Public Document

GMCA GREATER MANCHESTER COMBINED AUTHORITY

Greater Manchester Integrated Care Partnership

NHS GREATER MANCHESTER INTEGRATED CARE PARTNERSHIP BOARD

DATE: **Friday, 29th September, 2023**

TIME: **1.00 pm**

VENUE: **Leigh Sports Village Company, Leigh Stadium, Sale Way, Leigh, WN7 4JY**

AGENDA

1. Welcome and apologies

2. Chair's Announcements and Urgent Business

3. Declarations of Interest 1 - 4

To receive declarations of interest in any item for discussion at the meeting. A blank form for declaring interests has been circulated with the agenda; please ensure that this is returned to the Governance & Scrutiny Officer at least 48 hours in advance of the meeting.

4. Minutes of the meeting of the NHS GM Integrated Care Partnership Board held on 30 June 2023 5 - 12

To consider the approval of the minutes of the meeting held on 30 June 2023.

BOLTON	**MANCHESTER**	**ROCHDALE**	**STOCKPORT**	**TRAFFORD**
BURY	**OLDHAM**	**SALFORD**	**TAMESIDE**	**WIGAN**

Please note that this meeting will be livestreamed via www.greatermanchester-ca.gov.uk, please speak to a Governance Officer before the meeting should you not wish to consent to being included in this recording.

5.	**Mission 2: Helping People stay well and detecting illness earlier** Report of Sarah Price – Chief Officer: Population Health and Inequalities (NHS GM), and Manisha Kumar – Chief Medical Officer (NHS GM)	13 - 58
6.	**Greater Manchester Primary Care Blueprint** Report of Rob Bellingham, Director for Primary Care and Strategic Commissioning, NHS Greater Manchester Integrated Care and Dr Tracey Vell, Primary Care Provider Board Chief Officer	59 - 156
7.	**Mental Health Strategy** Report of Prof. Manisha Kumar, Chief Medical Officer, NHS Greater Manchester Integrated Care	157 - 186
8.	**Work Programme**	187 - 188
9.	**Date and time of next meeting** The next meeting will be held on 15 December 2023.	

ITEMS FOR INFORMATION ONLY

GM Health and Care Digital Transformation Strategy	189 - 248
Optimizing the Role of the NHS in Tackling Poverty	249 - 324

For copies of papers and further information on this meeting please refer to the website www.greatermanchester-ca.gov.uk. or contact

Elaine Mottershead, Senior Governance & Scrutiny Officer

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This agenda was issued on Thursday, 21 September 2023

on behalf of Julie Connor, Secretary to the Greater Manchester Combined Authority,

Churchgate House, 56 Oxford Street,Manchester M1 6EU

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Declaration of Interests in Items Appearing on the Agenda

Name and Date of Committee: NHS GM Integrated Care Partnership Board, 29 September 2023

Agenda Item Number	Type of Interest - PERSONAL AND NON PREJUDICIAL Reason for declaration of interest	NON PREJUDICIAL Reason for declaration of interest Type of Interest – PREJUDICIAL Reason for declaration of interest	Type of Interest – DISCLOSABLE PECUNIARY INTEREST Reason for declaration of interest

Please see overleaf for a quick guide to declaring interests at GMCA meetings.

Quick Guide to Declaring Interests at GMCA Meetings

Please Note: should you have a personal interest that is prejudicial in an item on the agenda, you should leave the meeting for the duration of the discussion and the voting thereon.

This is a summary of the rules around declaring interests at meetings. It does not replace the Member's Code of Conduct, the full description can be found in the GMCA's constitution Part 7A.

Your personal interests must be registered on the GMCA's Annual Register within 28 days of your appointment onto a GMCA committee and any changes to these interests must notified within 28 days. Personal interests that should be on the register include:

1. Bodies to which you have been appointed by the GMCA
2. Your membership of bodies exercising functions of a public nature, including charities, societies, political parties or trade unions.

You are also legally bound to disclose the following information called Disclosable Personal Interests which includes:

1. You, and your partner's business interests (eg employment, trade, profession, contracts, or any company with which you are associated).
2. You and your partner's wider financial interests (eg trust funds, investments, and assets including land and property).
3. Any sponsorship you receive.

Failure to disclose this information is a criminal offence

Step One: Establish whether you have an interest in the business of the agenda

1. If the answer to that question is 'No' then that is the end of the matter.
2. If the answer is 'Yes' or Very Likely' then you must go on to consider if that personal interest can be construed as being a prejudicial interest.

Step Two: Determining if your interest is prejudicial

A personal interest becomes a prejudicial interest:

1. where the wellbeing, or financial position of you, your partner, members of your family, or people with whom you have a close association (people who are more than just an acquaintance) are likely to be affected by the business of the meeting more than it would affect most people in the area.
2. the interest is one which a member of the public with knowledge of the relevant facts would reasonably regard as so significant that it is likely to prejudice your judgement of the public interest.

For a non-prejudicial interest, you must:

1. Notify the governance officer for the meeting as soon as you realise you have an interest.
2. Inform the meeting that you have a personal interest and the nature of the interest.
3. Fill in the declarations of interest form.

To note:

1. You may remain in the room and speak and vote on the matter
2. If your interest relates to a body to which the GMCA has appointed you to, you only have to inform the meeting of that interest if you speak on the matter.

For prejudicial interests, you must:

1. Notify the governance officer for the meeting as soon as you realise you have a prejudicial interest (before or during the meeting).
2. Inform the meeting that you have a prejudicial interest and the nature of the interest.
3. Fill in the declarations of interest form.
4. Leave the meeting while that item of business is discussed.
5. Make sure the interest is recorded on your annual register of interests form if it relates to you or your partner's business or financial affairs. If it is not on the Register update it within 28 days of the interest becoming apparent.

You must not:

Participate in any discussion of the business at the meeting, or if you become aware of your disclosable pecuniary interest during the meeting participate further in any discussion of the business,
participate in any vote or further vote taken on the matter at the meeting.

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MINUTES OF THE MEETING OF THE
NHS GREATER MANCHESTER INTEGRATED CARE PARTNERSHIP BOARD
HELD FRIDAY, 30TH JUNE, 2023 AT CONFERENCE ROOMS 1 & 2 - (GREATER MANCHESTER PENSION FUND BUILDING), GUARDSMAN TONY DOWNES HOUSE, 5 MANCHESTER ROAD, DROYLSDEN, M43 6SF

PRESENT

City Mayor Paul Dennett	Salford Council (Chair)
GM Mayor Andy Burnham	GMCA
Councillor Thomas Robinson	Manchester
Councillor Barbara Brownridge	Oldham Council
Councillor Daalat Ali	Rochdale
Councillor Eleanor Wills	Tameside
Councillor Jane Slater	Trafford Council
Councillor Keith Cunliffe	Wigan MBC
Mark Fisher	NHS GM Integrated Care
Warren Heppolette	NHS GM Integrated Care
Paul Lynch	NHS GM Integrated Care
Professor Manisha Kumar	NHS GM Integrated Care
Alexia Mitton	NHS GM Integrated Care
Claire Norman	NHS GM Integrated Care
Lynzi Shepherd	NHS GM Integrated Care
Professor Renote	NHS GM Integrated Care
Zoe Porter	NHS GM Integrated Care
Debra Thompson	NHS GM Integrated Care
Gill Gibson	NHS GM Integrated Care
Eamonn Boylan	GMCA
Gillian Duckworth	GMCA
Elaine Mottershead	GMCA

Debbie Watson	GM Directors of Public Health
Joanne Roney	Manchester City Council
Stephanie Butterworth	Tameside Adult Services
Lynne Stafford	Voluntary, Community & Social Enterprise Sector
Heather Fairfield	Healthwatch Greater Manchester
Janet Crofts	GM Primary Care
Luvjit Kandula	GM Primary Care
James Bull	UNISON
Rowena Burns	Health Innovation Manchester
Kathy Cowell	Provider Federation
Daniel Benjamin	Provider Federation

ICPB/14/23 WELCOME AND APOLOGIES

RESOLVED /-

That apologies be received and noted from Sir Richard Leese (NHS GM Integrated Care), Councillor Bev Craig (Manchester), Councillor John Merry (Salford), Chris McLoughlin (Stockport), Janet Wilkinson (NHS GM Integrated Care) and Evelyn Asante-Mensah (Provider Federation).

