, the recruitment supplier has been unable to provide the anticipated volumes of GPs and this has been further exacerbated by the uncertainty surrounding Brexit. This is recognised as a national issue; it is not limited to Greater Manchester.
- There is a risk that established services in localities may become destabilised as PCNs recruit to the new roles.

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### Lead(s)

- Primary Care, GM Health and Social Care Partnership
- Primary Care Workforce, GM Health and Social Care Partnership
- Primary Care Networks
Primary Care Vision
To improve the health and wellbeing of GM residents by providing digitally enabled, multidisciplinary, integrated and preventative support, based in the right place for local populations.

Population Health Outcomes

**Overall**
We will live longer and healthier lives, with the greatest improvements in the areas and groups which have the worst outcomes.

**Start Well**
We will have the best possible start in life.

**Live Well**
We will all have the opportunity to live well and fulfil our potential.

**Age Well**
We will have the opportunity to age well and remain at home, safe and independent for as long as possible.

Primary Care Outcomes

- People are more informed and have greater involvement in their health and care
- People’s experience of primary care is improved
- Primary care better addresses health inequalities
- Primary care is better able to contribute to improving population health
- Primary care is more responsive to people's needs
- Primary care works seamlessly with LCOs, secondary care, community services and the VCSE sector
- Primary care workforce is expanded and more integrated
- Primary care infrastructure - physical and digital - is improved
<table>
<thead>
<tr>
<th>PROJECT</th>
<th>METRICS/ MEASURES</th>
<th>DATA SOURCE</th>
<th>FREQUENCY</th>
<th>PRIMARY CARE OUTCOME</th>
<th>POPULATION HEALTH OUTCOME</th>
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<tbody>
<tr>
<td>PCN Development</td>
<td># of PCNs accessing development resource</td>
<td>PCN assurance framework</td>
<td>Quarterly</td>
<td>Primary care is more responsive to people’s needs</td>
<td>We will all have the opportunity to live well and fulfil our potential</td>
</tr>
<tr>
<td>Leadership and OD</td>
<td># of primary care providers accessing leadership development support</td>
<td></td>
<td></td>
<td>Primary care is better able to contribute to improving population health</td>
<td>We will all have the opportunity to live well and fulfil our potential</td>
</tr>
<tr>
<td>Comms and Engagement</td>
<td># number of stakeholders reached through comms</td>
<td>Mailchimp</td>
<td>Quarterly</td>
<td>People are more informed and have greater involvement in their health and care</td>
<td>We will all have the opportunity to live well and fulfil our potential</td>
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<td></td>
<td># number of stakeholders subscribing to newsletters</td>
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<td></td>
<td># of people engaging with Citizens network (physically and virtually)</td>
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<tr>
<td>Estates</td>
<td># of approved schemes</td>
<td>GM Business case and capital investment steering group</td>
<td>Monthly</td>
<td>Primary care infrastructure - physical and digital - is improved</td>
<td>We will live longer and healthier lives, with the greatest improvements in the areas and groups which have the worst outcomes</td>
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<tr>
<td>Social Prescribing</td>
<td># referrals to social prescribing services</td>
<td>Elemental software</td>
<td>Quarterly</td>
<td>People are more informed and have greater involvement in their health and care</td>
<td>We will all have the opportunity to live well and fulfil our potential</td>
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<td></td>
<td>% reduction in demand for GP services</td>
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<td></td>
<td>% reduction in A&amp;E attendances</td>
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<tr>
<td>Group Consultations</td>
<td>Increase in # of staff trained</td>
<td>Programme reporting GP patient survey</td>
<td>Quarterly</td>
<td>Primary care workforce is expanded and more integrated</td>
<td>We will all have the opportunity to live well and fulfil our potential</td>
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<tr>
<td></td>
<td>Increase in # of patients accessing group consultations</td>
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<td></td>
<td>% increase in patient experience</td>
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<tr>
<td>Use of GP Online Services</td>
<td>Increase in # of patients registered for online services</td>
<td>POMI data (NHS Digital)</td>
<td>Quarterly</td>
<td>Primary care is more responsive to people’s needs</td>
<td>We will all have the opportunity to live well and fulfil our potential</td>
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<td></td>
<td>Increase in # of GP practices achieving 30% uptake target</td>
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<tr>
<td>Direct Booking</td>
<td>Increase in # of extended access appointments booked through NHS111</td>
<td>eDeclaration Programme reporting</td>
<td>Quarterly</td>
<td>Primary care is more responsive to people’s needs</td>
<td>We will all have the opportunity to live well and fulfil our potential</td>
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<tr>
<td></td>
<td>Increase in # of practices that have enabled direct booking</td>
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<td></td>
<td>Increase in # of GP practice appointments booked through NHS111</td>
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<tr>
<td>Information Management and Technology</td>
<td># of approved schemes # of completed schemes</td>
<td>GM Business case and capital investment steering group</td>
<td>Monthly</td>
<td>Primary care infrastructure - physical and digital - is improved</td>
<td>We will live longer and healthier lives, with the greatest improvements in the areas and groups which have the worst outcomes</td>
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*Note: The table continues with additional projects and metrics.*
<table>
<thead>
<tr>
<th>PROJECT / ENABLER PROJECT</th>
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<th>PRIMARY CARE OUTCOME</th>
<th>POPULATION HEALTH OUTCOME</th>
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</thead>
<tbody>
<tr>
<td>Primary Care Platform</td>
<td>Total users per month Sources of users # of new users per month # of sessions per month, average duration Average pages viewed and bounce rate Vacancies advertised Feedback from users Tracking referrals/traffic to other GM websites</td>
<td>Website host</td>
<td>Monthly</td>
<td>Primary care infrastructure - physical and digital - is improved</td>
<td>We will live longer and healthier lives, with the greatest improvements in the areas and groups which have the worst outcomes</td>
</tr>
<tr>
<td>Online and video consultations</td>
<td>Increase in # of practices offering online consultations Increase in # of online consultations being provided % increase in patient experience % reduction in demand for GP services</td>
<td>Programme Reporting</td>
<td>Quarterly</td>
<td>Primary care infrastructure - physical and digital - is improved</td>
<td>We will all have the opportunity to live well and fulfil our potential</td>
</tr>
<tr>
<td>Seamless Care</td>
<td>Increase in # of electronic referrals made Increase in # of secondary care settings to enable electronic referrals Increase in # of new medicine reviews as a result of electronic referrals</td>
<td>Programme Reporting</td>
<td>Quarterly</td>
<td>Primary care works seamlessly with LCOs, acutes, community, VCSE</td>
<td>We will all have the opportunity to live well and fulfil our potential</td>
</tr>
<tr>
<td>Eye Health IT Enabler Project</td>
<td>Increase in # of electronic referrals made to secondary care Increase in # of optical practices sending electronic information to general practice</td>
<td>Programme Reporting</td>
<td>Quarterly</td>
<td>Primary care works seamlessly with LCOs, acutes, community, VCSE</td>
<td>We will all have the opportunity to live well and fulfil our potential</td>
</tr>
<tr>
<td>Meeting Demand</td>
<td>% reduction in emergency admissions across GM % reduction in A&amp;E attendances</td>
<td>SUS data</td>
<td>Quarterly</td>
<td>People’s experience of primary care is improved</td>
<td>We will all have the opportunity to live well and fulfil our potential</td>
</tr>
<tr>
<td>7 Day Access</td>
<td># of appointments available in extended access hubs % increase in utilisation % decrease in DNAs % improvement in patient experience % reduction in A&amp;E attendances</td>
<td>GM Primary Care Reform Programme monitoring GP Pt survey</td>
<td>Quarterly</td>
<td>People’s experience of primary care is improved</td>
<td>We will all have the opportunity to live well and fulfil our potential</td>
</tr>
<tr>
<td>Primary Eye Care Service Framework</td>
<td># of localities commissioning the service</td>
<td>Locality reported</td>
<td>Bi-annually</td>
<td>Primary care infrastructure - physical and digital - is improved</td>
<td>We will all have the opportunity to live well and fulfil our potential</td>
</tr>
<tr>
<td>Proactive Children’s Dental Management</td>
<td>% reduction in children’s dental related GAs % increase in proportion of children under 5 years old attending a dentist % increase in proportion of children receiving preventative interventions</td>
<td>PBR data (SLAM/SUS) NHS BSA Dental Access statistics/ prescribing data (NHS Digital)</td>
<td>Quarterly</td>
<td>Primary care better addresses health inequalities</td>
<td>We will have the best possible start in life</td>
</tr>
<tr>
<td>PROJECT</td>
<td>METRICS/ MEASURES</td>
<td>DATA SOURCE</td>
<td>FREQUENCY</td>
<td>PRIMARY CARE OUTCOME</td>
<td>POPULATION HEALTH OUTCOME</td>
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<tr>
<td>Community Pharmacist Consultation Service</td>
<td># of urgent medicine referrals # of minor illness referrals # of referrals from GP practices to community pharmacies # of referrals from NHS 111 to community pharmacies</td>
<td>Programme reporting</td>
<td>Quarterly</td>
<td>People’s experience of primary care is improved</td>
<td>We will all have the opportunity to live well and fulfil our potential</td>
</tr>
<tr>
<td>Contraceptive services in community pharmacy</td>
<td># of contraceptive choices consultations # of women starting a regular contraceptive following supply of EHC</td>
<td>Programme reporting</td>
<td>Quarterly</td>
<td>Primary care is more responsive to people’s needs</td>
<td>We will all have the opportunity to live well and fulfil our potential</td>
</tr>
<tr>
<td>Healthy Living Framework</td>
<td>Increase in # of 'healthy living' providers Increase in # of interventions per campaign Increase in # of health champions Increase in # of dementia friends</td>
<td>Pharmoutcomes LPCs Self declaration</td>
<td>Quarterly</td>
<td>Primary care is better able to contribute to improving population health</td>
<td>We will all have the opportunity to live well and fulfil our potential</td>
</tr>
<tr>
<td>Primary Care Health Campaigns</td>
<td>Increase in # of providers delivering joint health campaigns # of brief interventions per campaign</td>
<td>Pharmoutcomes Self declaration</td>
<td>Per campaign</td>
<td>People are more informed and have greater involvement in their health and care</td>
<td>We will live longer and healthier lives, with the greatest improvements in the areas and groups which have the worst outcomes</td>
</tr>
<tr>
<td>Environmental Sustainability</td>
<td># of providers undertaking carbon literacy training</td>
<td>Self declaration</td>
<td></td>
<td>Primary care is better able to contribute to improving population health</td>
<td>We will all have the opportunity to live well and fulfil our potential</td>
</tr>
<tr>
<td>MenACWY catch up vaccinations</td>
<td># of contractors offering the service # of patients vaccinated</td>
<td>Programme reporting</td>
<td>Quarterly</td>
<td>Primary care is better able to contribute to improving population health</td>
<td>We will all have the opportunity to live well and fulfil our potential</td>
</tr>
<tr>
<td>Increased uptake of sight tests</td>
<td>% increase in sight tests for children % increase in sight tests for people in employment % increase in sight tests for homeless people % increase in sight tests for people with learning disabilities</td>
<td>Programme reporting</td>
<td>Quarterly</td>
<td>Primary care better addresses health inequalities</td>
<td>We will live longer and healthier lives, with the greatest improvements in the areas and groups which have the worst outcomes</td>
</tr>
<tr>
<td>Community sight loss framework</td>
<td># of localities commissioning the service</td>
<td></td>
<td></td>
<td>Primary care better addresses health inequalities</td>
<td>We will all have the opportunity to live well and fulfil our potential.</td>
</tr>
<tr>
<td>Pride in practice</td>
<td>Increase in # of providers achieving pride in practice accreditation % increase in patient experience</td>
<td>Programme reporting GP Pt Survey</td>
<td>Quarterly</td>
<td>Primary care better addresses health inequalities</td>
<td>We will all have the opportunity to live well and fulfil our potential</td>
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<tr>
<td>Transgender health service</td>
<td># of referrals to service</td>
<td>Programme reporting</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>PROJECT</td>
<td>METRICS/ MEASURES</td>
<td>DATA SOURCE</td>
<td>FREQUENCY</td>
<td>PRIMARY CARE OUTCOME</td>
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<tr>
<td>Primary care input to adult social care</td>
<td># of localities commissioning service</td>
<td>Locality reported</td>
<td></td>
<td>Primary care better addresses health inequalities</td>
<td>We will have the opportunity to age well and remain at home, safe and independent for as long as possible.</td>
</tr>
<tr>
<td>Oral health in older people</td>
<td># of care home staff trained in oral health improvement</td>
<td>Programme reporting</td>
<td>Quarterly</td>
<td>Primary care better addresses health inequalities</td>
<td>We will have the opportunity to age well and remain at home, safe and independent for as long as possible.</td>
</tr>
<tr>
<td>Hypertension and AF find and treat</td>
<td># of patients with AF identified</td>
<td>Programme reporting</td>
<td>Quarterly</td>
<td>Primary care better addresses health inequalities</td>
<td>We will all have the opportunity to live well and fulfil our potential</td>
</tr>
<tr>
<td>Asthma reviews in community pharmacy</td>
<td># of patients attending an asthma review with community pharmacy</td>
<td>Programme reporting</td>
<td>Quarterly</td>
<td>Primary care is more responsive to people’s needs</td>
<td>We will all have the opportunity to live well and fulfil our potential</td>
</tr>
<tr>
<td>GM excellence</td>
<td>Increase in # of self referrers increase in # of providers supported with bespoke packages Increase in # of staff trained / supported with education</td>
<td>Programme reporting</td>
<td>Quarterly</td>
<td>Primary care is more responsive to people’s needs</td>
<td>Primary care is more responsive to people’s needs</td>
</tr>
<tr>
<td>Primary care standards</td>
<td>Collectively agreed performance and improvement measures (TBA)</td>
<td>Local business intelligence teams</td>
<td>Bi-annually</td>
<td>Primary care is more responsive to people’s needs</td>
<td>We will live longer and healthier lives, with the greatest improvements in the areas and groups which have the worst outcomes</td>
</tr>
<tr>
<td>Increasing research</td>
<td>Increased # of primary care providers undertaking research</td>
<td></td>
<td></td>
<td>People’s experience of primary care is improved</td>
<td>We will all have the opportunity to live well and fulfil our potential.</td>
</tr>
<tr>
<td>Primary care dashboard</td>
<td>Increase in # of providers accessing Tableau</td>
<td>Tableau</td>
<td>Quarterly</td>
<td>Primary care is more responsive to people’s needs</td>
<td>We will live longer and healthier lives, with the greatest improvements in the areas and groups which have the worst outcomes</td>
</tr>
<tr>
<td>Workforce visualisation tool</td>
<td>Increase in # of practices submitting workforce data Increase in accuracy of data inputted to NWRS Increase in usage of the tool</td>
<td>NHS Digital Programme reporting</td>
<td>Quarterly</td>
<td>Primary care is more responsive to people’s needs</td>
<td>We will live longer and healthier lives, with the greatest improvements in the areas and groups which have the worst outcomes</td>
</tr>
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<td>PROJECT</td>
<td>METRICS/ MEASURES</td>
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<tr>
<td>Retention</td>
<td># of primary care staff retained</td>
<td>Programme reporting</td>
<td>Quarterly</td>
<td>Primary care is more responsive to people’s needs</td>
<td>We will live longer and healthier lives, with the greatest improvements in the areas and groups which have the worst outcomes</td>
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<tr>
<td>Expanding the</td>
<td>Increase in # of staff working in new roles</td>
<td>Programme reporting</td>
<td>Quarterly</td>
<td>Primary care is more responsive to people’s needs</td>
<td>We will live longer and healthier lives, with the greatest improvements in the areas and groups which have the worst outcomes</td>
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<tr>
<td>team</td>
<td>Increase in # of international GPs recruited</td>
<td></td>
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The Greater Manchester Primary Care Workforce Strategy

2019 - 2024
OUR VISION FOR PRIMARY CARE

Across Greater Manchester (GM) we aim to deliver the fastest and greatest improvement in the health and wellbeing of our whole population, by enabling the fastest and most comprehensive improvements in capacity and capability of the Greater Manchester primary care workforce.

The five-year GM primary care strategy aims to expand the traditional concept of primary care to create a much wider integrated health system to achieve the broader, long-term vision for Greater Manchester. This will improve the health and wellbeing of GM residents and contribute to the further economic viability of the region. The traditional model of primary care will evolve, with more focus on digitally enabled, multidisciplinary, integrated and preventative support, based in the right place for local populations. This will not only improve the quality of primary care delivery and improved population health outcomes, it will also ensure its future sustainability. Having the right workforce is essential to the delivery of the GM primary care strategy.

The NHS Long Term Plan (2019) commits to whole scale community service redesign. It describes plans to ‘boost’ out of hospital care, reduce pressure on emergency hospital services and digitally enable primary and outpatient care. It reflects the need to provide more care closer to home, improving the links between primary, community and secondary care, and improving support to care homes.

In Greater Manchester, our ambition exceeds this.

Our people and communities will have access to high quality, fully integrated, place-based care, provided across established neighbourhoods of 30-50,000 people. The power of our 67 Primary Care Networks (PCNs) will be integral to the design and delivery of these and will collaborative, as a vital part of their local communities, with general practice, pharmacy, dentistry and optometry operating as a single system. Multidisciplinary working will be commonplace, with strong relationships and seamless care across primary, community and secondary care, Local Care Organisations and the VCSE sector.

Greater Manchester will have a resilient paid and unpaid workforce that feels sufficiently motivated, supported and empowered, equipped to deliver high quality services and able to drive sustainable improvements that positively influence the health and wellbeing of the population.

The primary care workforce will be much broader in terms of roles and skills. They will feel recognised and valued, with parity of esteem across organisations and sectors. They will enjoy fulfilling work that provides opportunities for development and career progression.

This primary care workforce strategy signals a renewed focus on integrated delivery across neighbourhoods, population health and working at scale, while making the best use of the collective skills in primary care and the community to meet current challenges and maximise the opportunities to improve people’s healthy life outcomes. It is about people and places, not organisations and boundaries.
INTRODUCTION

On 1 April 2016 Greater Manchester became the first region in the country to have devolved control over integrated health and social care budgets, a sum of more than £6bn. A year later, Greater Manchester got a mayor and extra powers to make decisions locally to tackle wider problems that affect people’s health and everyday life.

The vision for Greater Manchester is “to ensure the greatest and fastest possible improvements to the health and wellbeing of the 2.8 million population of GM”. Key to achieving this vision is having the right GM workforce.