ICPB/15/23 CHAIR'S ANNOUNCEMENTS AND URGENT BUSINESS

There were no Chair's announcements or urgent business.

ICPB/16/23 DECLARATIONS OF INTEREST

There were no declarations received in relation to any item on the agenda.

ICPB/17/23 MINUTES OF THE PREVIOUS MEETING HELD ON 24 MARCH 2023

RESOLVED /-

That the minutes of the meeting held on 24 March 2023 be approved as a correct record.

ICPB/18/23 JOINT FORWARD PLAN

The Joint Forward Plan was presented by Warren Heppolette, Chief Officer for Strategy and Innovation, NHS GM Integrated Care. This statutory document had been drawn up to meet national requirements and as the delivery plan for the strategy. The ambitious structure was based on the six missions detailed in the strategy and had been tested and informed by Locality Boards and system wide programmes. The deadline for formal submission of the Forward Plan was today but this was being viewed as a milestone, rather than a date for conclusion, given that there was still ongoing work to be done.

Four points were highlighted:

- There was an immense amount of detail and content that needed to be phased appropriately.
- The main activity was on finalising performance frameworks and key metrics would be needed to measure successful implementation.
- There was recognition of the leadership review and the need for clarity around the operating model and accountability for delivery.
- Further work on planning for financial sustainability would be required and should be completed by the end of September.

Questions and Comments

- It was noted that the challenge to strengthen accountability was evident in this latest draft.
- There were various comments around the need for financial sustainability and how this would underpin planning across the whole system. Some of the financial challenges had been inherited and this should be explicit. The financial element of the strategy and Forward Plan was viewed as one of the highest priorities in being able to meet the ambitious outcomes set out in the strategy. The plan should be viewed as business-

as-usual and not additional services so that some of the financial provision was inherent. Everyone should be an advocate for the ambitions set out.

- Paragraph 8.3.3. (page 99) refers to mental health being “historically under-invested”. It was suggested that this could be strengthened by referring to the specific amount of under-investment.
- There should be a shift away from the cycle of waiting lists and inherent pressures. The challenges should not be under-estimated and support would be needed from members of the board. The Integrated Care partners would need to act as one if health outcomes were to be improved.
- A decisive move to prevention was needed, looking at where changes could be made to primary care. There needed to be a real willingness in primary care to work differently. Whilst there were still clearly developments and plans to be finalised, the services should not feel frozen in terms of transformation and should still move ahead. There was a mix of in terms of the current position of different services but there was an ambition that enthusiastic advocates would encourage progress with others.
- A member raised concerns about reaching marginalised groups e.g. where perhaps a particular community was not recognised and there were barriers to using particular services. Whilst there had been some equality proofing, there were limits as to how much could be done within the strategy. More could be achieved at a neighbourhood level. Lessons learned during Covid and the vaccination programme were given as an example of how services were tailored locally to particular communities.
- Primary care was increasingly dealing with additional problems for patients, for example, housing issues and domestic violence. More could be done if there was a drive to change and additional funding and resources were made available.
- The approach to develop further partnerships between the voluntary sector and primary care needed to be considered so that they work alongside each other in neighbourhoods.
- The approach to commissioning should be reviewed as this could drive some efficiencies.

RESOLVED /-

1. That the draft Joint Forward Plan be noted.

2. That the comments provided by the Committee be considered for inclusion in a future draft.

ICPB/19/23 IMPLEMENTING THE INTEGRATED CARE STRATEGY - STRONGER COMMUNITIES MISSION

This was the first paper presented to the Committee relating to the implementation of the strategy in consideration of what actions could be taken to deliver each of the missions. It focussed on Mission 1 – Strengthening our Communities.

There was a defined neighbourhood model published in 2019 and, whilst some progress had been made since then, there was now an opportunity to look deeper into neighbourhood working and take a different approach. The Greater Manchester Reform Delivery Executive had commissioned stock-take and lessons-learned exercises which had helped to shape the priorities along with follow-up discussions across Greater Manchester to look at key themes. There were some great examples of integration but, in other areas, there was a fear of losing autonomy. The ambition set out was for reform, innovation, integration, and equity.

There were some agreed areas of focus including the Live Well programme. This had highlighted how feeling lonely could result in multiple ill-health effects and was aimed at giving residents the opportunity to access activities and support and to feel connected. A funding bid had been made to the National Lottery for five accelerator sites for the Live Well programme to build district-based budgets for community led and determined prevention activity.

Another area of focus was around trauma response, safety and violence reduction to increase identification and support for victims. There was discussion around initiatives

such as the UniteHER programme and the impact of ADViSE on disclosure rates of domestic violence and abuse in sexual health clinics. Violence reduction approaches should be embedded in the whole system.

RESOLVED /-

That the update and discussion on Mission 1 – Strengthening our Communities be noted.

ICPB/20/23 GREATER MANCHESTER MENTAL HEALTH & WELLBEING STRATEGY

The Chair requested that this item be deferred for either a future meeting or for discussion separately, outside of the meeting.

A Committee member raised awareness of the Baton of Hope (www.batonofhopeuk.org) which was welcomed to Greater Manchester earlier this week. The vision for the Baton of Hope initiative was a zero-suicide society and for suicide prevention to be openly and widely discussed. The links between this and the earlier discussion about violence reduction were noted. The Trades Union representative reported that there had been a rise in violence incidents in the care industry and that hybrid working had also exacerbated some situations for members. Funding had been applied for relating to a project in Wigan about awareness training for all levels of staff to identify victims of violence.

RESOLVED /-

That arrangements be made for the Greater Manchester Mental Health & Wellbeing Strategy paper to be deferred to a future meeting and/or discussed separately.

ICPB/21/23 FORWARD PLAN FOR NHS GM INTEGRATED CARE PARTNERSHIP BOARD

The Forward Plan for development of the Integrated Care Partnership Board had been circulated. The suggestion was to ensure that engagement drives the work of the Board and that mechanisms should be established to drive the agenda and inform discussions

and work between Board meetings. There could also be additional single-subject or themed sessions.

RESOLVED /-

That the proposals for the Forward Plan be noted.

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Greater Manchester Integrated Care Partnership Board

Date: 29th September 2023

Subject: Implementing the Integrated Care Strategy – Mission 2: Helping People Stay Well and Detecting Illness Earlier

Report of: Sarah Price – Chief Officer: Population Health and Inequalities (NHS GM)
Manisha Kumar – Chief Medical Officer (NHS GM)

SUMMARY OF REPORT:

1. The Greater Manchester Integrated Care Partnership Strategy was approved by the ICP Board in March 2023 and is underpinned by a Joint Forward Plan which was signed of in June 2023.

2. A key part of the Board's role in the implementation of our strategy and plan will be to examine in depth the delivery of the six missions in the strategy with a focus on the key system actions we can take collectively to deliver the missions effectively, efficiently and with impact on health outcomes and inequalities.

3. This meeting of the Board will focus on Mission 2 - Helping people stay well and detecting illness earlier.

4. A slide deck is enclosed with this cover note which explores in more detail:

   a) An overview of the priority actions in Mission 2

   b) What are we doing? Strategic shift towards prevention: GM Prevention and Early Intervention Framework

c) How will we achieve this?

- Fairer Health for All
- NHS GM Clinical Effectiveness Programmes

d) What it looks like in practice – summary examples:

- Making Smoking History in Greater Manchester
- Ending All New Cases of HIV in Greater Manchester by 2030
- Tackling Alcohol Harm
- GM Moving
- Mental Wellbeing
- Early Cancer Diagnosis
- CVD Prevention – Blood Pressure Optimisation
- A Multimorbidity Approach – Manchester Locality
- GM Dementia and Brain Health Delivery Plan

RECOMMENDATIONS:

The Greater Manchester Integrated Care Partnership Board is asked to:

- Note the update on Mission 2 and the work that is ongoing.

- Endorse the Prevention and Early Intervention Framework as a visual representation of our collective approach to preventing poor health.