GM Context

Across GM there are 10 local authorities, 15 NHS trusts, a GM police service, a GM fire and rescue service, 10 Clinical Commissioning Groups, over 15,000 voluntary organisations, community groups and social enterprises and over 2000 points of primary care delivery (including general practice, community pharmacy, community optometry and general dental service). As the only city region with health devolution, we are able to remake the connection between health and other public services that has been lost over the years.

Because devolution means decisions are now made right here, in Greater Manchester, we can do something about the issues that affect all 2.8 million of us – such as helping children have the best start in life, improving our physical and mental health and helping us stay well for as long as possible. Primary care has a major role to play in this.

The GM plans for devolution reflect a clear and distinct philosophy – that the NHS is part of a wider system of population health, accountable to the people through the framework of local democracy. Devolution continues to offer the unique opportunity to take charge and do things differently to meet local people’s needs.

‘Taking Charge of our Health and Social Care in Greater Manchester’\(^1\) (2015), described primary care as the driving force behind a new approach focused on predicting and preventing ill health, and at the heart of new models of care that enable this approach to be embedded in all 10 Greater Manchester localities.

The refreshed five-year strategy for primary care focuses on the GM neighbourhood model of care, improving the quality of primary care and ensuring that primary care is sustainable and fit for the future. The delivery of the primary care strategy will not be possible without the transformation and sustainability of the workforce.

In 2017, the GM workforce strategy was published, focusing on four key priorities:

- **Talent Development and System Leadership** – proactively invest in nurturing the skills and competencies of our workforce
- **Grow our own** – widening access for and accelerating talent development across a range of new and existing roles

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• **Employment offer and brand** – nurturing a vibrant employment environment that makes GM the best place to work for health and social care professionals

• **Filling difficult gaps** – co-ordinated action to address specific long-term skills and capacity shortages across health and social care.

The GM workforce strategy aims to offer the current and future workforce a supportive and inclusive working environment where staff are recognised and valued, with opportunities to develop and flexible and attractive benefits. This is reflected in the plans for primary care.

**National Context**

The Five Year Forward View\(^2\) (2014) describes how the NHS needs to evolve in order to meet the challenges of people living longer with more complex needs as well as take advantage of the opportunities brought by new technologies to improve care. It acknowledges the need for an appropriately skilled workforce that is able to deal with today’s challenges and adapt to changing models of care.

The General Practice Forward View\(^3\) (2016) focuses on the transformation and stabilisation of General Practice. It describes a bold ambition to create and extra 5,000 GPs and 5,000 non-medical staff across England over five years, growing the workforce and improving the use of wider, multidisciplinary workforce.

The Interim NHS People Plan\(^4\) (2019), which was published in 2019 outlines plans to make the NHS the best place to work, improve the leadership culture, tackle the nursing challenge, deliver 21\(^{st}\) Century Care and embed a new operating model for workforce.

Primary Care Networks (PCNs) were introduced as part of the NHS Long Term Plan. GP practices were able to join networks with populations of around 30,000-50,000 populations to create fully integrated community-based health services. The PCNs will be required to deliver seven national service specifications and will receive funding for new roles.

**Challenges**

Greater Manchester (GM) has many strengths as well as many challenges. With around 2.8 million people living in GM, the population grew by over 170,000 in the last decade. There is a £7 million gap between public spend and tax income. Around 65,000 people are out of work, which includes 1/4 of 16-19 year olds. Currently the life expectancy of women in GM is 81.3 years compared to the England average of 83.1. For men, the life expectancy in GM is 77.8 which is below the England average of 79.5. Around 441,000 of GM residents are aged 65 and over. That figure grew by over 50,000 in the last 25 years. 268 people are rough sleeping in GM, with another 18,000 at risk of becoming homeless.

Many people are seen by GPs when they could be supported in a different setting. Care between teams is sometimes not joined up, with patients having to explain their story multiple times. Medicines related queries are regularly dealt with in general practices, when they could be managed more conveniently in community pharmacy. Ophthalmology is the highest specialty with

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the highest cause of attendance at hospital outpatients when a number of these appointments could be proactively managed in primary care optical practices. People regularly attend A&E when there is provision in the community. With better communications and engagement with the public, more of these cases could be seen closer to home in a timely manner.

Although there are pockets of good practice, there is little insight into the primary care workforce in terms of capacity and workload. In General Practice, where data is routinely collected, it is often not provided in a consistent manner. While data collection has improved, completion rates are still not at a level which enables robust and detailed analysis. The pace in which employment and vacancy rates can fluctuate across hundreds of individual providers makes it more difficult to gain up to date information. In dental, optometry and pharmacy the provision of workforce data is not a contractual obligation. Work is ongoing with Local Professional Networks and Local Representative Committees to facilitate workforce data collection solutions.

**General Practice**

According to the BMA, nine out of 10 GPs feel their workload had a negative impact on the quality of care they give to their patients. Primary Care Networks will enable at-scale working which brings resilience to general practice and economies of scale across both workforce and estates alike.

Increasingly the needs of patients are a blend of physical and mental health needs, social and environmental factors that require coordinated responses – well beyond the traditional medical model of care – which places further demands on practices both to navigate the system for their patients and to coordinate the response. It requires practices and GPs to work in different and more integrated ways with colleagues from across the public, community and voluntary sectors. Workload is higher than ever, with GPs and practice staff working long hours and struggling to maintain a sustainable work/life balance. Morale in general practice is low. More GPs are now entering the profession on a salaried basis or choosing to leave partnerships to take up salaried positions.

Problems with recruitment and retention create further workforce challenges. A third of GPs hope to retire within the next five years, and a fifth of current GP trainees plan to move abroad. A large proportion of practice nurses are aged 50-59, with a third hoping to retire in 2020. Outcomes from the Ninth GP Worklife Survey undertaken in 2017 are outlined below.

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Other parts of the primary care workforce face similar challenges, for example in practice nursing, over 64% of practice nurses are over 50, and only 3% are under 40. There is variation in employment models, qualifications and access to continuing education and development across Greater Manchester primary and community nursing workforce. This is compounded by variation in pay terms and conditions, integration of nursing roles into primary care networks, and lack of sustainable funding for nursing development. Policies and information supporting best practice in primary care could be more robust. There is a risk that the population will not receive care and treatment of a consistent quality and safety.

In December 2017, the National Institute for Health Research Collaboration for Leadership in Applied Health Research and Care (NIHR CLAHRC) Greater Manchester undertook a study to explore the workforce challenges facing General Practices across GM.

In GM, female staff account for 86% of the General Practice workforce. There are very few men working in non-GP roles, including 1% of nursing staff, 7% of other clinical staff and 5% of administration staff. The data suggests that more female GPs tend to work part time than men, although this varies by age. The retention of practice nurses is an issue across the whole of GM.

Administration staff make up the largest staffing group, accounting for 60% of the general practice workforce. 21% of staff are GPs, making them the second largest staff group. Nursing and other clinical roles make up the remainder of the general practice workforce.

For the non-medical workforce, the largest age group is 50-54, followed by people aged 55-59. 20% of Greater Manchester Practitioners (excluding registrars, retainers and locums) are aged over 55.

**Dental**

The General Dental Council regulates dental professionals in the UK and holds the professional registers for dentists and dental care professionals (DCPs). The term DCP covers a range of registered professions including dental nurse, dental technician, dental therapist, dental hygienist, orthodontic therapist and clinical dental technician, all of which require different qualifications and have different scopes of practice.
The dental workforce is diverse, and GM encourages the use of skill mix in dental practices, such as Dental therapists and Dental nurses with extended duties. There is a shortage of dentists both nationally and locally, some of this is attributed to a cultural change in working patterns where clinicians are choosing to work fewer days to improve their work-life balance. It is difficult to establish the actual NHS dental workforce for Greater Manchester as there is no explicit comprehensive dental workforce survey. Furthermore, the workforce delivers a mixed economy of NHS and independent private services.

Many newly qualified dentists prefer to become associates, meaning they complete their usual dentist duties but do not own the business. There has been recent growth in the private sector and many dentists are choosing to treat private patients and/or provide private treatment in addition or as an alternative to NHS care for NHS patients, leaving a shortage of NHS dentists.

70% of Dentists responding to the NHS Confidence Monitor Survey (2018) do not envision being in the NHS in five years' time, 27% intend to leave the profession altogether. There has also been a trend towards dentists working fewer hours. 51% of registered dentists are male and 49% female. The majority are aged 31-40 years with 7% aged 61 or over. There are opportunities to work with the dental profession to develop new options and flexible models of working.

The role of dentist as a clinician is dependent on having an adequate supply of dental care professionals, particularly dental nurses. A dentist can only increase the number of patients seen within a practice by increasing the number of practitioners in the practice. Recruitment of dental nurses is an increasingly worrying problem for many dental practices. Dental nursing must be made a more attractive employment option to ensure that numbers increase across Greater Manchester, in order to meet the rising demand and support skill mixing.

The British Dental Association survey found that, of those practices seeking to recruit a dental nurse, over half (55 per cent) had experienced difficulties. The only source of funding for dental nurses is dentists themselves. The cost of GDC registration and indemnity fees, may make the profession less attractive.

Pharmacy

Pharmacists in primary care deliver a wide range of roles and work within community pharmacies, general practice, clinical commissioning groups, care homes, out of hours and community services teams. The last 5-10 years have seen an increase in pharmacists working in general practice as well as becoming independent prescribers.

The last 5-10 years has also seen the introduction of Accredited Checking Pharmacy Technicians (ACPTs), who are empowered to undertake the final accuracy check on a dispensed prescription. Pharmacy technicians have also been employed to assist pharmacists in practice-based medicines optimisation work.

Other members of the community pharmacy team include Dispensers, Pharmacy Assistants, Healthy Living Champions and Delivery Drivers. Their career paths and motivations are neither well-defined nor understood, despite the significant contribution that they make to primary care pharmacy practice.

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Demand for places on the Master of Pharmacy degree course, nationally and even the well-established University of Manchester programme, is falling amongst school leavers.

Pharmacy Local Professional Network Workforce Group members report a shortage of pharmacists and other team members across all sectors and frequent movement across sectors and localities to take advantage of better salaries and terms/conditions resulting in low retention. Again, due to the lack of meaningful workforce data, the actual workforce numbers are not known. The Pharmacy Local Professional Network has plans to address this gap in information.

Optometry

There are a broad range of professionals and skill sets working across the eye health system, with over 2000 people working across several roles. This includes over 800 clinicians – with 571 optometrists and 235 Dispensing Opticians/Contact Lens Opticians across GM.

The majority (87%) of the workforce is permanent, with a very small proportion of the workforce comprising bank or temporary staff.

It is nationally recognised by the Royal College of Ophthalmologists that there are capacity and demand concerns within secondary care ophthalmology departments across the country and a need to explore new ways of working across the boundaries of primary, community and secondary care to meet these needs.

One of the recommendations is to upskill the workforce to enable them to work across organisational boundaries, delivering new models of care as part of multidisciplinary teams to deliver co-ordinated services such as glaucoma monitoring.

Progress to Date

There is significant work to do to support the GM primary care workforce. However, progress has already been made in a number of areas:

£41.2m of the Greater Manchester Transformation Fund has been invested in general practice, over four years, to deliver the Primary Care Reform Programme – the GM response to the General Practice Forward View.

People can now access general practice for routine appointment as well as urgent contact any day of the week, with all Greater Manchester localities offering full population coverage during evening and weekends. Care is provided by a range of people including GPs, nurses, Health Care Assistants and Pharmacists. This also means there is greater scope to provide a wider range of services outside of traditional daytime hours.

There are now over 100 pharmacists working as part of general practice teams and PCNs, providing direct patient care for both acute and long-term conditions with a particular emphasis on supporting patients to get the best outcomes from their medicines.
So far, 5,000 primary care professionals have been trained as part of the Pride in Practice\(^9\) (PiP) quality assurance service that supports primary care providers to strengthen relationships with the lesbian, gay, bisexual and transgender (LGBT) community.

Administrative and clerical staff at Greater Manchester general practices are better prepared to actively signpost people to appropriate services and manage clinical correspondence, with over 1,700 of them having received specialist training. Care navigation and active signposting services are increasing the use of services out in the Community, reducing GP appointment times and ensuring people receive the appropriate care in the right place at the right time.

The GM GP Excellence Programme, in partnership with the Royal College of General Practitioners (RCGP), continued to support general practice in important areas such as rescue, resilience, improvement and excellence. So far this has included helping GP practices with their Care Quality Commission (CQC) compliance, delivering organisational resilience, development and GP management training and courses on ‘working at scale’. At least 160 practice managers are being supported in management development and education through diploma courses. Our ambition is to expand GP Excellence to all primary care providers by 2020.

The Greater Manchester Health Care Academy has been established to provide training and support to Community Pharmacists and their wider teams, to ensure that the workforce going forward is fit for purpose, its potential maximised, and staff are developed and supported to meet the needs of the population. Although developed for community pharmacies, there is scope to extend this model to all primary care.

Across GM we are actively promoting primary care to new recruits through initiatives such as the first Greater Manchester-wide primary care careers event, which was attended by more than 200 school and college aged young people.

Tier 2 sponsorship licences enable the recruitment of non-EEC nationals. We have actively worked with GP practices to increase the number of licences from five to 58.

The GM Primary Care Workforce Strategy

The GM primary care workforce strategy signifies a move away from the traditional approach to care, which will ensure people have access to the most appropriate professional and service. This might include physiotherapy, midwifery, podiatry, work advisers or social care, as well as voluntary, community and social enterprise (VCSE) organisations. New and enhanced roles in primary care, such as pharmacists in General Practice, social prescribing link workers and physician associates, will further ensure that people are always seen by the most appropriate person, and in the most appropriate setting.

A wider, more flexible workforce means that primary care will be able to concentrate on what they do best i.e. to provide high quality and accessible care for patients. This will provide not just better care for our population but offer our workforce more satisfying work and improve their work-life balance.

The primary care workforce strategy aims to tackle the workforce challenges as well as develop a workforce that is fit for the future. It provides a framework for a range of initiatives, solutions

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\(^9\) Pride in Practice https://lgbt.foundation/prideinpractice
and interventions. It focuses on practical and deliverable long-term solutions to key challenges, bringing together local, GM and national priorities.

To make these plans a reality, this strategy focuses on:

- Delivering 21st century care by embracing neighbourhood working and making the workforce sustainable while ensuring they are fit for the future
- Addressing workforce shortages by identifying critical gaps, attracting new talent to primary care and supporting and optimising new roles
- Making primary care in GM a great place to work by engaging our staff, supporting and retaining the current workforce, supporting wellbeing, promoting diversity and supporting career development
- Improving the leadership culture by developing staff and managing talent and succession
- Developing a new operating model for the primary care workforce ensuring they have the capacity and capability to deliver
DELIVERING 21ST CENTURY CARE

In Greater Manchester we want to create a system that understands the relationship between health and the wider determinants of health. This will mean people can access support to identify and address their medical, social and emotional needs in one process, so they receive more timely and appropriate help from the professionals and services best placed to provide it. Primary care will embrace the opportunities for the VCSE sector to be partners in the delivery of health and wellbeing.

Care Closer to Home

Increasingly primary care providers are expanding their services to accommodate the needs of people who would previously have been treated in hospital.

Population-level services are both cost effective and make a real difference to local people, so our primary care providers will be given the necessary skills and competencies to deliver a range of services in the community that have traditionally been provided in hospital. For example, provision of glaucoma repeat measures and pre and post cataract referrals will become commonplace in the community, as will services such as dermatology, endoscopy and musculoskeletal clinics. Across Greater Manchester, primary care will be upskilled to deliver these services.

More of the primary care workforce, including nurses, pharmacists, optometrists and physiotherapists, will be supported to become independent prescribers, improving peoples’ access to medication. Social Prescribing Link Workers will also be embedded across neighbourhoods, connecting people to community assets.

Primary Care Networks

There are 67 newly formed Primary Care Networks (PCNs) across Greater Manchester. These PCNs are based on GP-registered lists, typically serving natural communities of around 30-50,000 – as described in our Greater Manchester neighbourhood model. They are designed to be small enough to provide the personal care valued by both patients and GPs, but large enough to have impact and economies of scale through better collaboration between practices and others in the local health and social care system.

GM will embrace the evolution of PCNs, as an integral part of the GM model of integrated neighbourhood working. PCNs and the neighbourhood model present opportunities for integration with wider primary care and public sector services to create ‘one public service’. They also present opportunities for our workforce to operate differently – such as GPs, pharmacists and nurses working in rotating roles across general practice, community settings and the acute sector. As part of the PCN Directed Enhanced Service (DES), there will be a number of new roles. These include Clinical Pharmacists, Social Prescribing Link Workers, Community Paramedics, First Contact Physiotherapists and Physicians Associates. Work is underway to ensure new staff are primary care ready. Ensuring the appropriate employment models are in place will be a key enabler to embedding new roles across PCNs.

The increased capacity and resource brought by the establishment of the PCNs will enable more personalised care, longer consultations and earlier diagnosis. Although PCNs are a
national construct, each PCN and surrounding neighbourhood is individual and will need to develop models of care specific to their local needs. As the PCNs become more established they will be able to bring in specialists, for example, paediatric consultants or drugs and alcohol workers, on a subcontracting arrangement to tackle the specific health inequalities in their local neighbourhood.

**Digitally Enabled Primary Care**

Currently most people access primary care services face to face and one to one, however the way people access care is likely to change over time. Digital technology is a part of our everyday lives, improving the way we socialise, shop and work. It also has the potential to transform the way we deliver health and care services. We will deliver consistent digital and online services to the population of Greater Manchester. People will be able to choose how they access services. Online services will help people to manage their health and wellbeing needs, backed up by face-to-face care when needed. We will develop digital solutions to promote healthy living and self-management.

Our ambition for GM is to go further, faster – providing virtual as well as face-to-face services via a computer or smartphone. Increased use of technology will promote wellness and encourage people to attend appointments and comply with their medication.

Embracing digital technology will require a culture change for patients and the workforce. The workforce will be supported to enable them to work with new technologies and innovations while continuing to provide quality services that are accessible to all.

Digitally enabling primary care will free up frontline staff to focus on providing care navigation and active signposting. By providing health and care teams with the right technology we will support them to complete administrative tasks more efficiently, freeing up time to spend with patients.

**The Contribution of the Voluntary, Community and Social Enterprise sector**

The GM approach to care delivery is both person and community-centred. It allows the use of wider community assets, engage local people in non-traditional ways and settings, and adopt peer support and other techniques.

The dedication and effort of people working in the Voluntary, Community and Social Enterprise (VCSE) sector makes an extremely valuable contribution to the delivery of health, care and support in Greater Manchester.

Across GM, volunteers and the VCSE sector contribute to a number of health and care roles and services, from patient participation groups, to the delivery of services and everything in between. The VCSE sector makes a valuable contribution to the local economy and an immeasurable difference to the lives they touch. Volunteering, for example, not only benefits the GM health and care system, it also brings multiple benefits to volunteers themselves, including better career prospects and improved mental and physical health.

The GM asset-based approach recognises and builds on the strength of local communities and will also help to develop and sustain a strong and vibrant VCSE sector. Organisations within the VCSE sector often must operate within extremely tight financial constraints. There are opportunities for public services, including primary care, to better support the sector including providing training alongside primary and community care teams, being advocates for the VCSE.
sector and the services they provide, promoting the recruitment of and benefits for volunteering in primary care.

**Nurse Associates**

The development and sustainability of Primary Care Nurses is a key GM priority. Nurses play a critical role in delivering high quality care across health and care settings. Nurses need to be supported and developed in their careers, ensuring there are a diverse range of options for career progression.

In Greater Manchester, we will develop the nurse associate role in primary care. This role bridges the gap between healthcare assistants and the registered nurse. This role provides additional capacity as well as increase and improve skill mix. Trainee Nurse Associates will be trained to work independently under both direct and indirect supervision of the registered nurse.

<table>
<thead>
<tr>
<th>Greater Manchester Nurse Associate Programme</th>
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<tbody>
<tr>
<td>Greater Manchester is developing an apprenticeship programme that will embed the Nurse Associate role. The programme will offer trainees a new perspective on nursing across a community, ensuring skills are shared across sectors and population health outcomes are improved through focused care delivery built around patient needs. A devolved system has enabled nurse leaders to explore a new approach; offering reciprocal placement arrangements with key partners to support the development of multi-discipline, multi-skilled community focused individuals.</td>
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**Population Health**

Primary care is at the heart of the GM population health model and will work alongside wider public services to tackle health inequalities and promote better population health outcomes. Primary care providers play a very important role in prevention and early detection. GP practices already deliver many prevention services like flu immunisation and cancer screening programmes. Regular eye or dental checks can identify the initial indications of some health conditions such as diabetes, high blood pressure and cancer. The advice and support of pharmacists can help people at higher risk to self-care or better manage medicines to protect themselves. Where possible, care will be provided away from traditional settings for example, inhaler techniques and supervised tooth brushing in schools.

GM Local Professional Networks (LPN) will continue to develop the role of Healthy Living Champions across primary care, giving our non-clinical workforce additional skills in brief advice and brief intervention on a range of population health topics such as smoking and weight management. More of the non-clinical general practice staff will also be upskilled to become care navigators.

**Supporting Resilience**

Primary care is predominantly comprised of a series of small to medium enterprises and multiple providers, meaning that in many cases there is no overarching HR or Organisational Development function to support employers and staff. The primary care voice is not represented within existing GM Human Resources networks, as they are predominantly acute sector led. This
means that HR leads may be unaware of the issues and challenges faced by primary care, which is a potential barrier to true integration.

GM could explore mechanisms to support primary care with practical HR advice and ways to share best practice, for example the GM GP Nurse Resource pack. There are opportunities that neighbourhoods and local care organisations bring to create a pool of ‘bank’ staff or additional resource, to provide support when members of staff need to take time off suddenly for sickness or caring responsibilities etc.

The GP Excellence Programme\(^1\), delivered in partnership with the Royal College of General Practitioners (RCGP) since 2017, supports general practices to become more sustainable, resilient and better placed to tackle the challenges they face now and into the future, and to secure continuing high-quality care for patients.

The GM Excellence Programme will support all of primary care through a delivery of a wide menu of support which will help primary care to become more sustainable and resilient, better placed to deliver new models of care.

This programme supplements existing mechanisms of support to Primary Care and will work with localities to ensure alignment with existing quality improvement initiatives. The model has already been tried and tested across General Practice. The next phase of the programme will be to expand the model to all of primary care.

There is variation in employment practices, qualifications and access to continuing education and development across Greater Manchester primary and community nursing workforce. This is compounded by variation in pay terms and conditions, integration of nursing roles into primary care networks, and lack of sustainable funding for nursing development. Policies and information supporting best practice in primary care could be more robust. There is a risk that the population will not receive care and treatment of a consistent quality and safety.

\(^1\) GP Excellence https://gpexcellencegm.org.uk/
CREATING A SUSTAINABLE WORKFORCE

Primary care should be the best possible, most suitable, primary care for the 2.8 million population of Greater Manchester, ensuring it is adaptable and has underlying support to continue to be so for many years to come.

However, certain things are necessary to achieve this level of sustainability. First and foremost is having the right number and type of organisations and workforce to provide primary care. Primary care needs leaders who can develop systems and local responses fit for both current and future needs. It must have the infrastructure in place to meet the changing demands of primary care provision as it evolves over time.

Generally, people are more likely to leave the NHS at the beginning or end of their careers. Newly qualified staff do not always receive the support they may need, particularly while they are going through their preceptorship (the period of supervised practical experience and training required to develop their practice further once they are no longer students) and during other transitional periods. This can have a negative effect on people’s engagement and mental wellbeing and make them more likely to leave.

Improving the retention of existing staff, including utilising people towards the end of their careers in a different way will reduce the reliance on new staff or locums to meet increasing demands. Opportunities presented through from ‘Return to Practice’, retire and return programmes and international recruitment must be maximised.

To retain our workforce, there needs to be competitive rates of pay and improved terms and conditions wherever possible. More flexible working arrangements are required – be it hours of work or the range of employing organisations, improving work/life balance and ensuring people can fit work around their lives. More wrap-around support for new members of staff will help to ensure they feel supported to fulfil their roles. Opportunities for training and development will help staff to feel valued.

Health and care services on the whole are struggling to attract enough new recruits, and this is true in primary care. Being part of the Greater Manchester primary care workforce should be seen as the ‘career of choice’, and the changes detailed below will help attract the best talent by providing flexible, multidisciplinary work options.

Understanding the Workforce

GM will develop a tool to support workforce data collection. The tool will aim to provide baseline intelligence, support workforce planning and support real time workforce management. It will facilitate workforce planning at a locality and PCN level while providing a simple process for GP practices to collate workforce data, avoid duplication while meeting local and national requirements for information.

Attracting the Best Talent

The ambition for GM is to increase training places for a number of roles across the whole of primary care. The system needs to ensure the infrastructure is in place to increase this capacity. This will enable trainees to have high quality supervision and mentorship and feel supported in their roles. By utilising the GM Careers Hub, we will be able to raise the profile of all primary care.
Targeted recruitment campaigns for school leavers will introduce them to roles across primary care. Earlier than that, creating work experience placements in a range of primary care roles will give young people a detailed overview of the range of opportunities in primary care. Increased access to fellowships and pre-registration placements will also create more opportunities within primary care.

Greater Manchester Health and Care Careers Hub

A new, integrated health and care careers hub is being launched. The new service will build on the current NHS careers hub to include social care and primary care in its offers and will be hosted by Manchester University NHS Foundation Trust. The service will include engagement sessions with schools, colleges and other target groups supported by a network of ambassadors, as well as launching a new health and care careers website for Greater Manchester.

Work is already underway to develop an online primary care platform which will bring together general practice, dentistry, pharmacy and optometry, to support them to address recruitment and retention challenges. The online portal will act as the first port of call for workforce related matters including offering an additional recruitment method, a single point of access for career and workforce related information, guidance relating to schemes and initiatives (e.g. GP retention scheme) and signposting to other relevant sites.

GM will work much more closely with higher education institutions to get the best from primary care. New training programmes need to be developed that truly support a primary care neighbourhood delivery model. Undergraduates also need to increase the amount of exposure they have to primary care. Working closely with Health Education England will maximise clinical placement opportunities for non-medical colleagues.

The NHS England International GP Recruitment Programme will continue to be rolled out across GM. Where possible, the learning from the GP programme and the secondary care approach will be adapted to target international recruits for nursing and other key roles such as dentists. We will continue to support primary care to increase the number of Tier 2 sponsorship licences across GM.

Train in GM, Remain in GM

Apprenticeships provide on the job training, leading to a national qualification. Anyone over the age of 16, who is not in full time education, can apply to be an apprentice. Developing a Primary Care Apprenticeship Programme is a key priority of the GM Primary Care Workforce Strategy.

We aim to maximise the apprenticeship offer and develop collaborative working to support apprenticeship roles across localities and sectors, taking advantage of devolution opportunities that enabling levy sharing and rotational roles. There are still challenges with using the levy, including the fact it cannot be used for backfill. However, there is more that can be done to use the opportunity to expand the workforce and enhance skill mix. Engagement has already commenced with the Apprenticeship team at the Greater Manchester Combined Authority, with discussions regarding a number of roles including the Holistic Worker model, Assistant Practitioner, Peripatetic Nurse and Care Navigator.
The increased roll out of apprenticeships will contribute to bridging gaps in certain career pathways. The ambition is to see apprenticeships embedded across the whole of primary care.

**Retention**

Research shows that a complex combination of factors are leading to poor job satisfaction within general practice including workload, remuneration, perceived lack of recognition, increasing bureaucracy and lack of peer support. This is leading to an increase in the rate at which general practitioners are choosing to leave the workforce, or work on a more part-time basis. The NHS England Regional Retention programme aims to support local schemes to improve retention in general practice, through promoting new ways of working and offering additional support.

The workforce will have opportunities to improve their skills. This will include rotational working, opportunities to undertake research, mentoring and enabling backfill to undertake training, especially for our practice nurses and wider primary care teams who are not currently released for training with pay. There will be more defined career pathways for a range of roles. We will proactively engage with GP registrars and other primary care roles, prior to them completing their training to ensure they feel supported and are matched with employment opportunities.

**Greater Manchester Employment Charter**

Greater Manchester’s Employment Charter aims to help ALL employers reach excellent employment standards and become more successful as a result. The Charter sets out a vision of good employment – jobs which are secure, fairly paid and fulfilling, with opportunities to progress and develop. Health and care employers will be engaged and supported in order to meet the required standards. Our aim is to ensure health and care employers are leading the way in delivering good employment practices to their workforce.

**Embedding New Roles**

Understanding the current skill mix is the first step towards introducing the most appropriate new roles. Primary care will be supported in embedding these new roles by creating ‘ambassadors’ as advocates for the new roles, expanding the number of clinical supervisors available, creating a mechanism for peer support and working with employers to develop supportive preceptorship programmes for new roles.
MAKING PRIMARY CARE IN GM A GREAT PLACE TO WORK

Work is ongoing to develop a consistent offer for talent in GM and a future talent pipeline for leaders and workforce across the breadth of public services.

System Leadership

Good person-centred care requires close collaboration between a range of multidisciplinary professionals to ensure care is co-ordinated, appropriate, timely, avoids duplication or unnecessary interventions, and is cost effective. This is especially important across organisational and professional boundaries.

Primary care leaders in GM will need specific expertise required to lead a ‘place’ across organisational and professional boundaries, and a system in which people take priority over process.

GM is developing programmes that supports emerging system leaders to develop the skills and knowledge they will need. For instance, they will have to focus more on approaches that draw on local strengths.

GM will engage with the workforce to support them through this period of culture change, providing the necessary tools and competencies to enable new ways of working.

Equality, Diversity and Inclusion

In GM we must ensure that everyone contributing to our health and care services is fairly treated. Despite much good practice, there is still evidence that some staff may experience difficulties in developing their careers in the public sector. Some staff feel excluded from some occupations and grades. Bullying and harassment in the workplace can have a greater impact on some types of staff than others and staff disciplinary processes can focus on particular types of staff. Health and care in GM should be fair and accessible to all. This includes training and development opportunities being taken up and positively evaluated by all staff, staff free from abuse, harassment, bullying and violence, and flexible work policies consistently available to all staff, supporting the needs of the service as well as the way people live.

Group Consultations

Greater Manchester General Practice Nurses were among the first in the country to trial group consultations, these are an alternative way to deliver planned clinical care to people with long-term conditions that supports continuity and consistency of care and benefits both patients and professionals.

In group consultations, healthcare providers can see up to 10 patients at a time in a supportive group setting, usually in one 40-60 minute session. Working this way not only doubles capacity to deliver high-quality care, it systemises proactive follow-up care and is an opportunity to integrate primary care specialist and community services.
In studies, group consultations were shown to improve patient knowledge, improve quality of life, reduce bed days and A&E use. For the workforce, group consultations have been able to improve staff wellbeing, personal development and freeing up time to support people with more complex needs.

In the future Group Consultations could be the routine model for supporting people with long term conditions across primary care networks and neighbourhoods. It is our ambition to expand the workforce that delivers group consultations, so that these consultations can be delivered by a range of roles, including pharmacists and community paramedics.

**Training and Education**

Educational transformation is needed to support and encourage all professionals, ensuring they experience meaningful learning in primary care. GM will take the opportunity to influence Higher Education Institutes, colleges, Health Education England and NHS England to further support and prioritise primary care.

Undergraduate training needs to better reflect the changing needs of the population and the move to integrated neighbourhood delivery models of care. By transforming the way that training is delivered, it gives the opportunity for key professionals to train and develop together, building relationships and working towards common goals.

The GM ambition is to see Integrated Training Hubs spanning the breadth of primary care, in all 10 localities. This could be through the existing Enhanced Training Hubs or the Academy model and form part of the Greater Manchester Training Hub. The hubs would provide the career and skills development of all staff, reducing the burden on individual practices or providers. These training hubs will provide an opportunity to meet the educational and training needs of the multidisciplinary primary care workforce, working closely with PCNs to enable regular training rotations through primary care.

**Training and Employment**

Partnership working with educational institutes will ensure that primary care trainees are supported into employment across Greater Manchester; developing flexible and attractive roles with the potential for development. This will include working across geographical boundaries and in a range of sectors.
A NEW OPERATING MODEL FOR WORKFORCE

The Greater Manchester Training Hub

Our ambition for the future primary care workforce including clinical, non-clinical and academic will be to embrace and display a range of key skills and behaviours.

Facilitating the development of these skills will be a multidisciplinary GM focussed training hub. The hub will co-ordinate training, supervision and development across all localities, working closely with the 10 Locality Integrated Training Hubs and supported by Health Education England.

The GM Training Hub will be central to the development of primary care careers, co-ordinating multi-professional work experience placements, traineeships and apprenticeships – working closely with schools, Higher Education Institutes and the Primary Care School. They will advocate and support the principle that primary care is the ‘career of choice’, with GM seen as an exemplar for developing careers in primary and community care.

The Primary Care School

Primary Care will work closely with schools and colleges, creating a pipeline for the future health and care workforce, creating routes into primary care through traineeships, apprenticeships or formal education.

As the majority of health and care will take place in the community, all undergraduate training places will need to be weighted in favour of community and primary care, with trainees gaining skills across all sectors.

Following undergraduate training for primary and community care, further postgraduate studies will be through the ‘Primary Care School’, where undergraduates will be able to continue their generalist or specialist training in their career of choice. The Primary Care School will enable a number of key professions such as medicine, pharmacy, dentistry, optometry and nursing, to train alongside each other to develop the skills and behaviours needed for integrated, patient focused, preventative care.
HOW WE WILL DELIVER THE STRATEGY

Primary care is essential to the delivery of ‘Taking Charge’ and improved population health outcomes across Greater Manchester. In order to achieve this, a radical shift in the way health and care is delivered is required and this starts with our workforce.

By implementing the vision, a sustainable, integrated workforce will be created, which is able to work seamlessly across practices, networks, neighbourhoods and localities. The workforce will experience greater resilience and improved work-life balance while our people and communities will be able to access a wider range of services closer to home.

The implementation of this strategy will be locality driven. However, it may make more sense that some initiatives are delivered once at a Greater Manchester level. The design and delivery of the strategy will happen at a system wide level.

The primary care workforce team of the Greater Manchester Health and Social Care Partnership will work with stakeholders to deliver the ambition to transform the primary care workforce.

A 3-5 year implementation plan will be developed, with a series of measures and outcomes in order to quantify the benefits that result from the transformation of primary care.
GET IN TOUCH

England.primarycaretransformation@nhs.net
www.gmhsc.org.uk

@GM_HSC
@GMHSCPartnership
@GMHSCPartnership
SUMMARY OF REPORT:

Dementia was highlighted as one of the early Devolution priorities. Dementia United is the five-year Transformation Programme developed to enable the Greater Manchester system to meet the GM Dementia Standards and build on the great work that is already taking place, alongside developing a campaign and platform for improvements. It is being delivered through key partnerships, listening to the voice of people living with dementia and those who care for them, offering the opportunity to have a ‘big conversation’ across Greater Manchester (GM).

Dementia United and Alzheimer’s Society have worked together since the inception of the Dementia United programme and wish to enter into a collaboration to provide improved benefits and outcomes for people living with dementia in Greater Manchester (‘Collaboration’) (including, without limitation, by working towards the development and expansion of Dementia Connect and Dementia United’s agreed portfolio of work).

This Partnership Agreement sets out:

- the scope of the Collaboration, along with the key objectives and principles of the Collaboration;
- the respective roles and responsibilities of the Partners in relation to the Collaboration.
KEY MESSAGES:

The overarching strategic objective of the partnership is to achieve the shared ambition of a transformation of the health, wellbeing and experience of people living with dementia, and Carers in Greater Manchester (GM), together making GM the best place to live with dementia.

Key messages include:

- Work and support localities with the ambition to develop and expand Dementia Connect.

- Make use of the GM data systems and capability to generate real world evidence of post diagnostic care.

- Develop and build on Dementia United’s portfolio of work and all the key focus areas.

- Align to all themes of the GM Health and Social Care Partnership Transformation Plan.

- Support the development of new and wider partnerships enabling the gathering of more information about the impact of dementia support on the lives of people affected by dementia.

- Create a collaborative space allowing for innovation, a testing and learning culture, and reflection on what has previously worked for the partners to provide a variety of propositions, enabling the empowerment of people living with dementia.

- Agree measures for all shared areas of work, particularly around the standardisation in quality of care provision and increasing independence for people living with dementia and their carers.