- Endorse Fairer Health for All as our approach to ensuring that health inequalities are embedded across the work of NHS GM.

- Endorse the approach set out within the NHS GM Clinical Effectiveness Programme

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Mission 2: Helping People Stay Well and Detecting Illness Earlier

Greater Manchester Integrated Care Partnership

GM Integrated Care Partnership Board

29th September 2023

Summary of Report

a) **An overview of the priority actions in Mission 2**

b) **What are we doing?**

- Strategic shift towards prevention: GM Prevention and Early Intervention Framework

c) **How will we achieve this?**

- Fairer Health for All
- NHS GM Clinical Effectiveness Programmes

d) **What it looks like in practice – summary examples:**

- Making Smoking History in Greater Manchester
- Ending All New Cases of HIV in Greater Manchester by 2030
- Tackling Alcohol Harm
- GM Moving
- Mental Wellbeing
- Early Cancer Diagnosis
- CVD Prevention – Blood Pressure Optimisation
- A Multimorbidity Approach – Manchester Locality
- GM Dementia and Brain Health Delivery Plan

Mission 2: Summary of Priority Action Areas

Mission 2: Helping people stay well and detecting illness earlier

Areas of Focus	Actions
Tackling inequalities	Reducing health inequalities through CORE20PLUS5 (adults)
	Equity in access to care and improved experience and outcomes for all children and young people (CORE20PLUS5 clinical priorities)
	Implementing a GM Fairer Health for All Framework
Supporting people to live healthier lives	A renewed Making Smoking History Framework
	Alcohol
	Enabling an Active Population
	Promoting Mental Wellbeing
	Food and Healthy Weight
	Eliminating New Cases of HIV and Hepatitis C
	Increasing the uptake of vaccination and immunisation
Upscaling secondary prevention	Early Cancer Diagnosis
	Early detection and prevention of Cardiovascular Disease
	Earlier diagnosis of Respiratory Conditions through Quality Assured Spirometry
	Early detection of unmet health needs for those living with Learning Disability and those with Severe Mental Illness
Living well with long-term conditions	Managing Multimorbidity and Complexity
	Optimising Treatment of long-term conditions
	Expansion of the Manchester Amputation Reduction Strategy (MARS) across NHS GM
	The GM Dementia and Brain Health Delivery Plan
	Taking an evidenced based approach to responding to frailty and preventing falls
	Anticipatory Care and Management for people with life limiting illness

A Strategic Approach: GM Prevention & Early Detection Framework

A Comprehensive Approach to Prevention and Early Detection

- Preventing poor health, and returning people to good health as soon as possible following illness, are fundamental to achieving an operationally and financially sustainable health and care system.
- To achieve this, we need to enable a system-wide strategic shift towards Prevention.
- Prevention and Early Detection are complex and wide-ranging endeavours.
- To reflect this, we have developed an NHS GM Prevention and Early Detection Framework which sets out the breadth of preventive activity that is required to achieve the scale of transformational change that is required.
- The Framework sets out the priority areas of focus, our approach to addressing them, the system characteristics and enablers that are required to achieve impact, and the outcomes that we would anticipate.
- The Framework directly frames the delivery of Missions 1 to 3 of the Strategy and JFP, and also has significance for missions 4 to 6.
- Focussing our efforts on parts of the Framework will not be sufficient as all parts are interdependent and reflect the journey of our population as the progress through life.

Achieving the aims of the Greater Manchester ICP Strategy and Joint Forward Plan requires a comprehensive commitment to Prevention and Early Detection consisting of a system-wide approach to health creation and delivery of a person-centred, upstream model of care

Shaping GM as a place conducive to good health	Supporting people to live healthier lives	Early detection of risk and early diagnosis of illness	Living well with long-term conditions	Leading to	Better outcomes

Achieved by focussing resource and energy on the following area

Working together to address the root cause of ill health

We must address the 'causes of the causes' of ill health by considering the environments in which people live and work, and the experiences they have. These are the biggest determinants of health outcomes and inequalities. These often sit outside the direct control of the health system and require system-wide collaboration focussed on:

- Socio-economic factors: Education; employment; income; Social Capital
- Built and Natural Environment: Air Quality; Climate Change; Transport and Active Travel; Green Space, Housing
- Commercial influences

This will require NHS GM and providers to collaborate with key non-health partners at place and city-regional level to shape neighbourhoods that are conducive to good health.

Delivering comprehensive approaches to tackling behavioural risk factors

55% of years of life lost prematurely and 29% of years lived with disability are due to modifiable risk factors such as diet, alcohol, tobacco, physical activity, and drug use.

We recognise the stark disparities in the prevalence of healthy and unhealthy behaviour and variance in terms of the support that is available to people.

Addressing this will require us to play our role in creating environments that enable healthy choices and ensure that people who require additional support are able to access evidence-based interventions in a timely manner.

Upscaling secondary prevention across all parts of NHS

We must take a system approach to identity causes of ill health earlier by supporting people to take an active role in their health. Proximal risk factors can be detected and managed, and prevention measures (*such as screening, vaccination and immunisation, targeted health checks and evidence-based secondary prevention measures*) can sever the link between these risks and the development of preventable conditions.

The greatest impact will be achieved through an approach rooted in 'universal proportionalism' which includes universal services for all, and additional support for those who experience the worst health outcomes and inequalities, the highest risks, and who live in places that are not conducive to good health.

Optimising treatment and management of health conditions

For people who are diagnosed with a long-term health condition, it is important to provide timely access to high-quality, integrated and sustainable health and care where and when they need it.

It must be:

- Person-centred & personalised
- Holistic and mindful of multi-morbidity
- Supportive of people staying at home
- Anticipatory

Doing this in a way which tackles inequalities and supports the achievement of Core20Plus5 (including C20+5 CYP) ambitions requires a recognition of the additional challenges faced by some members of communities and rooting delivery in neighbourhoods and communities.

Tackling Inequalities & Reducing Unwarranted Variation
GM Fairer Health for All Framework
Core20Plus5 & Core20Plus5 CYP

Improve health and wellbeing leading to improved Healthy Life Expectancy and Life Expectancy

Reduction in inequalities and unwarranted variation in health outcomes and experiences

Reduction in preventable or unmet health needs leading to a reduction in demand

Increased economic and social productivity as a result of reduced ill-health

Everybody has an opportunity to live a good life

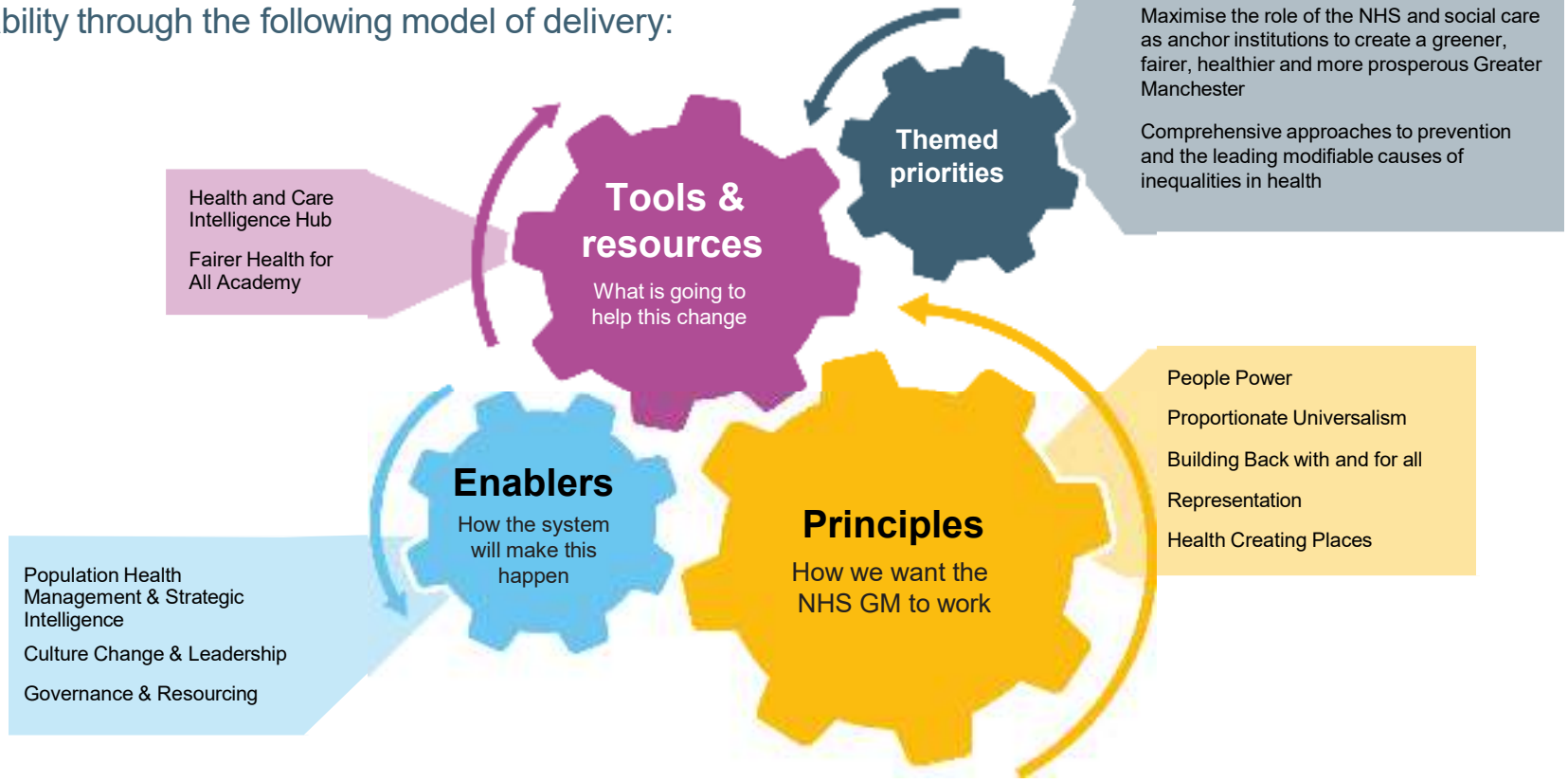
Harnessing the following system characteristics

Person and Community Centred Approaches to Health and Care	Strategic Intelligence and Population Health Management	Whole System Partnerships/ Collaboration	Public Service Reform	A highly skilled and prevention focused Workforce	Clinical Excellence & Leadership	Finance, Contracting & Accountability rebalanced to increase focus & investment in Prevention & Early Detection	Evidence, Research, Technology and Innovation

Fairer Health for All

Fairer Health for All In Summary

The Greater Manchester Fairer Health for All framework will enable neighbourhood, locality and system action on health equity, inclusion and sustainability through the following model of delivery:



Fairer Health for All Aims and Objectives

What we will do:

1 **Improve health and wellbeing to narrow the gap in healthy life expectancy**
Between men and women living in Greater Manchester, between all ten localities, as well as the England average by at least 15% by 2030.

2 **Reduce unwarranted variation in health outcomes and experiences**
Leading to significant reductions in health inequalities between and within localities in avoidable mortality by 2027. Reducing avoidable mortality will also require us to eliminate the fivefold difference between the highest and lowest social groups in the experience of having 3 or 4 multiple health harming behaviours such as smoking and excess alcohol consumption through whole system approaches.

3 **Increased social and economic activity because of reduced ill-health**
Narrowing the 15-year gap in the onset of multiple morbidities between the poorest and wealthiest sections of the population to 5 years by 2030.

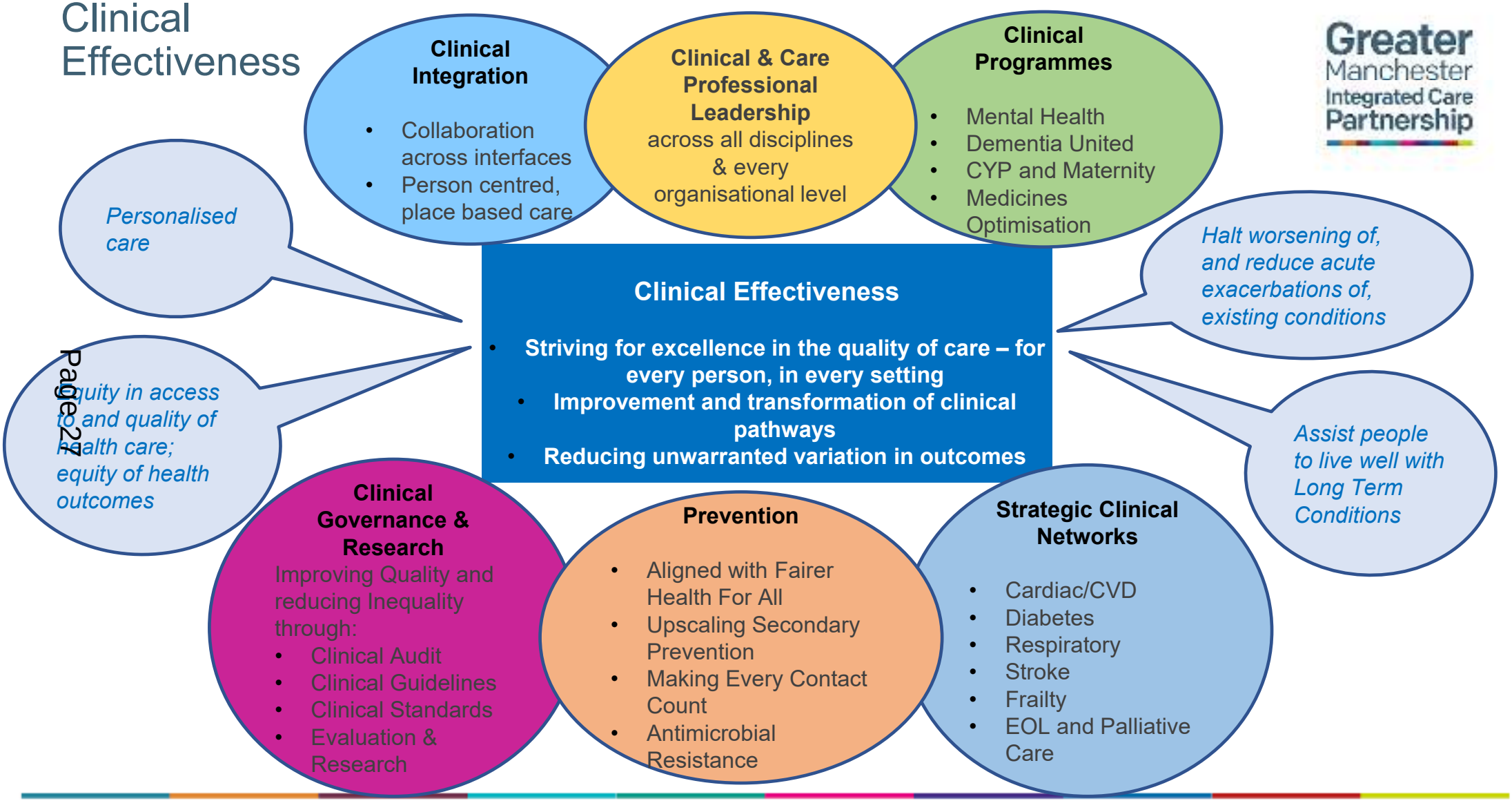
4 **Reductions in preventable or unmet health needs leading to reductions in demand**
Evidenced in part by closing the health inequalities gap in smoking with England by 2030. Smoking is our single greatest cause of preventable inequalities and 1 in 4 hospital patients' smoke.

5 **Eliminating the difference in life expectancy for those with serious mental illnes and incidence of physical health conditions**
For people experiencing mental health conditions by 2030.

6 **Ensuring all Greater Manchester children have the best start in life** Through measures including lower infant mortality by 2027, and when compared to England peers.