- Optimise all opportunities for greater engagement with research, including Join Dementia Research.

Dementia United will work across all ten localities and include stakeholders from NHS, local authorities, police, transport, housing, social care, the VCSE sector etc. to identify prioritisation criteria for the collaboration work based on GM population needs. They will ensure that they disseminate and encourage implementation of innovative scalable opportunities which are identified as part of the collaboration, whilst committing to adopting a whole system value-based approach rather than a cost minimisation approach ensuring the true value of innovation is appropriately calculated and measured.
Alzheimer’s Society will embrace the Dementia United vision and values set out in the GM H&SC Partnership Transformation Plan, attending all Dementia United governance board meetings and contributing to the delivery of dementia related health and wellbeing improvements for the people of GM.

PURPOSE OF REPORT:

The partnership agreement sets out the scope of collaboration, along with the key objectives and principles of the collaboration. The respective roles and responsibilities of the partners in relation to the collaboration.

RECOMMENDATIONS:

The Health and Care Board is asked to:

- note the content of this partnership agreement; and
- endorse the direction of travel.

CONTACT OFFICERS:

Zoe Aldcroft – Programme Manager
Zoe.aldcroft@nhs.net
This Partnership Agreement is dated 2019

Partnership Agreement
Between
Dementia United, The Greater Manchester Health and Social Care Partnership
And
Alzheimer’s Society

PARTNERS

(1) Alzheimer’s Society, company number 2115499, charity number 296645 of 43-44 Crutched Friars, London, EC3N 2AE (the ‘Society’)

(2) Dementia United of Greater Manchester Health & Social Care Partnership 4th Floor, 3 Piccadilly Place, Manchester, M1 3BN (‘Dementia United’)

1. Background
1.1 The Partners to this Partnership Agreement wish to enter into a collaboration to provide improved benefits and outcomes for people living with dementia in Greater Manchester (‘Collaboration’) (including, without limitation, by working towards the development and expansion of Dementia Connect and Dementia United’s agreed portfolio of work).

1.2 This Partnership Agreement sets out:

(a) the scope of the Collaboration, along with the key objectives and principles of the Collaboration;

(b) the respective roles and responsibilities of the Partners in relation to the Collaboration.

1.3 The Partners agree that this Partnership Agreement does not limit the scope for potential joint work and each Partner will seek to explore other collaborations between the Partners, locally, nationally or internationally.

2. Definitions
The following terms have the following meanings in this Partnership Agreement:
2.1 ‘Collaboration’ means the collaboration defined in clause 1 (Background) to this Partnership Agreement which is further described in the Schedule;

2.2 ‘Intellectual Property Rights’ include but are not limited to: (a) copyright, rights related to or affording protection similar to copyright, rights in databases, patents and rights in inventions, trademarks, rights in internet domain names and website addresses and other rights in trade names, designs, know-how, trade secrets and other rights in confidential information; (b) applications for registration, and the right to apply for registration, for any of the rights listed at (a) that are capable of being registered in any country or jurisdiction; and (c) all other rights having equivalent or similar effect in any country or jurisdiction;

2.3 ‘Dementia Connect’ is the Society’s multi-channel information, advice and support service model which aims to give people affected by dementia access to advice, support and self-management services;

2.4 ‘Data Protection Laws’ any legislation relating to the processing, privacy and use of Personal Data including, without limitation, the Data Protection Act 2018, the EU General Data Protection Regulation 2016/679 and any equivalent and applicable national legislation;

2.5 ‘GM’ means Greater Manchester;

2.6 ‘Golden Threads’ good practice that weaves throughout Dementia United’s work and ensures that it’s supported with evidence and by experience;

2.7 ‘Key Focus Areas’ focused work of Dementia United that can make an important difference to the lives of people living with dementia and those who care for them;

2.8 ‘Managers’ the managers of each party as specified in Clause 4.5;

2.9 ‘Partners’ collectively means the Society and Dementia United, each of which is further described in Appendix 1;

2.10 ‘Principles’ as detailed in Clause 3;

2.11 ‘Personal Data’ as defined in the Data Protection Laws;

2.12 ‘Process’ as defined in the Data Protection Laws; and
2.13 ‘Schedule’ is the schedule to this Partnership Agreement.

3. **Ways of working – Principles of collaboration**

The Partners agree to adopt the following principles in their Collaboration:

(a) **act cooperatively:** share information, experience, materials and skills to learn from each other and develop effective working practices, work collaboratively to identify solutions, eliminate duplication of effort, mitigate risk and reduce cost. The Partners agree that any cooperation under this Partnership Agreement including without limitation sharing of any information or any collaborative working shall only be to the extent that is reasonably necessary for the Collaboration and subject to the terms of this Partnership Agreement;

(b) **be accountable:** take on, manage and account to each other for performance of the respective roles and responsibilities set out in this Partnership Agreement;

(c) **be open:** communicate openly about major concerns, issues or opportunities relating to the Collaboration;

(d) **be trustworthy:** the Partners have a stake in striving for the best outcomes for people living with dementia in GM;

(e) **be respectful:** respect each other’s strengths and expertise as well as competing demands and find the common ground;

(f) **be innovative:** an opportunity to challenge convention and trail blaze new ways of working that will be a test bed for the UK and beyond. To drive innovation into practice whilst generating evidence and opportunities to support future developments and improvements for people living with dementia in GM, nationally and internationally;

(g) **hold a shared commitment:** commitment to genuine collaboration and being ‘in the work’ together;

(h) **adhere to statutory requirements and best practice:** comply with all applicable laws and standards, including but not limited to Data Protection Laws, modern slavery, and anti-bribery legislation;
(i) **act in a timely manner**: recognise any time critical nature of activities associated with the Collaboration and respond as soon as reasonably practicable to requests for support;

(j) **deploy appropriate resources**: ensure sufficient and appropriately qualified resources are available and authorised to fulfil the responsibilities set out in this Partnership Agreement; and

(k) **act in good faith**: to support success of the Collaboration and compliance with these Principles.

4. **Roles and responsibilities**

4.1 The Partners shall undertake the roles and responsibilities set out in the Schedule.

4.2 The following are the named contacts for each party:

(a) the contact for the Society in relation to this Partnership Agreement, and who has authority to act on behalf of the Society, is: Jo Vavasour, Head of External Partnerships and Development, 07484924574, jo.vavasour@alzheimers.org.uk; and

(b) the contact for Dementia United in relation to this Partnership Agreement, and who has authority to act on behalf of Dementia United is: Zoe Aldcroft, Programme Manager (Dementia United), 07976660663, zoe.aldroft@nhs.net.

4.3 Both contacts listed above agree to communicate regularly during the term of this Partnership Agreement.

4.4 If either party has any issues, concerns or complaints about the Collaboration, or any matter in this Partnership Agreement, that party, through its contact detailed in Clause 4.2 shall notify the other party and the Partners shall then seek to resolve the issue by a process of consultation.

4.5 If the issue cannot be resolved within a reasonable period of time by the contacts detailed in Clause 4.2 (being no more than 14 working days), the matter shall be escalated to the named Manager of either party, namely:
(a) Zoe Campbell, Operations Director, Transition, Commercial and Outreach 07718960946, zoe.campbell@alzheimers.org.uk for the Society; and

(b) Warren Heppolette, Executive Lead, Strategy and System Development 01616257791, warrenheppolette@nhs.net for Dementia United.

4.6 The Managers shall then decide on the appropriate course of action to take.

5. **Data protection and confidentiality**

5.1 Each party agrees that:

(a) subject to Clause 5.1(b), it will not Process Personal Data for the purposes of this Partnership Agreement or the Collaboration;

(b) if a party does Process Personal Data for the purposes of this Partnership Agreement or the Collaboration, it will amend this Partnership Agreement in accordance with Clause 9 to the extent necessary to allow for such Processing; and

(c) at all times during the term of this Partnership Agreement, it will comply with the Data Protection Laws.

5.2 Each party undertakes that it shall not at any time disclose to any person any confidential information concerning the business, affairs, customers, clients or suppliers of the other party except as permitted by Clause 5.3.

5.3 Each party may disclose the other party’s confidential information:

(a) to its employees, officers, representatives or advisers who need to know such information for the purposes of the Collaboration and only in accordance with this Partnership Agreement. Each party shall ensure that its employees, officers, representatives or advisers to whom it discloses the other party’s confidential information comply with this Clause 5.3; and

(b) as may be required by law, court order or any governmental or regulatory authority.

5.4 No party shall use the other party’s confidential information for any purpose other than the Collaboration.
5.5 For the avoidance of doubt, information is not confidential information for the purposes of this Clause 5 if:

(a) it is already in the public domain;

(b) it was, is, or becomes available to the receiving party on a non-confidential basis from a person who is not bound by any confidentiality obligations with the disclosing party;

(c) the Partners agree in writing that the information is not confidential; or

(d) it is developed by or for the receiving party independently of the information disclosed to it by the disclosing party.

6. **Intellectual property**

6.1 The Society shall at all times own all Intellectual Property Rights in any logos, marks, pictures, documentation, information, data and databases that (i) it held prior to the date of this Partnership Agreement, (ii) it solely develops during the term of the Partnership Agreement.

6.2 Dementia United shall at all times own all Intellectual Property Rights in any logos, marks, pictures, documentation, information, data and databases that (i) it held prior to the date of this Partnership Agreement, and (ii) it solely develops during the terms of the Partnership Agreement.

6.3 The Partners agree that no Intellectual Property Rights will be developed by them for the purposes of the Collaboration.

7. **Inadequacy of damages**

Without prejudice to any other rights or remedies that either party may have, each party acknowledges and agrees that damages alone would not be an adequate remedy for any breach of Clause 5 and 6 by the other party. Accordingly, the non-defaulting party shall be entitled to the remedies of injunction, specific performance or other equitable relief for any threatened or actual breach of Clauses 5 and 6.

8. **Term and termination**

8.1 This Partnership Agreement shall commence on the date of signature of both Partners and shall continue until 30 March 2021 unless terminated earlier by either party in accordance with Clause 8.2.
8.2 Either party may terminate this Partnership Agreement by giving at least one month's notice in writing to the other party at any time.

8.3 On request at any time, and in the event of termination or expiry of this Partnership Agreement for any reason, each party will return the other the logos, marks, pictures, documentation, information, data and databases owned by the other party.

8.4 In the event of termination or expiry of this Partnership Agreement, the following clauses shall survive: 5, 6, 7, 10, 11, 12 and 13.

9. Variation

This Partnership Agreement, including the Schedule, may only be varied by the written agreement of both Partners.

10. Charges and liabilities

10.1 The Partners shall each bear their own costs and expenses incurred in complying with their obligations under this Partnership Agreement.

10.2 Both Partners shall remain liable for any losses or liabilities incurred due to their own or their employees' actions and neither party intends that the other party shall be liable for any loss it suffers as a result of this Partnership Agreement.

10.3 No payments will be made by any Partner under this agreement. There are commitments of investment, but these will be governed by separate agreements.

11. Status

11.1 With the exception of Clauses 5, 6, 7, 8, 9, 10, 11, 12, and 13, this Partnership Agreement is not legally binding.

11.2 Nothing in this Partnership Agreement is intended to, or shall be deemed to, establish any partnership or joint venture between the Partners, constitute either party as the agent of the other party, nor authorise either of the Partners to make or enter into any commitments for or on behalf of the other party.
12. **Governing law and jurisdiction**

   This Partnership Agreement shall be governed by and construed in accordance with English law and each party agrees to submit to the exclusive jurisdiction of the courts of England and Wales.

13. **Compliance with laws**

   Each party shall comply with all applicable laws, statutes, regulations and codes from time to time in force including but not limited to the Data Protection Laws, the Bribery Act 2010 and the Modern Slavery Act 2015.
Schedule

1. **Scope of the collaboration**

1.1 The Partners agree to form an alliance of the willing to work on programmes of work which aim to enhance dementia health and wellbeing in GM, and benefit people living with dementia and their carers in all 10 boroughs of GM.

1.2 Through this Collaboration the Partners aim to achieve the shared ambition of a transformation of the health, wellbeing and experience of people affected by dementia in GM and together the Partners will make GM the best place to live with dementia.

1.3 The programmes of work will:

   (a) make best use of GM data systems and capability (including, without limitation, to generate real world evidence for post diagnostic care);
   (b) aim to support localities with the ambition to develop and expand Dementia Connect;
   (c) aim to develop and build on Dementia United’s portfolio of work;
   (d) be aligned to the themes of the Greater Manchester Health and Social Care Partnership transformation plan.

1.4 The themes of the Greater Manchester Health and Social Care Partnership transformation plan include:

   (e) Radically upgrade population health prevention;
   (f) Transform community-based care and support;
   (g) Standardise acute hospital care;
   (h) Standardise clinical support and corporate functions; and
   (i) Enable better care.

1.5 This Collaboration will also offer the opportunity to develop new and wider partnerships between the Partners and to gather more information about the impact of dementia support on the lives of people living with dementia in the community.
2. **Objectives of the Collaboration**

2.1 The key objective of the Collaboration to achieve significant change to the lives of people living with dementia in GM at scale and through system change. Together the Partners aim to transform the health, wellbeing and experience of people affected by dementia in GM to make it the best place to live if you have dementia.

2.2 The Collaboration will also provide an opportunity for the Partners to:

(a) Reflect on what has worked in the relationship between the Partners since 2016 and build on this.

(b) Create space to listen, look at and do things differently, allowing innovation and a test and learn culture which provides opportunities and different propositions to enable healthier, more resilient and empowered people living with dementia to take charge of their own well-being.

(c) Agree appropriate shared measures for all joint areas of work, which will focus on decreasing the variation in quality and access of services across GM and increase the independence of people living with dementia and those who care for them.

(d) Have a joined-up conversation supporting the 30,000+ people living with dementia in GM to live well.

(e) Demonstrate impact across Dementia United's Key Focus Areas and Golden threads and Dementia Connect.

(f) Enable and encourage greater engagement with Join Dementia Research and increase access to research and innovation opportunities across GM.

2. **The role and responsibilities**

2.1 Dementia United will:

(a) Work across 10 localities - partnerships and stakeholders are varied and wide including colleagues from the NHS, Local Authority, Police, Transport, Housing, Population Health, Social Care and the Voluntary, Community and Social Enterprise (VCSE) sector.
(b) Commit to adopting a whole system value-based approach rather than a perceived cost-minimisation approach, so that the value of innovation to people and to the entire Health and Social Care system is appropriately calculated and measured;

(c) Identify prioritisation criteria based on GM population needs, to ensure the efforts of the Partners to this Partnership Agreement is appropriately directed; and

(d) Ensure that when dementia specific innovative, cost-effective, scalable opportunities are identified and evidenced, dissemination is promoted, and implementation is encouraged throughout GM.

2.2 The Society will:

(a) Embrace the Dementia United vision, the Greater Manchester Health and Social Care Partnership transformation plan, the values set out in that plan, and the principles of the Collaboration set out in this Partnership Agreement; and

(b) Contribute to the delivery of health and wellbeing improvements in people living with dementia in GM and their carers.

(c) Attend all agreed Dementia United governance board meetings. The lead on this from the Society will be Sue Clarke, but if she is unavailable a suitable deputy will attend in her place.

2.3 Both Partners will meet at least once per quarter to review the progress of the Collaboration and ensure the Partners remain on track to achieve the objectives of this Collaboration as described in this Schedule. These meetings will be held face-to-face in a mutually convenient location or by telephone if required. The Society will be responsible for arranging these meetings on behalf of the Partners. In the event that the contacts specified in Clause 4.2 are unavailable a suitably knowledgeable deputy may attend in their place.
We confirm our agreement to the above

SIGNATURE: ......................................................................................................................

PRINT NAME: ....................................................................................................................

TITLE: ................................................................................................................................

DATE: ................................................................................................................................

for and on behalf of ALZHEIMER’S SOCIETY

SIGNATURE: ......................................................................................................................

PRINT NAME: ....................................................................................................................

TITLE: ................................................................................................................................

DATE: ................................................................................................................................

for and on behalf of DEMENTIA UNITED
Appendix 1 Partners’ details

The Society

(a) The Society is the UK’s leading dementia support and research charity.

(b) The Society’s mission is to transform the landscape of dementia forever. To achieve this, as well as delivering services directly to people living with dementia, the Society works to shape society through partnerships, influencing and social action. The Society also funds cutting-edge research to improve dementia care, bringing everyone closer to knowing how to prevent, treat and cure dementia. The Society enables more people affected by dementia to go on living life to the full, while also working towards a cure.

(c) The Society’s objectives are split into three strands as part of its ambitious five-year strategy, The New Deal on Dementia (2017-2022):

(1) Support: Delivering the Society’s new service Dementia Connect, which will revolutionise the dementia care pathway by offering personalised, joined-up and ongoing support. Creating partnerships with corporate, community and voluntary organisations to extend the reach of the Society’s one-to-one services, and expand the number of local group services the Society delivers.

(2) Society: Inspiring more individuals and communities to become dementia friendly. Calling on the Department of Health and Social Care and NHS England to ‘Fix Dementia Care’ by tackling the social care crisis and giving people with dementia a fair deal. Campaigning nationally and locally to keep dementia at the top of the agenda in Government.

(3) Research: Investing more money than ever in research into the cause, care, prevention and treatment of dementia. Supporting drug re-purposing studies designed to make effective treatments available to people more quickly. Establishing research ‘Centres of Excellence’ to advance understanding of good practice in dementia care, and translate
this into frontline practice. Collaborating with the Medical Research Council and Alzheimer’s Research UK to fund the UK’s first ever Dementia Research Institute, which brings together 700 world-leading scientists to catalyse progress in dementia research.

The Society sees alignment with Dementia United in their priority to deliver their new service model, Dementia Connect. Through the engagement, promotion and encouragement of Dementia Connect to all potential partners, expanding the reach of support across Greater Manchester

**Dementia United**

(a) Dementia has been a priority for GM since Devolution in 2016. This enabled GM to approach dementia in a more joined up way bringing together people affected by dementia, career, professionals and organisations from both within the NHS and outside it. The commitment was reflected in the funding and development of Dementia United – GM’s strategy and associated portfolio of work for dementia which led to agreement of the GM dementia standards and the establishment of locality profiles. These give GM a means of comparing and benchmarking current services and outcomes whilst highlighting challenges and opportunities or making improvements.

(b) GM aspires to be the best place to live with dementia.

(c) The aims are aspirational, and can be reflected across other condition areas, although Dementia United sees itself at the forefront of this work.

(d) Dementia United aims to:

- Improve the lived experience for people with dementia and those who care for them
- Increase independence by reducing dependence on health and social care
- Decrease variation in access to and quality of services for people with dementia and those who care for them
(e) Dementia United’s strategy is working towards these aims through a set of Key Focus Areas:

(f) By March 2024 GM aims to be able to show improvements against each of the Dementia United’s standards alongside the aspirations of GM’s Mayor Andy Burnham to make GM the most accessible city-region in the UK with an ambition of making GM Age-Friendly, Autism-Friendly and Dementia-Friendly.

(g) Learning from the voice of those with lived experience of dementia (people with dementia and those who care for them) is at the heart of who Dementia United are, and will continue to be, an integral part of Dementia United’s work through the Dementia Carers Expert Reference Group and People Living with Dementia Network (*name subject to change*) which this Collaboration will be able to support.
In support of the above key focus areas Dementia United see alignment with the Society in the following ways:

- Sharing up to date research and collaboration in relation to the gold standard of care & support which can be expected by those affected by dementia (post-diagnostic support).

- Sharing expertise and collaborating on Under Served Populations working group, ensuring both DU and the Society are working from the same point of view about the current standard and distribution of provision across GM.

- Supporting the development of the lived experience network.

- Collaborating with the Society Knowledge teams to ensure most efficient use of resources for Dementia United to develop young onset and rarer forms of dementia guidelines.

- Supporting and contributing to the End of Life care task and finish groups, ensuring the sharing of research and knowledge.
SUMMARY OF REPORT:

This report introduces the new Integrated Health and Justice Strategy for the Greater Manchester city region which aims to address the gap in health and social wellbeing for people seen in the criminal justice system. It will contribute significantly to evolving work in localities to address health and social inequalities experienced by victims and offenders. Both groups often have complex psychological, social and healthcare support needs which require a person-centred, holistic and integrated response. This combination of needs can mean that victims and offenders are some of the most vulnerable people living in our communities.

KEY MESSAGES:

The strategy has been in development for around 12 months which has allowed for an ongoing and iterative process of engagement with strategic and operational colleagues and people who have direct experience of the criminal justice system.

Whilst all children, young people and adults seen in the criminal justice system across Greater Manchester are intended to benefit from the strategy, the four groups that particularly emerged from the development and engagement processes are:

- Children and young people up to age 18, however, where young adults have additional vulnerabilities this could extend to age 25.
- Marginalised female victims of domestic abuse and/or sexual violence.

---

1 With particular reference to victims of sexual and domestic abuse.
• People with a learning disability, autism or a communication disorder.

• People who are rough-sleeping.

These groups will provide the initial focus for the strategy and have influenced the nine new delivery priorities (listed in the main report) and how they are implemented in practice.

PURPOSE OF REPORT:

This strategy introduces and operates across a relatively new area of public policy, which focuses on the health and social care needs of a typically vulnerable, disadvantaged and excluded group of children, young people and adults.

As well as promoting understanding of the ‘health and justice’ policy area, the risk factors for victimhood and offending, and the needs of this population group across Greater Manchester, the strategy specifically seeks to develop a more coherent and integrated approach to service commissioning, design, planning and delivery, which meets individual’s needs more effectively and consistently.

In operational and best practice terms, ‘health and justice’ is a field of practice which is still emerging in England and what we develop and test in Greater Manchester will add to the evidence base, helping us to understand how best to support vulnerable people seen in the criminal justice system.

The Strategy has already been approved by the Partnership Executive Board (within the Health and Social Care Partnership) in December 2019 and will be considered by the GMCA Board on 31 January 2020.

RECOMMENDATIONS:

The Greater Manchester Health & Care Board is asked to:

• Receive and note the new Integrated Health and Justice Strategy for Greater Manchester.

• Share the strategy with colleagues in their own organisations, helping to promote knowledge of its introduction, focus and priorities.

CONTACT OFFICERS:

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Laura Mercer – Principal - Victims and Vulnerability (Greater Manchester Combined Authority)
laura.mercer@greatermanchester-ca.gov.uk
1.0  OVERVIEW

1.1  The Health and Justice Strategy focuses on the physical, psychological, mental health and social care needs of victims and offenders and how the service response to these often vulnerable children, young people and adults can be enhanced and joined up in Greater Manchester. It directs effort towards the causes of the deep health and social inequalities that can be experienced by people seen in the criminal justice system, by identifying and intervening earlier to address the risk factors known to be associated with victimhood and offending.

1.2  The strategy has been in development for around 12 months. There has been an ongoing process of both formal and informal stakeholder engagement since November 2018 - with strategic and operational colleagues, people who have direct experience of the criminal justice system, and numerous Boards across health, social care and criminal justice governance arrangements - culminating with an online public consultation in Autumn 2019. This engagement of colleagues, partners and the public has fed directly into the choice of priority groups and delivery priorities.

1.3  Devolution provides a unique opportunity to address the health and social care needs of vulnerable people who are seen in the criminal justice system. The strategy brings coherence to the health and justice agenda in Greater Manchester and represents an integrated vision and approach. This consists of nine new priority areas, alongside complementary strategic developments in the existing health and justice work programme (see below). Together these priorities set the strategic direction for health and justice in Greater Manchester for the next five years. There is an accompanying delivery plan - a working document that will be adapted and developed during the life of the strategy and monitored annually.

2.0  BUILDING ON CURRENT COMMISSIONING AND PROVISION

2.1.  The strategy builds on work that has been implemented across Greater Manchester in recent years to develop and improve health and social care provision for victims and offenders.

2.2.  Services such as the Integrated Healthcare in Custody and Wider Liaison and Diversion Service (which identifies and treats the physical and mental health needs of people who come into contact with the formal criminal justice system) and the Mental Health Tactical Advice Service (which advises and
supports frontline police officers who are called to support people with mental health problems) are relatively new, whilst the Sexual Assault and Referral Centre (SARC) at Saint Mary’s hospital has been established since the mid-1980s.

2.3. These ongoing services and commissioning plans are represented in the following six existing priorities and set the immediate strategic direction of health and justice provision in Greater Manchester for the next 1-3 years:

1. Improve the identification of health needs and support for young offenders and victims who may face barriers to accessing services through the newly established Collaborative Commissioning Network.

2. Enhance the GM-wide response to members of the public with health vulnerabilities who come into contact with the Police, including:
   - Services that ensure the most appropriate response and reduce the likelihood of re-presentation for those individuals who present to the police in a state of mental health crisis e.g. control room triage;
   - The GM Integrated Custody Healthcare and Wider Liaison and Diversion Service, which identifies and addresses the mental and physical health needs of children and young people (and other priority cohorts).

3. Work with NHSE commissioners to address continuity of care for people on reception and after release from prison by agreeing clear communication, transition and service pathways.

4. Review the current model and approach to commissioning of rape and sexual assault services to ensure the needs of victims are met.

5. Explore with locality commissioners the scope for developing a city region model for improving the primary care response to sexual and domestic violence and abuse, such as the evidenced based IRIS general practice programme.

6. Use data and intelligence available across the health and justice interface to enable earlier and more focused intervention, establish data sharing protocols that support this approach and develop a consistent set of indicators which can track progress against health and justice strategic aims and outcomes.
3.0 NEW STRATEGIC PRIORITIES

3.1. The selection of the nine new priorities has been more directly influenced by the research, development, engagement and socialisation processes undertaken for the strategy.

3.2. These processes pointed towards an emphasis on the four groups mentioned earlier in this report (see key messages), which many strategic and operational commentators felt needed specific attention in Greater Manchester due to:

- the potential to identify risk factors and at-risk individuals earlier,
- the potential to intervene earlier, or
- to ensure that services and support are tailored appropriately to meet the additional psychological, physical health or social care needs that many vulnerable people have.

3.3. These themes of earlier identification and intervention with vulnerable children, young people or adults, and a more holistic approach to support, also feature heavily in the nine new strategic priorities, which are:

**Prevention**

1. Introduce a public health approach to violence reduction across public service provision, with a focus on children and young people at increased risk of committing anti-social or criminal activity.

2. Work with schools, youth justice and children and young people’s services to develop upstream, targeted interventions that reduce the risk of first-time entry to the criminal justice system.

3. Building on the work with the Women’s Alliance Partnership, extend provision to reach a wider cohort of vulnerable women who are at risk of victimisation or committing criminal activity, and, strengthen health care pathways between existing services.

**Intervention**

4. Develop best practice approaches and pathways that appropriately identify and support offenders and victims of violence or exploitation who have a learning, autistic spectrum or communication/speech and language issue.
5. Agree a standardised health improvement model with the NHS and youth justice teams that targets and addresses health vulnerability in this group of young adults.

6. Work with partner organisations to promote and embed the principles of Family Justice within the strategic direction and operational delivery of unified public services in Greater Manchester.

**Enablers/Systems**

7. Develop a long-term, sustainable approach to commissioning services that deliver specialist healthcare and therapeutic support to offenders and the victims of crime, agreeing common quality standards for Greater Manchester.

8. Collaboratively develop workforce training and development programmes that promote insight into trauma, abuse, learning disability and communication disorder presentation and how to identify and support these issues effectively.

9. Establish more consistent approaches to service user engagement in the design and delivery of specialist health and justice services.

3.4. Whilst all of these nine priorities will play an important part in improving the way public services, including those delivered by colleagues in the VCSE sector in Greater Manchester, work with people seen in the criminal justice system, 1. and 8. introduce concepts that are potentially transformative at a system level and have led to significant change and progress in other parts of the UK, including in Scotland and Wales.

3.5. The first is a public health informed approach to preventing and tackling serious violence, which was adopted in Scotland in 2006 through the Scottish Violence Reduction Unit (VRU). Greater Manchester has recently established its own VRU funded by the Home Office. The VRU model is typically a dedicated, co-located, multi-agency team including representation from policing, health, local authorities, schools and the voluntary sector. These partners then work together to tackle violent crime and its underlying causes, by identifying the drivers of serious violence locally and developing a coordinated response to tackle them. The approach uses data, intelligence and evidence, including insight from communities, victims and offenders, to design and introduce new approaches to prevent serious violent crime, often focusing on children and young adults.

3.6. Priority 8. highlights the importance of understanding the causes of victimhood and offending. The effects of adverse experiences in childhood and young adulthood (termed ‘adverse childhood experiences’ or ACEs),
particular those which are sustained over a period of time, are known to impact negatively on child development, sometimes leaving a young person with psychological trauma long into their adulthood. Many victims and offenders have complex and traumatic personal histories, which may include abuse and exploitation, and this is widely regarded as a common but underlying cause of offending or being a repeat victim of crime or exploitation.

3.7. Improving awareness and adopting methods of support which are ‘trauma-informed’ e.g. that consider and respond appropriately to the underlying psychological factors that influence anti-social behaviour or that increase vulnerability, has been adopted in Wales in the past 2-3 years. The goal in Wales is to create ACE-informed public services and thereby help to prevent and reduce the often enduring and destructive effects of ACEs on children, families and future generations.

3.8. The Greater Manchester Public Sector Reform Board has sponsored a piece of work to explore and develop how trauma-informed approaches and awareness of ACEs might be adopted across Greater Manchester. This work is being led by Helen Lowey, the Director of Public Health at Bolton, with the support of a multi-agency / multi-sector task and finish group which will meet for the first time in January 2020.

4.0 DELIVERY

4.1. Delivery plans for the existing and new priorities have been developed to accompany the strategy. These are working documents that will be reviewed on an annual basis by the Health and Justice Board. Following sign-off on the Health and Justice Strategy, the delivery plans will be collectively reviewed with the delivery leads to ensure that the work programme as a whole is aligned with other developments and integrates them wherever appropriate. Leadership and governance of the delivery plans will also be revisited.

4.2. The Health and Justice Board, Chaired by Baroness Beverley Hughes, and the Chief Officer of GMHSCP will oversee the overall delivery of the strategy and monitor outcomes.

5.0 OUTCOMES

5.1. Whilst the development of the Integrated Health and Justice Strategy is an important step towards improving the system response to health and social inequalities experienced by people seen in the criminal justice system, it is not an outcome in itself.
5.2. The strategy puts forward an ambitious work programme over the next five years, which will be monitored by the Health and Justice Board. One of the early priorities identified in the delivery plan is to create a progress dashboard and logic model, which will help to monitor high level progress and understand the process of change. Until this is developed, these are some examples of the types of practical improvement we would expect to see for vulnerable people in this population group.

- Vulnerable young people will have their psychological and mental health, physical health, and specific developmental / learning disability / autistic spectrum / communication needs comprehensively assessed in a timely way.

- Better support for young people with additional vulnerabilities such as learning disability, autism, school exclusion, or childhood trauma, to help to break the cycle of becoming a victim or offender.

- Tailored support for vulnerable women at risk of offending or re-offending to improve their access to healthcare provision they may not otherwise have accessed independently.

- Victims of rape and sexual assault will receive high quality forensic and therapeutic services at the right time and in the right location for them.

- Decisions about people who present to the police in a state of mental health distress will be supported by 24/7 access to a mental health professional, increasing the likelihood of people being supported in their own home and community.

- The public service and voluntary sector workforce will be more able to meet the needs of vulnerable people by providing more responsive, trauma-informed support.

- People disclosing domestic violence or abuse in a healthcare setting will receive prompt, specialist advice.

- Work will start with people before they are released from prison so that they receive continuous community-based health and care services that provide the support that they need.

- People with lived experience of health and justice services will be engaged on an ongoing basis so that their real-world perspectives help to improve the way services are commissioned and delivered.
6.0 RECOMMENDATIONS

6.1. The Greater Manchester Health & Care Board is asked to:

- Receive and note the new Integrated Health and Justice Strategy for Greater Manchester.

- Share the strategy with colleagues in their own organisations, helping to promote knowledge of its introduction, focus and priorities.
# CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health and justice in Greater Manchester</td>
<td>6</td>
</tr>
<tr>
<td>Executive summary</td>
<td>8</td>
</tr>
<tr>
<td>Our priorities</td>
<td>10</td>
</tr>
<tr>
<td>1. Why focus on health and justice?</td>
<td>12</td>
</tr>
<tr>
<td>Our opportunity in Greater Manchester</td>
<td>12</td>
</tr>
<tr>
<td>Defining the case for change</td>
<td>13</td>
</tr>
<tr>
<td>Risk factors associated with contact with the criminal justice system</td>
<td>17</td>
</tr>
<tr>
<td>National and international policy and evidence</td>
<td>19</td>
</tr>
<tr>
<td>Greater Manchester evidence and insight</td>
<td>24</td>
</tr>
<tr>
<td>Benefits of violence reduction in human and system costs</td>
<td>26</td>
</tr>
<tr>
<td>2. Whole-system leadership for health and justice</td>
<td>27</td>
</tr>
<tr>
<td>A whole-system approach to Family Justice</td>
<td>28</td>
</tr>
<tr>
<td>3. Overview of specialist health and justice provision in Greater Manchester</td>
<td>30</td>
</tr>
<tr>
<td>4. Rationale for strategic focus on particular groups</td>
<td>33</td>
</tr>
<tr>
<td>5. Health and justice strategic framework and priorities</td>
<td>36</td>
</tr>
<tr>
<td>Existing health and justice work programmes</td>
<td>36</td>
</tr>
<tr>
<td>New strategic priorities</td>
<td>37</td>
</tr>
<tr>
<td>6. Delivery and resource planning</td>
<td>38</td>
</tr>
<tr>
<td>Delivery</td>
<td>38</td>
</tr>
<tr>
<td>Resource planning</td>
<td>38</td>
</tr>
</tbody>
</table>
In Greater Manchester, justice devolution has provided us with a unique opportunity to address the typically very poor physical and mental health of people, both victims and offenders, who come through our criminal justice system. This includes a focus on earlier identification of health and support needs, more responsive interventions, and providing health and care services, which are equal to those available to people living in the wider community.

This strategy describes in detail the broad range of risk factors and the complexity of individual, family and social circumstances that contribute to victimhood and offending behaviour. These complexities only serve to emphasise the value of closer integration and collaboration between our public services. From services providing health and social care, education and accommodation to the police, Crown Prosecution Service, courts, prisons and probation services – each has collective responsibility to address the issues outlined in this strategy. Justice devolution will help to consolidate and strengthen the way services work together around the needs of people seen in the criminal justice system.

"We believe this approach will support the most vulnerable people to recover from their experiences, build their physical and emotional resilience, and eventually enable them to thrive."

The values and priorities represented in this strategy closely reflect our public service reform principles for the city-region and our model of public service delivery – preventative, proactive and person-centred. We believe that this approach will support the most vulnerable members of our community, including victims and offenders, to recover from their experiences, build their physical and emotional resilience, and eventually enable them to succeed and thrive.

 Whilst individuals and families benefit most directly from this approach, there is also a ‘community dividend’ for society as a whole, including safer communities, less children in care, fewer people at risk of homelessness, lower rates of violent crime, more vulnerable children and young people participating in education, and better health for all.

The development of this integrated health and justice strategy is a first for Greater Manchester and potentially also the first placed-based strategy in England developed specifically to address the health and social inequalities experienced by vulnerable children, young people and adults seen across our criminal justice systems. Like justice devolution, health and social care devolution in Greater Manchester creates new opportunities to address the ongoing social challenge of health inequalities. This strategy is a significant part of that effort, focusing on perhaps the most vulnerable members of our communities.

The health inequalities experienced by children and adults seen in the criminal justice system are broad and deep, and in some cases, contact with the criminal justice system will be the first time that they have had their health needs assessed or have had any consistent contact with a health or social care professional. This is why the strategy places high value on the early identification of health care and support needs, to ensure that they are recognised on first contact with the criminal justice system and that effective action is taken to prevent issues from getting worse.

The strategy also adds to our appreciation that being either a victim of serious violent crime, or an offender, is often an indicator of past or current vulnerability. The priority groups that are a focus for our early strategic work reflect this understanding – children and young people, vulnerable and marginalised women; people with learning disabilities, autism or communication disorders; and people who are rough-sleeping. However, the choice of these priority groups has been made with an awareness that the risk factors that lead to victimhood and offending are broad, complex and overlap with each other and this is highlighted in the strategy.