NHS GM Clinical Effectiveness Programmes

Clinical Effectiveness

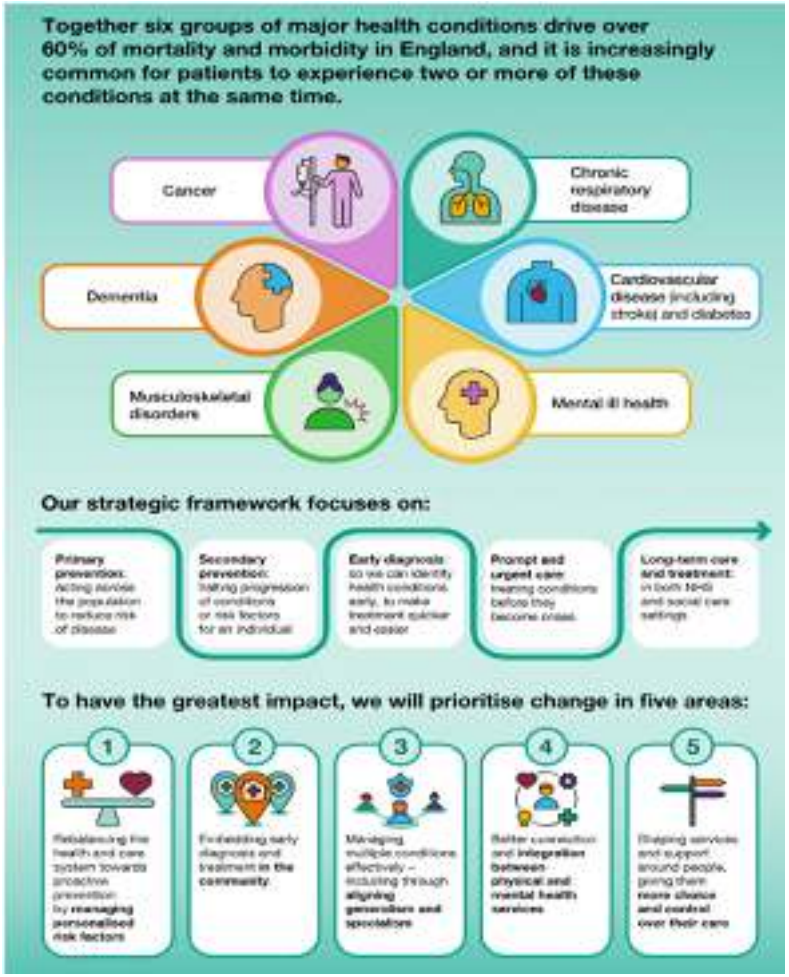


Major Conditions Strategy

- DHSC Strategy launched August 2023

Emphasis on the shift away from acute, reactive care towards:

- Prevention of ill-health and prevention of worsening illness
  Early diagnosis and treatment
  Managing multi-morbidity and complexity
- Alignment with our ICP Strategy and Mission 2 of JFP and Early Detection are complex and wide-ranging endeavours



Making Smoking History

Making Smoking History Approach

Based on the World Health Organization's Framework Convention on Tobacco Control (WHO FCTC), Greater Manchester uses the adapted GMPOWER model to underpin its strategy to reduce demand for tobacco.

- **G** Growing a social movement
- **M** Monitoring tobacco use and prevention policies
- **P** Protecting people from tobacco smoke
- **O** Offering help to stop smoking
- **W** Warning about the dangers of tobacco
- **E** Enforcing tobacco regulation
- **R** Raising the real price of tobacco

MSH Highlights

- VCFSE leadership for Making Smoking History across city region
- Research, monitoring and evaluation through GM ARC and STS
- Expanding Smokefree Spaces with WHO Partnerships for Healthy Cities and as part of local Healthy Spaces
- Behaviour change campaigns shaping SF norms and quitting
- Advocacy for further regulation plus GM-wide enforcement activity
- Advocacy for price escalator plus regional illicit tobacco programme
- Local & specialist services, SF app, phoneline, pharmacy, GP – plus targeted Social Housing focus

Long Term Plan Delivery Highlights and Goals 2023/2024

Specialist Tackling Tobacco Dependency (TTD) services

- 100% delivery in all acute services since 2020
- 100% delivery in all maternity services since 2019
- 100% delivery in tertiary care since April 2023
- 100% delivery in all mental health trusts by September 2023
- NHS Staff Stop Smoking Offer in all GM Trusts

Coming this year…

- Advanced Pharmacy pathway rollout
- System wide digital platform to provide better reporting and monitoring of TTD pathway smoking status and quit journey (in development)
- Smokefree Hospital Toolkit for Trusts, following outcomes of behavioural insights review project
- Enhanced training and engagement package for all healthcare professionals and clerical staff

Making Smoking History Impact

Greater Manchester Integrated Care Partnership

4.1

percentage point reduction in adult smoking prevalence

90,000

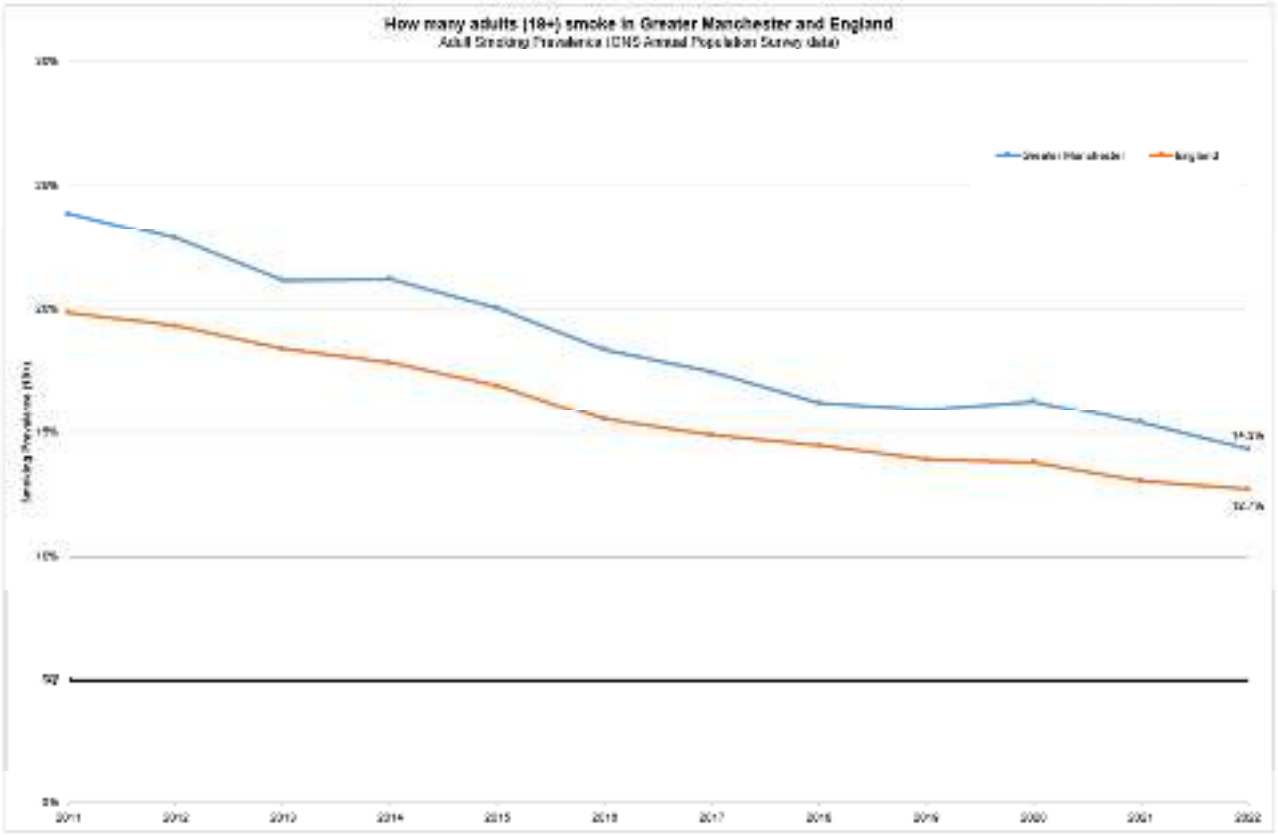
fewer smokers

1/3

reduction in smoking at time of delivery

4,500

more babies born smokefree



Ending all new cases of HIV by 2030

Ending HIV – A multicomponent, partnership approach

Greater Manchester Integrated Care Partnership

TARGETED WORK TO ADDRESS INEQUALITIES

Scaling and extending reach of community HIV prevention and sexual health interventions – condom/lube distribution, face-to-face and digital information, tailored resources and outreach/ community engagement