One of these risk factors is mental health. The strong association of poor mental wellbeing, low to moderate mental health issues and clinical mental health conditions, with health and justice has been widely referenced by colleagues, partners and the public during the development of and consultation for the strategy. For the purposes of this health and justice strategy, a broad definition of ‘mental health’ has been adopted, which crucially recognises the psychological and emotional impact of adverse childhood experiences on lifetime mental health and wellbeing.

This is why the strategy recommends a trauma-based model of intervention and support, which is also more likely to prevent youth offending and effectively support victims of sexual violence and abuse. This signifies an important change in the way public services will work with victims and offenders in Greater Manchester.
Health and justice in Greater Manchester

These Greater Manchester specific research and insight exercises tell us that:

- Over 50% of the women who go to the Greater Manchester Sexual Assault and Referral Centre (SARC) have a history of domestic abuse. Repeat attenders at the SARC are typically female and have a background mental health problem, a learning disability, or are a child.

- Between 76-83% of women who have been assessed by a Greater Manchester Women’s Centre have mental health issues, often linked to their experiences of domestic abuse. 25% of women who have accessed Greater Manchester Women’s Alliance Partnership services have a physical health issue. 55% of women who use these centres have a child under the age of 18.

- In HM Prison Manchester, 16% of prisoners were reported as being homeless during the year before imprisonment. A review of the Cheshire and Greater Manchester Community Rehabilitation Company (CRC) caseload in 2018 found that 33% of people had an issue with accommodation. This proportion was higher for those who had an identified mental health or suicide/self-harm need.

- Mental and physical health problems are often enduring and can be a cause of re-offending. 16% of men and 24% of women who are on probation self-identify as having a mental health problem. Suicide is the most common cause of death among offenders. It is the cause of 44% of deaths for those open to the National Probation Service.

- Mental and physical health needs are highly common in prisons. High levels of severe and enduring mental health problems are matched by very high instances of physical illness, including 34% with cardiovascular disease (like angina), 24% with musculoskeletal problems (like arthritis), and 20% with respiratory problems (like asthma). Many of these conditions go unidentified and untreated.

- More than one in four victims of crime will develop symptoms of post-traumatic stress disorder as a result. People who have experienced crime can often be surprised by how much distress they experience. Experiencing crime can lead to the development of long-term problems such as depression or anxiety, which in turn can manifest as physical problems. Many victims of crime experienced harm – often severe – as a direct result of the crime that was committed. The experience of each victim will vary.
The purpose of this first Integrated Health and Justice Strategy for Greater Manchester is to inform and enhance the way in which we understand and address the health, social care and criminal justice factors that can lead to life-long poor physical and emotional health, and reduced life-expectancy, for people who are seen in the criminal justice system, as offenders or victims.

The devolution opportunity

The benefits of focusing on addressing the social and health inequalities experienced by this group of often vulnerable people will be seen at an individual level – in the form of improved physical and mental resilience, healthy relationships, reintegration in community life and the avoidance of first or repeat offending or victimisation – and at a community level, reduced health inequalities, lower crime rates, and safer and more cohesive communities.

Increasing national focus on effective healthcare for the victims of abuse and sexual violence, and offenders the prison estate, provides a backdrop for the development of this Greater Manchester city-region approach, alongside local needs assessments and strategic review work.

Greater Manchester’s long-standing ambition as a city-region has been to take greater control of its own destiny. Our devolution deals, including health and social care and now justice devolution, are enablers to achieving that. Integrating and reforming public services is the key to breaking down service silos and moving towards a preventative approach which serves residents and communities better. This strategy emphasises and embraces this vision of public service reform.

Targeting our efforts

The engagement work that has fed into the development of the strategy has pointed towards an initial strategic focus on four particularly vulnerable groups:

- children and young people
- vulnerable and marginalised female victims of domestic abuse or sexual violence
- people with a learning disability, autism or communication disorder
- and people who are rough sleeping.

Doing things differently

The strategy introduces two key concepts that offer the potential to transform the way that public services across all sectors in Greater Manchester identify, engage with and support some of the most vulnerable people living in our communities.

The first is the idea of adopting a public health informed approach to health and justice strategy, policy and delivery. This is intended to stimulate a more preventative model of identification and support for victims and offenders, with an explicit aim of intervening earlier to reduce the likelihood of offending or being victimised. In practice, this means using data and intelligence to understand this typically vulnerable population of children, young people and adults and the complex often interdependent factors that have led them to be in contact with the criminal justice system.

The second concept introduced through the strategy is the development of trauma-informed approaches that involve moving to a position where public services in Greater Manchester regularly and consistently use more therapeutic practices, which recognise the impact of previous trauma or difficult life experiences. What works to support and address the health, care and wider social needs of people in contact with the criminal justice system is currently an evolving field, and the delivery programmes identified in the strategy will no doubt add to this relatively narrow evidence base.

However, there is broad acknowledgement that the application of trauma-led practice is especially important in supporting this population of children, young people and adults, as many victims and offenders have a history of challenging life experiences including abuse, which can in some cases lead to poor, ongoing psychological and emotional health.

Building on our assets

It is important to recognise that there are already a number of well-established public and VCSE sector services across Greater Manchester whose purpose it is to improve the health and wellbeing of people seen in the criminal justice system, such as the Sexual Assault and Referral Centre (SARC), the Women’s Support Alliance services and wider victim support services. Whilst Greater Manchester is leading the way nationally with new, jointly commissioned service models, i.e. Integrated Healthcare in Custody and wider Liaison and Diversion, there is scope for greater alignment and collaboration across Greater Manchester around the needs of this population group, not only across health and justice provision, but across mainstream services and professional domains.

This strategy and the delivery plan in particular reflects this combination of existing development work and new health and justice ambitions and priorities, with a view to bringing greater strategic coherence to both programmes of work, and eventually bringing them together as one. As well as seeing the emergence of a more consistent, whole system approach to health and justice in Greater Manchester within the first 5 years of the strategy, a further success factor will be tangible evidence of health, social care, Voluntary, Community and Social Enterprise (VCSE) sector and criminal justice services providing more trauma-informed, collaborative care and support to this population group, with a stronger emphasis on prevention and earlier intervention. In due course, this should manifest in better health and wellbeing and reduced offending and reoffending.

This first Integrated Health and Justice Strategy for Greater Manchester therefore provides both a case for change and a platform for improvement and development in health and justice intelligence, commissioning and service provision through its delivery plan.
### Our priorities

#### Prevention

1. Introduce a public health approach to violence reduction across public service provision, with a focus on children and young people at increased risk of committing anti-social or criminal activity.

2. Work with schools, youth justice and children and young people’s services to develop upstream, targeted interventions that reduce the risk of first-time entry to the criminal justice system.

3. Building on the work with the Women’s Alliance Partnership, extend provision to reach a wider cohort of vulnerable women who are at risk of victimisation or committing criminal activity, and strengthen health care pathways between existing services.

4. Develop best practice approaches and pathways that appropriately identify and support offenders and victims of violence or exploitation who have a learning, autistic spectrum or communication/speech and language issue.

5. Agree a standardised health improvement model with the NHS and youth justice teams that targets and addresses health vulnerability in this group of young adults.

6. Work with partner organisations to promote and embed the principles of Family Justice within the strategic direction and operational delivery of unified public services in Greater Manchester.

#### Intervention

7. Develop a long-term, sustainable approach to commissioning services that deliver specialist healthcare and therapeutic support to offenders and the victims of crime, agreeing common quality standards for Greater Manchester.

8. Collaboratively develop workforce training and development programmes that promote insight into trauma, abuse, learning disability and communication disorder presentation and how to identify and support these issues effectively.

9. Establish more consistent approaches to service user engagement in the design and delivery of specialist health and justice services.

#### Enablers/Systems

10. Agree a standardised health improvement model with the NHS and youth justice teams that targets and addresses health vulnerability in the group of young adults.
1. Why focus on health and justice?

Our opportunity in Greater Manchester

The 2016 devolution of responsibilities for health and social care brought to life through ‘Taking Charge’ Plan, and the 2019-2021 justice devolution agreement, create an opportunity for Greater Manchester to innovate and integrate public policy and services in the field of health and justice.

Devolution has created a framework to do this, enhanced by a new Greater Manchester integrated public services model and reform principles which emphasise prevention, people and place. Together these act as enablers for change, but they are also helping to stimulate a shared understanding of the health needs and health inequalities of a population group who have traditionally been ‘seen’ separately by public services.

Focusing our collective efforts specifically on the health needs of people in contact with the criminal justice system, or at risk of entering it, is a relatively new approach for the city region, and it presents a chance to deliver high-impact change in the medium to long-term for some of our most marginalised and vulnerable children, young people and adults. The emphasis throughout this strategy is to integrate policy and services relating to health and justice, including the development of innovative approaches to support people who can often become stuck in a cycle of exclusion, vulnerability, offending, victimhood or exploitation. In line with a shared ambition in Greater Manchester to invest in preventative approaches, the strategy focuses on the need for earlier identification of risk factors and health and social care needs, as well as appropriate interventions and support.

Defining the case for change

The founding premise of this strategy is that health and wellbeing of people in contact with the criminal justice system, as a victim or an offender, is a shared responsibility of local authorities, CCGs, NHS healthcare providers, the Greater Manchester Health and Social Care Partnership (GMHSC), the Greater Manchester Combined Authority (GMCA), the Voluntary Community and Social Enterprise (VCSE) sector and criminal justice services.

This is because the majority of people that have been a victim of crime, or a perpetrator, live in and are part of our local communities and it is in a community setting that health, wellbeing and resilience can be best supported and improved.

In fact, many more offenders are supervised in the community than in secure custody, and the majority of custodial sentences are relatively short at 12 months or less. This means most custodial sentences allow for a relatively limited opportunity for the health and wider care and support needs of offenders to be identified and addressed, before they return to their communities.

In addition, the transitional period of returning to the community after a prison sentence is known to carry significantly increased risks to physical and mental health, including premature death – suicide, accidental death and homicide – and reoffending. Identifying and supporting the health, care and wider social needs of offenders, as well as victims of crime, whose multiple and complex needs may not always be recognised, is regarded to be a major factor in rehabilitation and recovery.

However, poor physical and mental health amongst victims and offenders is also attributed in part to the priority and value that individuals place on their own health, with vulnerable people often not accessing health and care support in proportion with their needs, leading to pronounced differences in life course health and life expectancy. Whilst health inequalities are often driven by socio-economic disadvantage and poorer opportunities and life chances, amongst children, young people and adults who come into contact with the criminal justice system, it is common to see a further layer of complexity which increases the risk of exposure to criminality or victimhood. These risk factors include:

- complex and traumatic personal histories and relationships, which may also include abuse and exploitation;
- enduring mental health and/or substance misuse issues;
- learning disabilities, autistic spectrum disorders and communication disorders;
- gender, in particular women and girls; and
- race, particularly Black and mixed ethnic minority men in terms of offending.

This combination of risk factors can lead to entrenched health inequalities, which then negatively impact upon personal resilience and reinforce vulnerability, meaning that people in contact with the criminal justice system are some of the most marginalised, vulnerable and health-deprived population groups in any community.
The Public Health England CAPRICORN framework, showing the interaction between risk and protective factors for children and young people.

In the case of victims of interpersonal violence or harm, there is an opportunity to improve identification and specialist support, initially through mainstream health and care provision. Victims of violence, including domestic abuse and sexual abuse or exploitation, are more likely to be seen in a healthcare or social care context, so for many victims the route to accessing help and support is typically outside of the criminal justice system. Existing examples of this in Greater Manchester include the independent domestic and sexual violence advocates and the GP-based IRIS domestic abuse referral programme. Further details of existing health and justice programmes are set out on p36.

**CASE STUDY: Support for Victims of Violence**

An individual was referred to the Women’s Centre by her Offender Manager after receiving a community sentence for assault. At this point, her children had been taken into care. In addition to managing her probation, the Centre identified that she needed support with several areas, including substance misuse, financial problems and relationship issues. Together, these factors had given her the unstable lifestyle that had led to the assault.

The Women’s Centre worked with her to address her most immediate needs. This included:

- Working to help her maintain her tenancy, avoiding potential homelessness
- Providing her with advice, support and advocacy regarding how social services were working with her children
- Supporting her to access donations from a local food bank
- Liaising with probation staff to help her understand how to avoid breaching her Community Order (which may have resulted in prison)
- Supporting her into drug and alcohol services to help her stop misusing substances
- Providing her with support to stop self-harming.

It took some time to build a trusting relationship with the woman. After a period of disengagement, she returned to the service, disclosing that she was suffering domestic violence, and was traumatised by an abusive childhood. Her disclosure became possible because her lifestyle had become more settled, including having suitable accommodation. She also stopped abusing substances, and her drug and alcohol worker agreed that she seemed to have given up for good. She also became more aware of the coercive nature of some of her relationships.

Through ongoing work with health and justice professionals over several months, and in particular with the support of her key worker, the woman was able to have more positive discussions with social care regarding her children, increasing her access to them with a view to them returning to her full-time care.
A focus on health and social care needs in a criminal justice context justice therefore has the potential to:

- Increase identification of people affected by interpersonal violence or abuse
- Improve the health, wellbeing and resilience of people seen in the health and justice context, including their sense of safety and security
- Create an awareness that offending and victimhood can be markers of poor psychological and physical health and wellbeing
- Reduce health inequalities in a locality
- Reduce the risks associated with offending or becoming a victim of violence or harm
- Reduce offending and reoffending rates

Risk factors associated with contact with the criminal justice system

The risk factors associated with offending behaviour and victimhood range from individual, relationship and situational factors – such as race, gender, relationship/parenting styles, exposure to substance misuse, being a refugee or asylum seeker – to wider social norms, inequalities and determinants, including access to education, secure housing and work.

However, the evidence suggests that some risk factors may have a more pronounced effect by inherently increasing vulnerability to violent crime, offending and being a victim of abuse. These risk factors include:

- adverse childhood experiences
- mental health issues and psychological trauma
- having a learning disability, autism or a communication disorder

Whilst multiple factors combined may increase the risk of entering the criminal justice system, including factors commonly associated with socio-economic disadvantage and social exclusion e.g. homelessness, unemployment, some factors may also create a context in which the risk of violence or harm is normalised e.g. trans-generational family violence or abuse.

Responding to the risks

Many of the strategic interventions recommended by the World Health Organisation (WHO) (see page 22) focus on protective factors or provision which evidence suggests may mitigate some of these risk factors. Public Health England (see page 14) also emphasises the value of individual, family and social protective factors for vulnerable children and young people.

The following case studies from existing services in Greater Manchester, and further examples throughout the strategy, exemplify effective responses to various presenting risk factors.

CASE STUDY: Adverse Childhood Experiences

A vulnerable 8-year-old child, who was living in a household where there was frequent domestic abuse, arrived at a new school. It wasn’t long before he began displaying extremely violent and disturbing behaviour towards other pupils and staff. The school is a trauma informed school. Trauma informed practice is a cornerstone of the approach set out in this strategy. Instead of approaching the child with traditional sanctions for disruptive and threatening behaviour, the child was supported with interventions that recognise the effects of adverse childhood experiences (ACEs). The child was allocated a 1-1 worker and also given access to a ‘calm room’.

Accompanied by some 1-1 therapeutic support this meant that the child’s disruptive and often violent episodes at school reduced from around 6 per month to nil, over the course of 6 months. Without these intensive trauma-informed interventions, it is likely that the child would have been permanently excluded, at significant cost to both the child and the school.

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5 Mental health and learning disabilities are both highlighted in the 2009 Bradley Report: Lord Bradley’s review of people with mental health problems or learning disabilities in the criminal justice system.

6 As 4.

7 As 6.
National and international policy and evidence

The national context for health and justice

In the UK over the period 2013-14, a series of structural and policy changes took effect in the delivery of local and national public health provision, the rehabilitation of offenders and the National Probation Service.

Public Health England (PHE), The Probation Chiefs Association (PCA) and the Revolving Doors Agency (a specialist national charity) responded to these changes by collaborating to produce a briefing paper called Balancing Act addressing health inequalities among people in contact with the criminal justice system.

The briefing highlighted that male and female offenders and ex-offenders are an often-overlooked group who disproportionately experience poor physical and mental health, who commonly engage in high-risk behaviours and whose needs are often multiple and complex.

In the intervening period since the publication of Balancing Act, the Revolving Doors Agency has published Rebalancing Act in January 2017. The primary message of Rebalancing Act is that a whole-system, integrated response is the only solution to supporting people with multiple, complex health and social needs and circumstances, and that addressing people’s needs in this way will give rise to wider social and community benefit – what they refer to as a ‘community dividend’.

One example of this is breaking the pattern of offending, abuse or psychological trauma that can sometimes be ‘passed’ between generations of the same family e.g. domestic abuse reducing the likelihood of poor mental health amongst wider family members, supporting effective parenting and caring, meaning that children are less likely to become ‘looked after’ by the state due to concerns about safeguarding.

An example of this in Greater Manchester is the success of the Women’s Support Alliance in reducing offending rates amongst women offenders, by tackling the issues that have contributed to offending which often include coercive and/or physically abusive relationships.

However, Rebalancing Act acknowledges that working in the arena of health inequalities with people who often have complex and multiple health, care and social needs is challenging. Whilst our understanding of the characteristics and needs of this population group is improving, our understanding of what works to reduce the health and social inequalities they experience is less well-developed.

Benefits of the Community Dividend

8 Diagram courtesy of PHE

Improved health = reduced costs to NHS
Reduced offending = reduced cost to law enforcement
Lower crime rates = improved community safety
Supporting rehabilitation = increasing levels of productive activity and social cohesion

8 Diagram courtesy of PHE
Health care in the criminal justice system

NHS England also published its *Strategic direction for health services in the justice system: 2016-2020*, covering the provision of care for men and women in all custodial settings (pre-, during and post-custody). The strategic priorities include:

- A radical upgrade in early intervention
- A decisive shift towards person-centred care that provides the right treatment and support
- Strengthening the voice and involvement of those with lived experience
- Supporting rehabilitation and the move to a pathway of recovery
- Ensuring continuity of care, on reception and post-release, by bridging the divide between healthcare services provided in justice, detained and community settings
- Greater integration of services driven by better partnerships, collaboration and delivery

Following on from this, NHS England then published its *Strategic direction for sexual assault and abuse services – Lifelong care for victims and survivors: 2018-2023*, which highlights:

- Strengthening the approach to prevention
- Promoting safeguarding and the safety, protection and welfare of victims and survivors
- Involving victims and survivors in the development and improvement of services
- Introducing consistent quality standards
- Driving collaboration and reducing fragmentation
- Ensuring an appropriately trained workforce

Most recently, the *NHS Long Term Plan* published in January 2019 reinforces the importance of access to health and social care for the vulnerable young people and adults seen in the criminal justice system. It also makes specific references to national pilot schemes including the Community Service Treatment Requirement (CSTR) programme and RECONNECT. The CSTR enables courts to require people to participate in community treatment, instead of a custodial sentence, whilst RECONNECT is a care after custody service which works with people before they leave prison to assist the transition to health and social care community-based services.

These national strategies set out expectations for the way healthcare needs to evolve for offenders in custody and victims and survivors. Similarly, this Greater Manchester Health and Justice Strategy creates a set of priorities for improving access to health and care provision for offenders, ex-offenders and the victims of abuse and sexual violence living in our Greater Manchester communities. As the work to develop the strategy has progressed, it is clear that many of the principles expressed in the national strategies are equally relevant to offenders, and victims of violence and abuse, living in the city region.

Violence reduction as a public service and population health goal

The World Health Organisation has been advocating for better awareness about violence as a public health issue, and the multiple effects of violence on health and wellbeing, since the publication of its first World report on violence and health in 2002.

It has developed an ‘ecological framework’ as a way of understanding the factors that influence violence, showing the interaction of multiple factors that can lead to violent behaviour and it is regarded to be a sound basis for understanding the issue.

Factors that Influence Violence – World Health Organisation

- **Societal**
  - Rapid social change
  - Gender, social and economic inequalities
  - Poverty
  - Weak economic safety nets
  - Poor rule of law
  - Cultural norms that support violence

- **Community**
  - Poverty
  - High crime levels
  - High residential mobility
  - High unemployment
  - Local illicit drug trade
  - Institutional factors

- **Relationship**
  - Poor parenting practices
  - Marital discord
  - Violent parental conflict
  - Low socioeconomic household status
  - Friends who engage in violence

- **Individual**
  - Victim of child maltreatment
  - Psychological/personality disorder
  - Alcohol/substance abuse
  - History of violent behaviour
In 2010, WHO published a series of evidence briefings on violence prevention, in which it advocated 7 main strategic interventions, based on a review of the available international evidence. They are listed below with some examples.

Public Health England has also developed a resource to support the local system response to violent crime, which advocates a balance between prevention and enforcement, and aligns with the evidence above. The resource outlines an approach to serious violence prevention (defined by the national Serious Violence Prevention, in which it advocated 7 main strategic interventions, based on a review of the available international evidence. They are listed below with some examples.

The evidence-base for what works to support vulnerable and marginalised people whose needs cut across health, care and the criminal justice system is still an emerging field in the UK, but current evidence and insight indicates that the style, aims and responsiveness of support may be as important as the focus of the intervention.

Some characteristics of positive support include:

- Non-judgemental and person-centred
- Approaches that build self-confidence and agency
- Eliminating stigma and focusing on inclusion in society
- Valuing the positive input of friends and also family, supporting people to reconnect with social networks and form healthy relationships

Who strategic interventions

<table>
<thead>
<tr>
<th>WHO strategic interventions</th>
<th>Examples of practical support / services that show emerging evidence of effectiveness</th>
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</thead>
<tbody>
<tr>
<td>Increasing safe, stable and nurturing relationships between children and their parents and caregivers</td>
<td>Programmes that provide parental support and family approaches / therapies which focus on attachment, family bonds and healthy relationships often in the Early Years e.g. Family Nurse Partnership, Triple P, Incredible Years Pre-school Multi-component approaches e.g. Multi-systemic therapy (an intensive family therapy which addresses multiple issues) and Sure Start programmes are also thought to have a positive effect.</td>
</tr>
<tr>
<td>Developing life skills in children and adolescents</td>
<td>Programmes that address life, social and emotional skills and competencies e.g. Incredible Years Child / teacher programmes, Training Promoting Alternative Thinking Strategies (PATHS).</td>
</tr>
<tr>
<td>Reducing availability and harmful use of alcohol</td>
<td>Programmes that offer brief interventions and longer-term treatment for problem drinking, including psychotherapeutic interventions such as CBT. Reducing alcohol sales has also been linked to reducing violence.</td>
</tr>
<tr>
<td>Reducing access to guns, knives and pesticides</td>
<td>Programmes that directly target young people in gangs e.g. as in USA and Glasgow.</td>
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<tr>
<td>Promoting gender equality</td>
<td>School-based programmes that address gender norms and attitudes and issues of gender-based power and control.</td>
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<tr>
<td>Changing cultural norms that support violence</td>
<td>Programmes that address dating violence and sexual violence amongst young people by challenging social and cultural norms.</td>
</tr>
<tr>
<td>Victim identification, care and support</td>
<td>Programmes that aim to identify victims e.g. through screening and referral, alongside interventions such as advocacy for victims of violence e.g. IRIS domestic violence intervention, and psychosocial interventions which address psychological trauma.</td>
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</table>

Reducing serious violence

Greater Manchester is one of several regions to have adopted a public health informed approach to violence reduction and has recently established a Violence Reduction Unit (VRU). This VRU is a dedicated, co-located, multi-agency team including representation from across policing, health, local authorities, schools and the voluntary sector. These partners will work together to tackle violent crime and its underlying causes, by identifying the drivers of serious violence locally and developing a coordinated response to tackle them.

Greater Manchester has modelled elements of its approach on the Scottish Violence Reduction Unit (SVRU), which has been operating since 2006. Other UK regions, including the West Midlands Violence Prevention Alliance and the Cardiff Model for Violence Prevention, have adopted approaches designed to understand and predict the prevalence, types and causes of violence within a community and take steps to address those issues through co-ordinated multi-agency action.

In developing its approach to violence reduction, the new Greater Manchester Serious Violence Action Plan will be informed by the most up to date evidence in the field and expertise in criminology, through a collaboration with Manchester Metropolitan University (MMU) academics.
Local research

Understanding the health and social care needs of the offender population and the victims of violence and abuse in depth is a relatively new arena of public policy and service delivery for public health and criminal justice teams, but the same principles apply as for other population health work:

• understand the needs of the population of interest;
• identify health-related risk factors and their causes; and
• intervene in ways that reduce the exposure to or offer protection from the detrimental effects of those risk factors.

Work has already been completed that will support the development of this strategy and advance our understanding of the needs and characteristics of people in contact with the criminal justice system in Greater Manchester. These include:

• A Greater Manchester Criminal Justice System Health Needs Assessment (CJS HNA) (2018)
• An independent Health and Criminal Justice Strategic Commissioning Review (2018)

There are also a number of pieces of victim-focused research and insight which have been undertaken by Greater Manchester partners working to support victims of domestic and sexual violence which inform this strategy.

They are:

• A Health Needs Assessment of the population served by the St Mary’s Sexual Advice and Referral Centre (SARC), which summarises the characteristics and needs of the people who have used the service, in particular multiple attendances
• The Voice of Survivors Research: Hearing Women for Change – conducted by MMU, MASH and Manchester Rape Crisis

All four documents are available separately and a collated summary of their main insights has fed into the development of this strategy.

Overall, local insight and research is consistent with national and international findings. These point towards a range of complex often interrelated factors that increase an individual's vulnerability to contact with the criminal justice system, including poor physical and mental health, and lifestyle factors including smoking, drug and alcohol use, alongside previous life experiences which may have been traumatic or challenging.

Greater Manchester evidence and insight

Additional insight from health and justice focused workshops

Several workshops were hosted as part of the stakeholder engagement for the development of the strategy. Some of these were general, whilst others focused on specific issues and groups, including children and young people; vulnerable and marginalised women; and people with learning disabilities and autism.

The feedback at the workshops reinforced many of the messages from the evidence above. Discussions at the children and young people's engagement event in particular drew attention to the additional vulnerability associated with having a learning disability, having autism, and/or having difficulties communicating, and their presentation among young people in contact with youth justice services.

Other service user feedback highlighted the following themes and issues:

• the long lasting and devastating impact of domestic violence and abuse within families and a reluctance to disclose it because of fear both of the perpetrator and of children being taken into care
• the impact of domestic violence and abuse on children and the need for services supporting children to be trauma-informed
• services in the right place, at the right time, for as long as people need support
• transition points and their impact on individuals are often particularly difficult and require additional and consistent support – including from primary to high school, from children's to adult social care, from prison to community, from a home environment to being looked after

Acting on what we know

Based on this Greater Manchester-specific evidence, and reinforced by wider national and international sources, this first integrated health and justice strategy for Greater Manchester has a strong focus on the groups of people in our communities who appear to be at an increased risk of violent crime and abuse.

This might be because of characteristics or circumstances which seem to increase vulnerability to criminality or victimhood, such as race, gender, having a learning disability/autism/communication issue, and rough-sleeping. Alternately, it could be because evidence and insight suggests that intervening earlier to reduce the risks associated with offending behaviour is the most effective approach e.g. focusing on identifying and supporting potentially vulnerable children and young people and addressing underlying problems as early as possible, such as trauma or hidden mental health issues.
Benefits of violence reduction in human and system costs

The World Health Organisation reports that although the economic case for a focus on interpersonal violence prevention isn’t currently well-developed, “the provision of treatment, mental health services, emergency care and criminal justice responses are some of the direct costs associated with violence.”

The need for additional and sometimes intensive support from public and voluntary services including health, social care and criminal justice services, for both victims of violence and offenders, is self-evident but largely unquantifiable.

Individuals, and their families, bear the most serious consequences of interpersonal violence including sometimes life-long effects on behaviour and health, including:

- Acute physical injury or disability: Lacerations, fractures, brain or major organ injury, burn and scalds.
- Mental health and behavioural effects: Alcohol and drug abuse, depression and anxiety, post-traumatic stress disorder, suicidal thoughts or behaviour, eating disorders and sleep disorders, smoking, unsafe sex.
- Sexual and reproductive effects: Untintended pregnancy, pregnancy complications, gynaecological disorders, chronic pelvic pain, HIV and other sexually transmitted infections.
- Chronic disease: Arthritis and asthma, cancer, cardiovascular diseases, diabetes, kidney problems, liver disease.
- Liver disease
- Cardiovascular diseases
- Diabetes
- Kidney problems
- Transmitted infections
- Disorders, chronic pelvic pain, HIV and other sexually transmitted infections
- Pregnancy, pregnancy complications, gynaecological disorders
- Chronic physical injury or disability: Lacerations, fractures, brain or major organ injury, burn and scalds.
- Mental health effects: Alcohol and drug abuse, depression and anxiety, post-traumatic stress disorder, suicidal thoughts or behaviour, eating disorders and sleep disorders, smoking, unsafe sex.
- Sexual and reproductive effects: Untintended pregnancy, pregnancy complications, gynaecological disorders, chronic pelvic pain, HIV and other sexually transmitted infections.
- Chronic disease: Arthritis and asthma, cancer, cardiovascular diseases, diabetes, kidney problems, liver disease.

2. Whole-system leadership for health and justice

Our one system approach

This strategy will be delivered by a wide variety of public service partners in the statutory and VCSE sectors and the implementation of the strategy will reinforce and complement a series of existing Greater Manchester-wide programmes, including programmes in support of:

- Gender based abuse and domestic violence
- Serious Violence Action Plan
- Learning disability
- Autism
- Mental health, including suicide prevention
- Substance misuse
- Homelessness

Alignment and integration with other Greater Manchester-wide strategies will be essential to achieving improvements in the field of health and justice. These programmes of work include:

- The Greater Manchester Children’s Plan
- The Children and Young People’s Health and Wellbeing Framework
- The Greater Manchester Mental Health in Education (MHIE) programme
- The ‘A Bed Every Night’ scheme and the Housing First Greater Manchester regional pilot
- The Justice and Rehabilitation Devolution memorandum of understanding
- The White Paper on Unified Public Services for the People of Greater Manchester
- Standing Together – The Police and Crime Plan
- Our People, Our Place – the Greater Manchester Strategy

Along with identifying what we plan to do differently in Greater Manchester to reduce health inequalities and improve life chances for victims and offenders, the strategy also sets out how the conditions will be created for professionals and practitioners to improve what they currently do and the way they do it.

Our strategy aims

In considering what is needed to create an environment in which colleagues are informed, equipped and supported to improve practice, the aims of the strategy are to:

- Highlight the risk factors, health vulnerabilities and health inequalities experienced by offenders, ex-offenders and the victims of personal violence.
- Provide clarity on the existing evidence base (and its limitations).
- Advocate for the introduction of trauma-informed practices proportionately across the workforce which emphasises the strong association between adverse childhood and life experiences and victimhood/offending – and collaboratively identify the resources to deliver high-quality workforce development.
- Inform integrated, whole system public health approaches to violence reduction with an emphasis on early help, early in life and stimulate Greater Manchester partners to work towards delivering this collaboratively.
- Create a clear account of ‘health and justice’ for mainstream health, care and criminal justice services, using and sharing data and intelligence, so that vulnerable and marginalised people are better identified and appropriately supported.
- Acknowledge the complexity of working where health and justice issues intersect and explore with localities and partners how to develop and share best practice across Greater Manchester and learn from each other, in the short and medium term.
- Understand how current organisational practices and processes may need to change to facilitate more effective early identification and intervention of vulnerable children, young people and adults, within organisations and between them e.g. assessment and referral practices.
- Emphasise collaboration amongst commissioners and providers in order to improve the accessibility and quality of support for this population group.

\[\text{WHO Global Status Report on Violence Prevention (2014)}\]
\[\text{Based on findings of WHO Global Status Report on Violence Prevention (2014)}\]
\[\text{Rebalancing Act 2015, p. 12}\]
A whole-system approach to Family Justice

Family Justice is a branch of the Health and Justice agenda which pursues the provision of integrated support for vulnerable families engaged in the criminal justice system. Its purpose is to ensure that services make decisions together which promote the holistic wellbeing of the whole family.

The internationally recognised principles of Family Justice are:

- "Safety-focused: increase safety, promote healing, and foster empowerment through services for victims and their children
- "Victim-centred: provide victim-centred services that promote victim autonomy
- "Survivor-driven: shape services to clients by asking them what they need
- "Relationship-based: maintain close working relationships among all collaborators/agencies
- "Offender-accountability: increase offender accountability through evidence-based prosecution strategies and/or evidence-based treatment programs
- "Transformative: evaluate and adjust services by including survivor input and evidence-based best practices
- "Culturally competent: commit to the utilisation of culturally competent services
- "Culturally competent: commit to the utilisation of culturally competent services
- "Empowered: offer survivors a place to belong even after crisis intervention services are no longer necessary
- "Kind-hearted: develop an approach that values, affirms, recognises and supports staff, volunteers, and clients."

In Greater Manchester, the principles of Family Justice are well-aligned with the broader ambitions set out in our approach to unify public services within a single, coherent and effective model. More specifically, integrated, place-based teams working within some of Greater Manchester’s neighbourhoods present an opportunity to deliver a Family Justice approach.

Unified Public Services in GM

The Greater Manchester Model: Further, Faster 2019

- and in some instances this is already the case. Colleagues from the Centre for Mental Health were asked to review emergent place-based initiatives already being delivered in Greater Manchester and found that they demonstrated “the ready capacity to deliver” on the principles of Family Justice.
3. Overview of specialist health and justice provision in Greater Manchester

Greater Manchester already has a strong record of accomplishment in health and justice, which includes ambitious collaboration between commissioners in health and policing. Building on national developments in health and justice provision, Greater Manchester has already developed a number of exciting and unique initiatives. The common feature of these services is a shared approach to commissioning, which recognises the interconnection between mitigating health needs, reducing demand on services, and improving the lives of Greater Manchester’s citizens.

This strategy will seek to build on learning from the health and justice services which it has established in recent years. Among our successes in bringing together health and justice to date, with some examples of effectiveness, are:

- **Integrated Healthcare in Custody and Wider Liaison and Diversion** – this service simultaneously delivers the traditional aspects of custody healthcare and the liaison and diversion care rolled out across England in recent years. The integration of these services at the point of commissioning was nationally unique. By unifying them, Greater Manchester has been able to enhance the scale of health support which is available to individuals with issues relating to physical or mental health, or substance misuse, when they come into contact with the criminal justice system. They are also able to ensure that these vulnerabilities are better supported when individuals return to the community – reducing the likelihood of re-offending in the long-term. This service is present in all police custody suites across Greater Manchester, and in our magistrate’s and crown courts.

- **Mental Health Tactical Advice Service (formerly Control Room Triage)** – this service was commissioned in the context of the ever-increasing burden placed on frontline police by mental ill health in the wider population. This service situates a team of mental health practitioners, including representation from all three of Greater Manchester’s mental health providers, within the police control room. This team provide frontline police officers with real-time advice on live incidents that are mental health-related, allowing for enhanced critical risk management and more appropriate outcomes. This team’s ability to advise on the needs of every mentally ill member of the public presenting to the police in Greater Manchester gives them a reach which surpasses that of other similar street triage schemes in England.

- **Sexual Assault and Referral Centre (SARC)** – Saint Mary’s Sexual Assault Referral Centre provides a comprehensive and co-ordinated forensic, counselling and aftercare service to men, women and children living in the Greater Manchester and Cheshire area who have experienced rape or sexual assault, recently or in the past. Partners from NHS England and GMCA work together to commission forensic support services and aftercare respectively as part of one service.

**CASE STUDY:**

**Mental Health Tactical Advice Service**

A resident contacted Greater Manchester Police (GMP) expressing concern that she was going to carry out a desire to stab someone. She also referred to hearing voices and told them that she was under the influence. GMP officers attended the home address to determine whether the woman posed a risk to herself or other members of the public. They quickly determined that they were able to manage and support the woman at her home address, and they were not concerned that she was an immediate threat to others. However, because she presented with mental ill health and had expressed an intent to harm, consideration needed to be given to appropriate follow-up measures. The police officers contacted the GMP mental health tactical advice service, an NHS service we have embedded in the police control room, via the police radio.

The advice service consulted the woman’s health care records. They were able to see that she had a diagnosis of paranoid schizophrenia and that she was being supported by her local community mental health team. The service provided the officers at the scene with these background details. They then contacted the woman’s community mental health team to see if they could better support her needs. It was agreed that community mental health would prioritise seeing the woman that day, and her psychiatrist made an appointment to visit her at home.

This collaborative approach enabled a prompt response which offered the most appropriate support to meet the woman’s needs, avoiding unnecessary escalation. GMP withdrew, and the police officers were able to attend to other police business, confident that the woman would receive the help she needed.