HIV/STI testing promoted and available through a variety of routes (PaSH)
Year-round access to postal self-sampling kits (SH24)
Opt-out testing in EDs

Intensive Support Service for people living with HIV who have complex needs – improving access to care, effective treatment and support (GHT)

Peer-led combination prevention campaign and website (PaSH)

Primary and Secondary Care awareness training and podcast featuring Positive Speakers (MFT, GHT, PASH)

E-learning module for healthcare professionals addressing HIV stigma (MFT, GHT & Dibby Theatre)

Positive Speaker programme reaching into a variety of settings (GHT)

HIV in the workplace resources (PASH)

ENDING HIV STIGMA AND DISCRIMINATION

Ending HIV – Highlights

Around 6,375 people living with HIV in GM **(95%) are aware of their status.***

99% of people aware of their status are receiving treatment to manage their condition.*

Over 130,000 people have been tested in Manchester and Salford emergency departments for HIV and/or HCV since April 2022. With **56 new diagnosis of HIV and 170 new diagnoses of HCV.**

97% of people being treated have an undetectable viral load meaning the condition cannot be passed on to others.*

Since 2011, there's been a 58% reduction in new HIV diagnoses amongst GM residents first diagnosed in the UK. **

36 people living with HIV and 46 people living with HCV have been identified who already had a diagnosis but **were not accessing care**. **53 people living with HIV and 140 people** living with HCV have now been linked to care, and many **have accessed community support.**

Greater Manchester attained 95:95:95 UNAIDS / Fast Track City Targets 9 years early

**UKHSA England Fast Track Cities Update 2022*
***OHID Sexual Reproductive Health Profiles 2019 data*

Ending HIV - Support and Impact

Greater Manchester Integrated Care Partnership

Evaluation of the Intensive Support Service showed that:

- People accessing the service had on average **96% improvement in clinic attendance**. They also had increased adherence to anti-retroviral (ARVs) resulting in nearly four out of five clients (79%) having, or being close to having, an undetectable viral load.
- 79% of people reported an **improvement in general wellbeing** within 9 months of allocation to the programme, and 85% reported an improvement in general wellness.
- After engagement with the service, **3 pregnant clients gave birth to HIV negative babies**.

ED opt-out diagnosed patient, male, aged 50

"I attended the emergency department for a completely unrelated reason. I was initially angry about being tested as I felt I had control taken away from me, but after being diagnosed and speaking with the doctors and learning HIV is just a long-term manageable condition and with treatment It does not reduce life expectancy, I now feel very grateful I have been diagnosed as I don't think it's something I would have been tested for in the near future."

Intensive support patient, female

"P wanted to say how grateful she was for Lauren's help. P had totally disengaged from services and was then admitted to Wythenshawe very unwell last year with a prolonged admission of 2 months with confusion. Since being discharged she has remained stable on treatment under the care of Withington, reached an undetectable viral load and her immunity is improving. She is now living independently and with Lauren's help now has PIP and a blue badge."

Tackling Alcohol Harms

Tackling Alcohol Harms Context

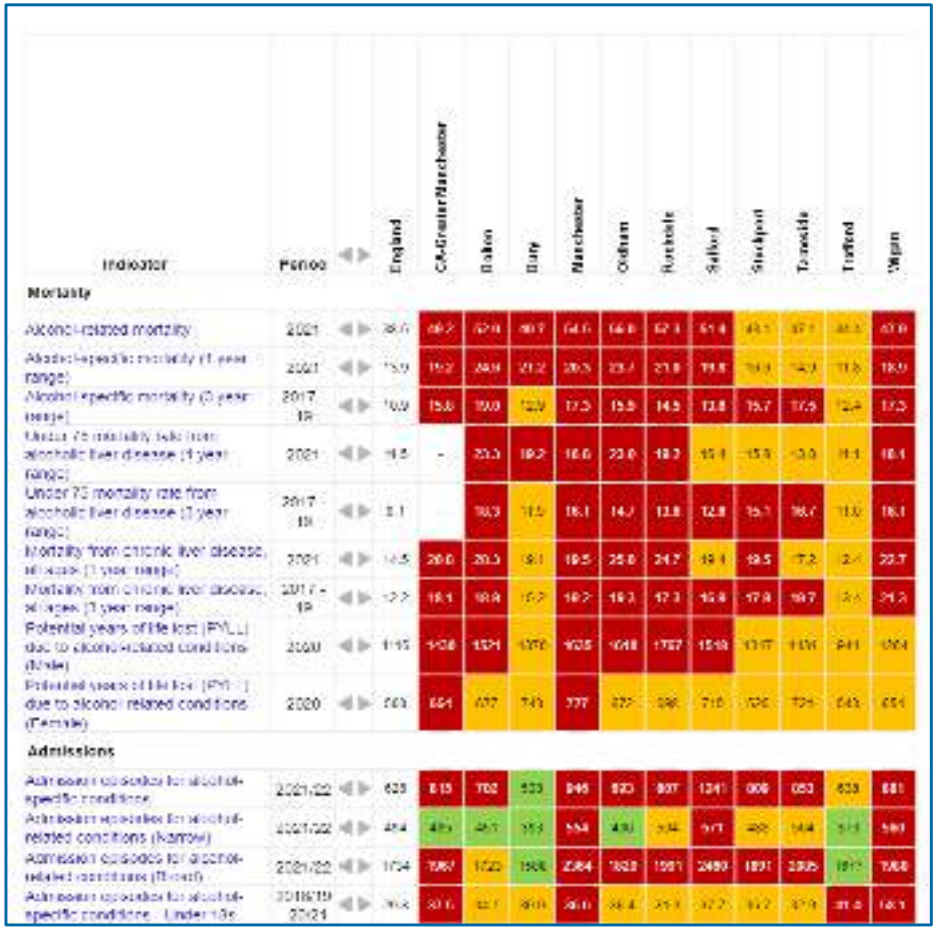
Greater Manchester Integrated Care Partnership

Our System Challenge

GM performance outcomes are worse than the national average across almost all key national indicators.

Alcohol is a significant drive of morbidity, mortality and demand.

Alcohol is a systemic challenge which require a whole system response.



Indicator	Period	England	CA/GreaterManchester	Bolton	Bury	Manchester	Oldham	Rochdale	Salford	Stockport	Tameside	Trafford	Wigan
Mortality													
Alcohol-related mortality	2021												
Alcohol-specific mortality (1 year range)	2021												
Alcohol-specific mortality (3 year range)	2017 - 19												
Under 75 mortality rate from alcoholic liver disease (1 year range)	2021		-										
Under 75 mortality rate from alcoholic liver disease (3 year range)	2017 - 19												
Mortality from chronic liver disease, all ages (1 year range)	2021												
Mortality from chronic liver disease, all ages (3 year range)	2017 - 19												
Potential years of life lost (PYLL) due to alcohol-related conditions (Male)	2020												
Potential years of life lost (PYLL) due to alcohol-related conditions (Female)	2020												
Admissions													
Admission episodes for alcohol-specific conditions	2021/22												
Admission episodes for alcohol-related conditions (Narrow)	2021/22												
Admission episodes for alcohol-related conditions (Broad)	2021/22												
Admission episodes for alcohol-specific conditions - Under 18s	2018/19 - 2020/21												

To tackle this our strategic priorities are:

- **Protecting Children and Young People from alcohol-related harm**
- **Providing high quality and integrated services**
- **Engaging people and communities**
- **Research, insight and future planning**

Tackling Alcohol Harms Deliverables

1. Protecting Children and Young People from drug and alcohol-related harm

- Maternity Equality and Equity Action Plan – "*Embed universally proportionate interventions to prevent the incidence and associated harms of alcohol use in pregnancy*" C
- Continued delivery of our nationally leading Alcohol in Pregnancy programme, and the implementation of the NICE Quality Standards for Fetal Alcohol Spectrum Disorder (FASD)
- Primary research into the drug and alcohol consumption behaviours of children and young people in Greater Manchester

2. Providing high quality and integrated services for those at the greatest risk of drug and alcohol-related health harms:

- Greater Manchester Maternity Equality and Equity Action Plan – "*Accelerate preventative programmes that engage those at greatest risk of poor health outcomes*".
- Strengthen end-to-end support for those experiencing drug and alcohol harm and/or those who are drug or alcohol dependent, including those who have co-morbid mental health needs.
- Monitor and evaluate Alcohol Care Teams (ACTs) in GM, improve quality and reduce variation, and assess future options post 2023/24 when funding ceases.
- Strengthen palliative and end of life care for individuals with drug or alcohol needs
- Reduce high risk opioid prescribing and routinely monitor the newly developed NHS GM Dependence Forming Medicines dashboard.
- Continue to support the development and delivery of HIV and HCV Emergency Department (ED) opt-out testing.
- Utilise Liaison and Diversion and Reconnect services to identify people in custody, court and through the gate and refer to substance misuse services

3. Engaging people and communities

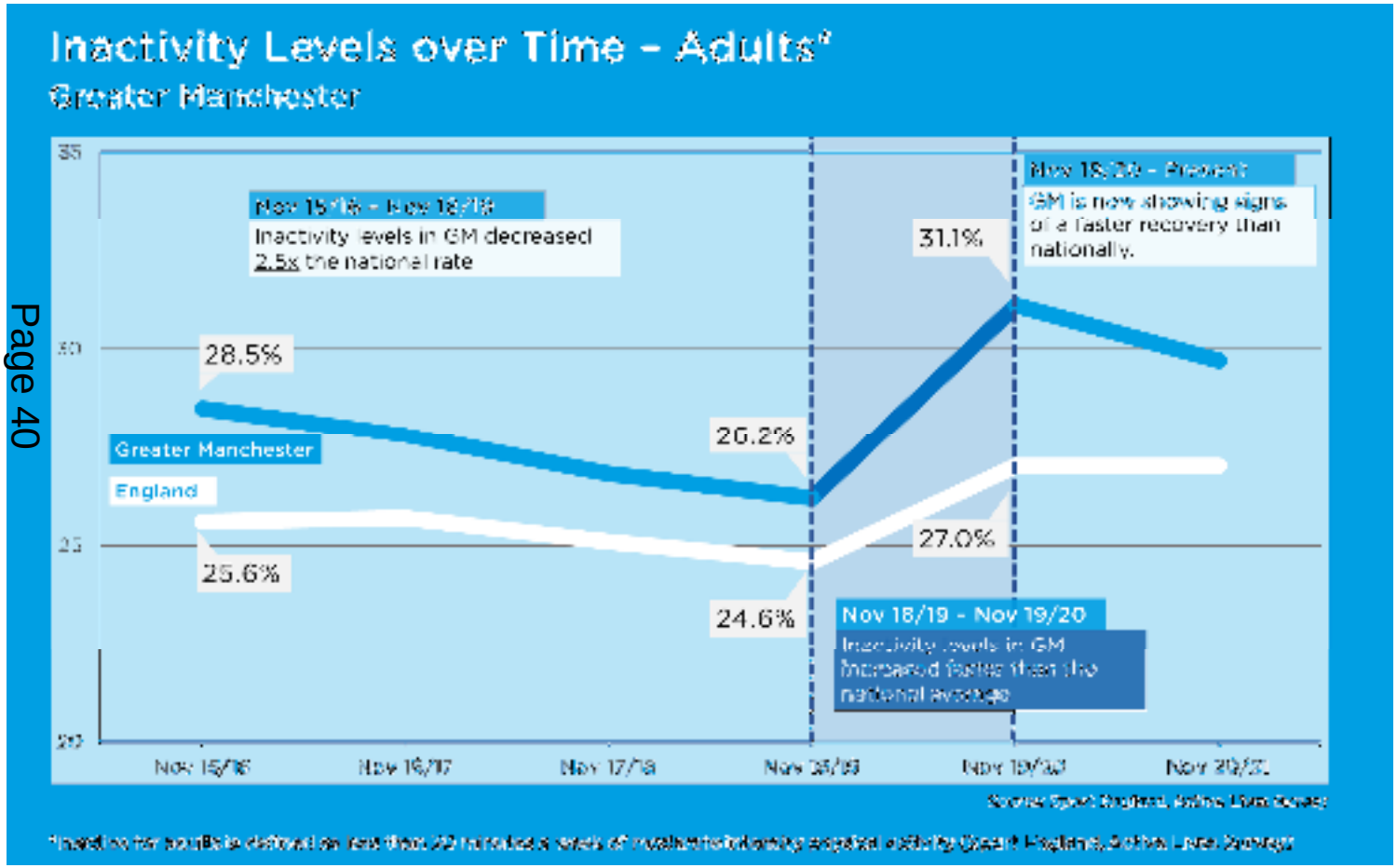
- Commission a community-led '*Ambition for Alcohol*' project aimed at catalysing a social movement for change in Greater Manchester, and a community-led demand for action.

4. Research, insight and future planning:

- Develop, implement, and commission the independent evaluation of an evidence-based and co-produced NHS GM plan to tackle the health harms associated with alcohol underpinned by:
- A Rapid Evidence Synthesis focussed upon the most effective approaches to reducing alcohol-related harm.
- An alcohol-focussed strategic evidence and research partnership with the NIHR Applied Research Collaboration (Greater Manchester).
- Focussed engagement with key risk cohorts within the GM population, including those from inclusion health cohorts, those who fall within the Core20Plus5 framework and those who have high levels of risk, but low levels of engagement.

Keep GM Moving

Keep GM Moving Context



Keep GM Moving Highlights

- Development of **GM Moving Integrating Physical Activity in Health and Care Forward Plan (23-28)** to combat this including work to date:
- Leading **priorities across the whole of the GM Moving in Action strategy** to **support Covid-19 recovery and resilience** and integration of physical activity at neighbourhood, locality and GM levels.
- Alignment of plans and investments to address health inequalities (e.g., **Together Fund** and Green Social Prescribing).
- Contributing to **Active Partnership Health and Inactivity Network** to connect with similar programme outside of GM.
- **Commissioning The Foundry to develop, test and learn from marketing and communications** approaches to develop the next phase of GM Moving and Health Integration.
- Developing '**Move More Better Conversations' to** increase knowledge of the benefits of moving for people working directly with communities.
- Continuing to grow and embed **the GM Walking Ambition** including a **Learning Event and GM Walking Grants** focused on health and long-term conditions.
- GM Walking Festival 2022 - **210 walks** were hosted by **66 organisations (10,000+ walkers** engaged in festival 2019-22).
- **Physical Activity and Health Integration Learning in Action Event** (over 80 attendees).

Mental Wellbeing

Mental Wellbeing Highlights

- There are **3,981 people** in GM in contact with mental health services for every 100,000 of the population compared to 2,176 nationally*. With the impact of Covid-19 and the cost of living crisis, mental wellbeing support is needed more than ever.
- We are currently working with OHID on a **nation wide community of practice linked to Mental Health prevention.**
- Work has been ongoing with population health analysis and Public Health leads across GM to co-develop **a Mental Wellbeing Outcomes Framework.**

This year, sees the development of **a system wide,, Mental Health and Wellbeing Strategy** delivered as part of the GM consultation workshop as well as the delivery of the following key achievements:

GM Mental Wellbeing Grants fund were awarded to over 90 GM VCSE organisations in 2022-23. A total of £150K allocated.

9 projects funded through the Culturally Appropriate Mental Wellbeing fund - £91,553 was awarded in May 2022 to communities specifically working with marginalised ethnic groups to reduce the disparities experienced by communities who experience inequalities.