**CASE STUDY:**

**Integrated Healthcare in Custody and Wider L&D Service #1**

A young woman was arrested by the police for a minor crime and taken to the police station. While she was being processed in police custody, she was picked up by the Liaison and Diversion (L&D) team. This is a new health service based in police custody suites and courts which supports vulnerable people with mental or physical health needs. The service helps people access health and care support in the community.

The L&D team put the girl in touch with a health care professional. This professional found bruising and a bite mark on the girl’s body. The girl disclosed to the health professional that these were caused by her mother and sister. This information was passed on to the arresting officer, and a social worker was called in to support the girl in custody. Appropriate arrangements were put in place to begin to safeguard the young woman back home after the police had finished processing her in custody.

**CASE STUDY:**

**Integrated Healthcare in Custody and Wider L&D Service #2**

A police officer on a routine patrol of police cells found a detainee breathing oddly in his cell. Prior to the integration of custody healthcare with liaison and diversion in the custody suites, the normal police response would have been to call for medical support when it next became available. Instead, the duty health care professional we have commissioned to assess and treat sick people in custody was requested and immediately attended the cell.

This health care professional diagnosed a suspected heroin overdose, and that the man was therefore at risk of death. An ambulance was called on a category 2 (i.e. emergency) response. The healthcare professional stayed with the man, and when he began to deteriorate, contacted the ambulance service and had the response grade updated to category 1 (i.e. life-threatening). The ambulance arrived promptly. The paramedic and health care professional together saved the man’s life.
Greater Manchester is also home to a range of complementary services which contribute to our wider health and justice offer. These services are each commissioned by individual commissioners within locality footprints. Achieving the priorities in this strategy will mean seeking guidance and partnership from stakeholders involved in commissioning and delivering these services, and other key services in Greater Manchester.

Examples include:

• Identification and Referral to Improve Safety (IRIS) – IRIS is a general practice-based domestic violence and abuse (DVA) training support and referral programme. It is a collaboration between primary care and third sector organisations specialising in DVA. An advocate educator is linked to general practices and based in a local specialist DVA service. It is aimed at women who are experiencing DVA from a current partner, ex-partner or adult family member. IRIS also provides information and signposting for male victims and for perpetrators. IRIS is currently commissioned in Manchester and Bollington.

• Independent domestic abuse/sexual violence advocacy – Independent domestic abuse advocates (IDVA) or sexual violence advocates (ISVA) who take referrals from a wide range of services where people have been identified as the victim of domestic or sexual violence. Advocacy service supports victims of abuse to make the right decision for them, from reporting experiences to the police to offering support, advice, information and advocacy through the criminal justice process.

• Women’s Support Alliance – The Women’s Support Alliance is made up of the providers who deliver nine women’s centres across Greater Manchester. These services are commissioned to support women offenders and reduce re-offending across the city region. Each women’s centre has a bespoke offer, and some support vulnerable women who are at risk of entering the criminal justice system, taking account of complex need.

• Existing support in youth justice services – Many of Greater Manchester’s existing statutory, multi-disciplinary youth offending teams (YOTs) already include offers of support for the health needs of young offenders, and other young people at risk of first-time entry into the criminal justice system. YOTs take a holistic approach towards young people and the issues they face, identifying and managing the risks they pose to themselves and to other people, and reducing the likelihood of them re-offending in the future. These risks often include health vulnerability or underlying and sometimes undiagnosed conditions as a driver of crime.

• The Greater Manchester Autism Consortium – providing forensic autism assessment and wider support to teams supporting people with autism across Greater Manchester. A commitment to ‘make Greater Manchester autism-friendly’ was set out in Andy Burnham’s mayoral manifesto. Early in 2019, a strategy was launched which seeks to establish Greater Manchester as the first autism-friendly city-region in the UK.

• Services that are funded by the Ministry of Justice (MOJ) victim grant – these grants enable services to provide support locally to victims of crime and focus on enabling them to cope and recover. The MOJ categories of need provide a framework against which progress and outcomes can be monitored, including documenting support provided through the criminal justice system.

Part of the remit of the Greater Manchester Deputy Mayor is to deliver services for the victims of crime. Each of Greater Manchester’s localities has a local victim support service offer, commissioned in line with that locality’s population and their needs.

CASE STUDY: Vulnerable and Marginalised Women

A 57 year-old women finally felt able to speak to the Victim Support service about sexual abuse which she experienced between the ages of 9 and 14. She had kept this abuse to herself for her entire life, but was finally compelled to come forwards after her sister made a disclosure at a family event, revealing the full extent of the situation. After hiding the abuse all her life, the woman’s disclosure had a dramatic effect on her health and wellbeing – she struggled to physically talk, her sleep was badly affected, and her physical health also deteriorated. She attended Victim Support for face to face sessions on a regular basis, and these were reinforced with phone contact in between. She was also referred to an independent advocate and a counsellor.

She needed help to understand the legal and court process alongside intensive emotional support to come to terms with the abuse she had suffered. This included help practising wellbeing techniques to independently manage her levels of stress, anxiety and anger. With support from a combination of health and justice services working together, she was gradually able to process the event and understand the full nature of the abuse. This included discussing some aspects of the crime with her own family, which had initially been a severe cause of distress for her.

4. Rationale for strategic focus on particular groups

The emphasis on particular priority groups in the strategy has been informed by a range of sources including, in particular, international evidence from WHO; national strategies and evidence from Public Health England and NHS England; national reports such as Beyond the High Fence, which represents the voices of people with a learning disability or autism in the criminal justice system, Rebalancing Act, the independently conducted Greater Manchester Health and Criminal Justice System Strategic Commissioning Review, and the stakeholder engagement process.

Whilst all children, young people and adults seen in the criminal justice system across Greater Manchester will benefit from the intent to reduce the prevalence and effects of health inequalities they experience. The four groups that the strategy will initially focus on are:

• Children and young people up to age 18, however, where young adults have additional vulnerabilities this could extend to age 25.

• Marginalised female victims of domestic abuse and/or sexual violence.

• People with a learning disability, autism or a communication disorder.

• People who are rough-sleeping.

However, all children, young people and adults seen in the criminal justice system will benefit from our intent to reduce the prevalence and effect of health inequalities they experience.

Within the above priority groups, specific vulnerabilities or risk factors may also be present. In the case of children and young people, for example, children who have been ‘looked after’ by the state for prolonged periods of time, children who have gone missing from their families, the children of refugee and asylum seeker families, and young people who have been permanently excluded from a school setting, may be at an increased risk.

Within and beyond these four priority groups, there is a recognition that both victims and offenders may have other characteristics which increase the likelihood of them being seen in a health and justice context, for example, Black and Minority Ethnic (BAME) young men are over-represented in the youth justice system and offender and prison populations, as are adult BAME men generally.

Although the development of the strategy led to the prioritisation of the four population groups above, this does not discount the presence or cumulative impact of ‘intersectional’ inequalities. Intersectionality is the idea that vulnerability, disadvantage and discrimination can arise from multiple, overlapping individual and social characteristics e.g. race, gender, age, sexuality, socio-economic status, educational attainment, ability to work and so on.

These factors, and specifically the 9 protected characteristics covered in the Equality Act (2010), will be considered in the implementation of the strategy, through the delivery planning process.

CASE STUDY: Children and Young People

A boy came into the youth offending service after committing multiple offences. When he was first seen by a case worker, he suspected that he may have ADHD. She was able to call for support from a child mental health worker, who undertook a quick screening and agreed with this impression. This mental health worker then made the child an appointment to attend a formal assessment. She built a trusting relationship with him, and made sure he made it to the appointment, where he was formally diagnosed with ADHD. After this, the same mental health worker then ensured that he picked up his prescription, and that his parents understood how it worked and agreed with this treatment. As a result of the health offer being made available in the youth justice system, staff working with the boy noticed a marked improvement in his behaviour. The case worker at the youth offending service continued to work with him and was able to help him to learn to use strategies that prevented him from behaving anti-socially or offending again.
Additional context for the choice of priority groups

WHO\(^\text{27}\) reports worldwide that women, children and elderly people experience the greatest non-fatal consequences of physical, sexual and psychological abuse and that the resulting negative health consequences of violence disproportionately affect women and children across the life-span. Public Health England\(^\text{28}\) also highlights the particular vulnerabilities of children and young people and the developmental and lifetime implications of offending behaviour from a young age.

The independent Strategic Commissioning Review also recommended that pathways of support for marginalised and vulnerable women, and children and young people in contact with the criminal justice system, would be a constructive focus from a Greater Manchester strategic commissioning viewpoint. Although specific data about the impact of violence and abuse in childhood is not available at a Greater Manchester level, the Crime Survey for England and Wales\(^\text{29}\) published a specific report on the effect of violent or abusive relationships in childhood.\(^\text{30}\) Data from the Crime Survey showed that 51% of adults who were abused as children (under the age of 16) experienced domestic abuse in later life, suggesting a strong correlation between psychological, physical or sexual abuse, including witnessing abuse in childhood, and later abuse in adulthood. This supports a case for early intervention and prevention of violence and harm in childhood as an end in itself, but also as a way of reducing the risk of lifetime abuse.

There is also growing awareness that people with a learning disability, learning difficulty, autistic spectrum disorder or communication issues are disproportionately represented in the criminal justice system, but in apparent contrast, their needs are often not recognised until after the fact. Beyond the High Fence\(^\text{31}\) captures the experiences of people with learning disabilities and autism in the criminal justice system, creating a shared narrative of life before, during and after prison or hospital. In Greater Manchester, it is thought that people with a learning disability or autism are significantly under-reported across criminal justice system data compared to national estimates, suggesting that the true extent of the issue is masked, which in turn may indicate low rates of early identification of people with learning, autistic spectrum and communication issues in contact with the criminal justice system.

Addressing rough-sleeping and homelessness is a local priority in Greater Manchester and there is a strong association between becoming homeless and victimhood and/or offending. Among the population of homeless people, a substantial proportion are believed to be care leavers, former prisoners and victims of domestic violence or abuse.\(^\text{32}\) Victimisation and offending both appear to be risk factors in homelessness, but for some people there is evidence that previous rough sleeping and homelessness can remain a risk factor for ongoing victimisation.\(^\text{33}\)

There is also a correlation between homelessness and poor health, with the LGA reporting in 2017 that 41 per cent of homeless people reported a long term physical health problem and 45 per cent had a diagnosed mental health problem, compared with 28 per cent and 25 per cent, respectively, in the general population.\(^\text{34}\)

It is also said that 25% of people in contact with multiple support services covering homelessness, criminal justice, healthcare and treatment services are young people aged 18-24.\(^\text{35}\)

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\(^{28}\) As in 5.

\(^{29}\) ONS. People who were abused as children are more likely to be abused as an adult: Exploring the impact of what can sometimes be hidden crimes.

\(^{30}\) Beyond the high fence – From the unheard voices of people with a learning disability, autism or both – Pathways Associates and NHS England (2017).

\(^{31}\) Revolving Doors Agency / Trust for London, July 2019, We are victims too: A peer study into repeat victimisation among people who moved from the streets into supported accommodation in London.


\(^{33}\) As 14, citing data from Lankelly Chase (2015).
5. Health and justice strategic framework and priorities

Whole system change requires a holistic framework which addresses prevention and risk reduction, integrated care and support for victims and offenders, and facilitates system change through effective use of data and resources.

Across Greater Manchester there have already been ambitious new developments in the field of health and justice such as the Integrated Healthcare in Custody and Wider Liaison and Diversion Liaison function and Mental Health Tactical Advice Service (formerly Control Room Triage). This strategy is an opportunity to realise greater strategic coherence, unifying existing provision and learning with the new activities and priorities identified in the strategy.

Developing this strategy has highlighted a series of existing activities and programmes within the health and justice arena that have strategic importance, alongside the recognition of additional new issues which represent an opportunity to transform practice by focusing attention on whole system and integrated responses to health and justice issues. The strategy therefore incorporates:

- Priorities reflecting new strategic objectives, with the potential for high impact system change in the medium to longer-term, initially up to 5 years; and
- Existing and ongoing strategic developments which are likely to be delivered over the next 1-3 years.

Resilience is a common theme throughout the strategy and the intention is that this approach will, over a 5-year period initially, consolidate existing practice whilst building knowledge, increasing expertise, identifying barriers to progress and create resilience at a system level that will provide the foundations for increased strategic integration across health and justice provision in Greater Manchester.

Existing health and justice work programmes

Six existing programmes of work that are underway (or are in planning) will set the immediate strategic direction of health and justice provision in Greater Manchester for the next 1-3 years are:

1. Improve the identification of health needs and support for young offenders and victims who may face barriers to accessing services through the newly established Collaborative Commissioning Network.
2. Enhance the Greater Manchester-wide response to members of the public with health vulnerabilities who come into contact with the police, including:
   - Services that ensure the most appropriate response and reduce the likelihood of re-presentation for those individuals who present to the police in a state of mental health crisis e.g. control room triage.
   - The Greater Manchester Integrated Custody Healthcare and Wider Liaison and Diversion Service, which identifies and addresses the mental & physical health needs of children and young people (and other priority cohorts).
3. Work with NHS England commissioners to address continuity of care for people on reception and post release from prison by agreeing clearer communication, transition and service pathways.
4. Review the current model and approach to commissioning of rape and sexual assault services to ensure the needs of victims are met.
5. Explore with locality commissioners the scope for developing a city region model for improving the primary care response to sexual and domestic violence and abuse, such as the evidenced based IRIS general practice programme.
6. Use data and intelligence available across the health and justice interface to enable earlier and more focused intervention, establish data sharing protocols that support this approach and develop a consistent set of indicators which can track progress against health and justice strategic aims and outcomes.

New strategic priorities

The new strategic objectives that have been identified and prioritised during the strategy development process are:

**Prevention**

1. Introduce a public health approach to violence reduction across public service provision, with a focus on children and young people at increased risk of committing anti-social or criminal activity.
2. Work with schools, youth justice and children and young people’s services to develop upstream targeted interventions that reduce the risk of first-time entry to the criminal justice system.
3. Building on the work with the Women’s Alliance Partnership, extend provision to reach a wider cohort of vulnerable women who are at risk of victimisation or committing criminal activity, and, strengthen health care pathways between existing services.

**Intervention**

4. Develop best practice approaches and pathways that appropriately identify and support offenders and victims of violence or exploitation who have a learning, autistic spectrum or communication/speech and language issue.
5. Agree a standardised health improvement model with the NHS and youth justice teams that targets and addresses health vulnerability in this group of young adults.
6. Work with partner organisations to promote and embed the principles of Family Justice within the strategic direction and operational delivery of unified public services in Greater Manchester.

**Enablers/Systems**

7. Develop a long-term, sustainable approach to commissioning services that deliver specialist healthcare and therapeutic support to offenders and the victims of crime, agreeing common quality standards for Greater Manchester.
8. Collaboratively develop workforce training and development programmes that promote insight into trauma, abuse, learning disability and communication disorder presentation and how to identify and support these issues effectively.
9. Establish more consistent approaches to service user engagement in the design and delivery of specialist health and justice services.
6. Delivery and resource planning

Delivery

A separate delivery plan accompanies the strategy, which provides greater detail on the proposed implementation of the new and existing work programmes set out above.

The common thread connecting all the strategic objectives is to secure reductions in the health and wider inequalities and exclusion experienced by people seen in the criminal justice system, by working with individuals in a more cohesive and person-centred way.

In practice this will be achieved through:

- Enhancements to the way current services work with vulnerable children and adults
- Earlier identification of vulnerable children, young people and adults and supporting them to access existing services
- Improvements in communication and collaboration across agencies around the needs of individuals and families
- Collaborative commissioning approaches which target unmet system needs
- Workforce development and training
- Developing an in-depth and robust Greater Manchester health and justice ‘profile’ covering people and services, which informs strategy and delivery

In order to track performance against the strategic objectives and the outcomes for vulnerable children, young people and adults, a dashboard and outcomes framework will be developed for periodic monitoring by the Health and Justice Board. This will be the main method for understanding and tracking benefits realised at a system and cohort level.

However, building on recent independent and in-house evaluations, such as those covering the women offenders model, an independent review of Independent Sexual Violence Advisor provision, the Control Room Triage evaluation, and the Health and Criminal Justice Strategic Commissioning Review, other targeted analyses and evaluations will be undertaken to enhance the understanding of health and justice delivery in the round.

Resource planning

Because the strategy identifies several new and developmental programmes of work, some of which are intended to be achieved over a period of up to five years, the implementation of some programmes necessarily includes the identification of resources and/or the development of business cases to potentially secure funding.

The existing programmes of work and some of the new programmes are largely funded from existing resources and do not depend on business case development to move forward, however, the more ambitious medium to longer-term work captured in the new priorities will need new and, in some cases, substantial funding to deliver systemic change in practice.

Activities which will take place in support of the priorities contained in this strategy broadly fall into three categories:

1. Activities which can be achieved within existing resources, including by reprioritising within existing human and financial resources
2. Activities which require moderate investment that could be achieved through joint commissioning at a Greater Manchester level and/or already have an associated funding stream, but this could also involve decommissioning/budget reallocation
3. Activities which require new and significant funding and for which a business case will be developed collaboratively

Expected outcomes arising from the delivery plans include improvements in early identification, accessibility, quality, timeliness and continuity of care, including:

- Vulnerable young people will have their psychological and mental health, physical health, and specific developmental/learning disability/autistic spectrum/communication needs comprehensively assessed in a timely way
- Better support for vulnerable young people with additional vulnerabilities such as learning disability, autism, school exclusion, or childhood trauma or adverse experiences, will help to break the cycle of becoming a victim or offender
- Tailored support for vulnerable women at risk of offending or re-offending will improve their access to healthcare provision they may not otherwise have accessed independently
- Victims of rape and sexual assault will receive high quality forensic and therapeutic services at the right time and in the right location for them
- Decisions about people who present to the police in a state of mental health distress will be supported by 24/7 access to a mental health professional, increasing the likelihood of people being supported in their own home and community
- The public service and voluntary sector workforce will be more able to meet the needs of vulnerable people by providing more responsive, trauma-informed support
- People disclosing domestic violence or abuse in a healthcare setting will receive prompt, specialist advice
- Work will start with people before they are released from prison so that they receive continuous community-based health and care services that provide the support that they need
- People with lived experience of health and justice services will be engaged on an ongoing basis so that their real-world perspectives help to improve the way services are commissioned and delivered