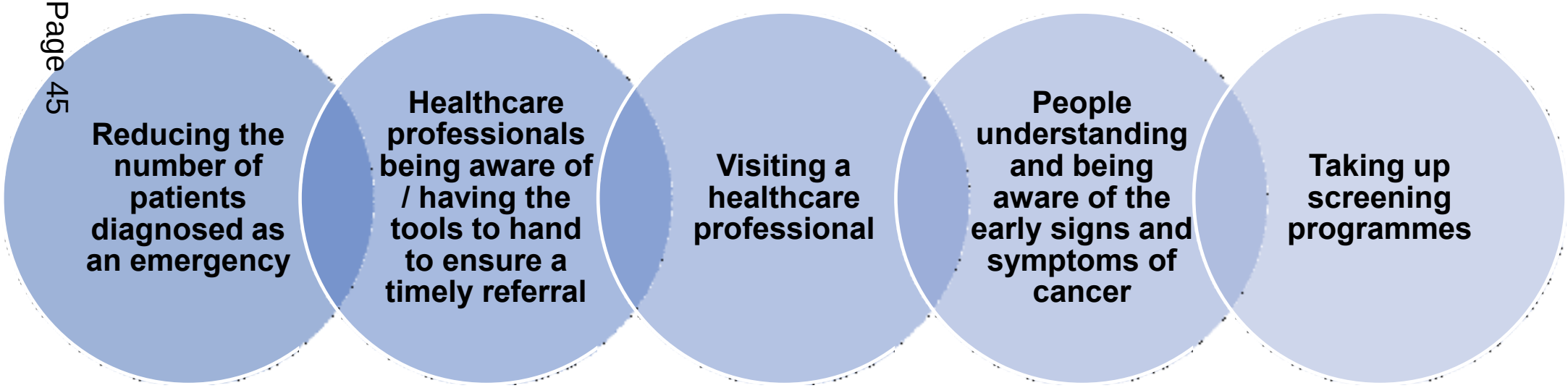
- **Eight of the 10 boroughs now have Councillor Mental Health Champions.**
- **Over 1,600 people participated in direct Connect 5 courses led by GM partners** (2020-2021) and over 200 train the trainers were trained to cascade Connect 5. GM has continued to offer direct delivery sessions (150 learners) to PCN workforce, Faith Sector and some localities who are not yet delivering Connect 5.

*Health Innovation 2019

Early Cancer Diagnosis

Early Cancer Diagnosis Context

By 2028, **75%** of people with Cancer will be diagnosed at an early stage (stage 1 or 2). Earlier and faster diagnosis of cancer is dependent on identifying and employing a range of interventions:



Greater Manchester Cancer Alliance – Early Diagnosis Programme Plan on a Page

Cross cutting: Health Inequalities Work Programme tackling inequalities across screening services, signs and symptoms recognition and barriers to seeking help.

1. Primary Care

Timely Presentation

+ Deliver projects encouraging symptom awareness and timely presentation from the public, supported by the Cancer Alliance's Communications and Engagement team.
+ Public & patient messaging re screening programme uptake
+ Tackle health inequalities with demographic data insights and produce resources in various languages and formats.
+ Work with each GM locality to deliver early diagnosis messages and engagement activities with their local population.

Primary Care Pathways and GP Education

+ Work with the 65 GM Primary Care Networks' Cancer Champions to support effective primary care pathways into secondary care on a suspected cancer pathway.
+ Review the Suspected Cancer Referral Forms annually.
+ Collaborate with GatewayC, GM Cancer Academy and GM Cancer pathway boards to deliver webinars and study days, increasing Primary Care knowledge and confidence in recognising and referring a suspected cancer.

PCN Engagement

+ Communicate with the PCN Cancer Leads via monthly meetings and bulletin; facilitate communities of practice.
+ Provide support to meet the requirements of the PCN DES (screening and symptomatic) via data searches, education and training resources.
+ Deliver Quality Improvement training aligned with the PCN DES.

2. Projects

NHSE Funded Projects

Prostate Cancer Case-finding

+ Mobile PSA testing health clinic in a van which is raising awareness of prostate cancer. The service is ONLY by invitation and for men, or people with a prostate, who are age 45 or over and fit the following criteria: black; family history of prostate, breast or ovarian cancer

Pharmacy Referral Project

+ Pilot project to test feasibility and acceptability of direct referral routes by Community Pharmacy into secondary care.
+ Evaluation will include patient, referrers and primary and secondary care experience.

Targeted Lung Health Checks

+ Establish local governance to provide oversight and coordination of programme delivery and expansion
+ Lead on locality engagement to ensure GM stakeholders can support programme expansion
+ Design and deliver communication and engagement projects to increase uptake and participation

Colon Capsule Endoscopy

+ National pilot of CCE to release capacity in LGI FDS pathway
+ Support pilot sites to establish and maintain CCE services
+ Ensure pilot sites report data efficiently and participate in the pilot evaluation

Cytosponge

+ National pilot of cytosponge to release capacity of endoscopy services.
+ Support pilot sites to establish and maintain cytosponge services

Lynch Syndrome

+ Support GMSAs in improving Lynch Syndrome testing in colorectal and endometrial cancer patients, as per NICE guidance
+ Embed mainstreaming of genetic testing required to diagnose Lynch Syndrome

3. Programme Governance

Early Diagnosis Programme Board

Steers the Early Diagnosis programme and ratifies decisions to be taken to Cancer Board. Membership includes representatives from GM Cancer programmes, GM Commissioning, Public Health, VCSE sector, and research.

GM Cancer Board

Brings together cancer providers, commissioners, clinicians, people affected by cancer and other colleagues to reflect the entire cancer system.

4. Innovation

Local Innovation

Commissioned 5 projects that result in innovative methods and outcomes for early cancer diagnosis.

GRAIL

+ Support retention of trial participants through producing and disseminating public-facing comms.
+ Work with providers to ensure clinical pathways for onward referral are functional

FIT

+ Implement FIT for symptomatic lower GI patients in primary care.
+ Support PCN's to monitor and achieve IIF target for lower GI cancer referrals.
+ Produced primary care pathway for Lower GI/FIT and education resources.

Early Cancer Diagnosis Actions

Primary Care Pathways: Review of referral forms for all cancer pathways; continued development of Clinical Decision Support Tool 'Think Cancer'; ongoing education programme for primary care – pathway specific; Quality Improvement Training to commence Sept 2023; monthly PCN bulletins and briefing calls

Symptom Awareness: Ongoing patient and public facing comms – participate in and amplify national 'Help Us Help You' plus specific local campaigns for skin, gynae, blood cancer, Oesophageal, lung, urology podcasts for cancer and Health Inequalities

Targeted Case Finding: Targeted Lung Health Checks expansion into Wigan locality from October 2023; Prostate Cancer Case Finding project ongoing; Liver case finding – 3 GM PCNs selected for national project

Data and evidence drive programme: Rapid Cancer Registration data shows 57% stage 1 or 2 Q3 2022-23 (variation – breast 78% OG 24%; Bolton FT 67% Stockport FT 45%)

Innovation: Investment in Early Cancer Diagnosis Innovation in 2023-24/5; Pathway specific projects in areas with greatest scope for improvement and impact – initially lower GI (colorectal) gynae and lung; Prehab4Cancer evaluation and scope expansion

Early Cancer Diagnosis Actions

Greater Manchester Integrated Care Partnership

BREAST SCREENING

Undertake a deep dive to ensure screening locations are being utilised efficiently, meeting the capacity needed to maintain 36-month round length for the population and identify high DNA locations to improve access and uptake. This work forms part of the improving specialist care board breast workstream.

BOWEL SCREENING

Continue the staged roll-out of the NHS Bowel Cancer Screening Programme to aged 54-year-olds in Manchester, Trafford, Stockport and Tameside. Lynch syndrome surveillance roll out completed within all screening programmes.

Increase the uptake of diagnostic colonoscopy following SSP consultation across GM: including undertaking an audit with patients and comparing data and processes with comparable areas and working with the system and diagnostic pathways to increase the number of sites delivering diagnostic colonoscopy

CERVICAL SCREENING

Implement mitigating actions to ensure the turnaround time of 14 days for cervical screening results is achieved and maintained

DATA

Progress work to ensure that detailed and timely data on cancer screening from the GM Shared Care Record is available at a GM, locality, and practice-level
Improve the data recording for the faster diagnosis standard for cervical and bowel screening programmes

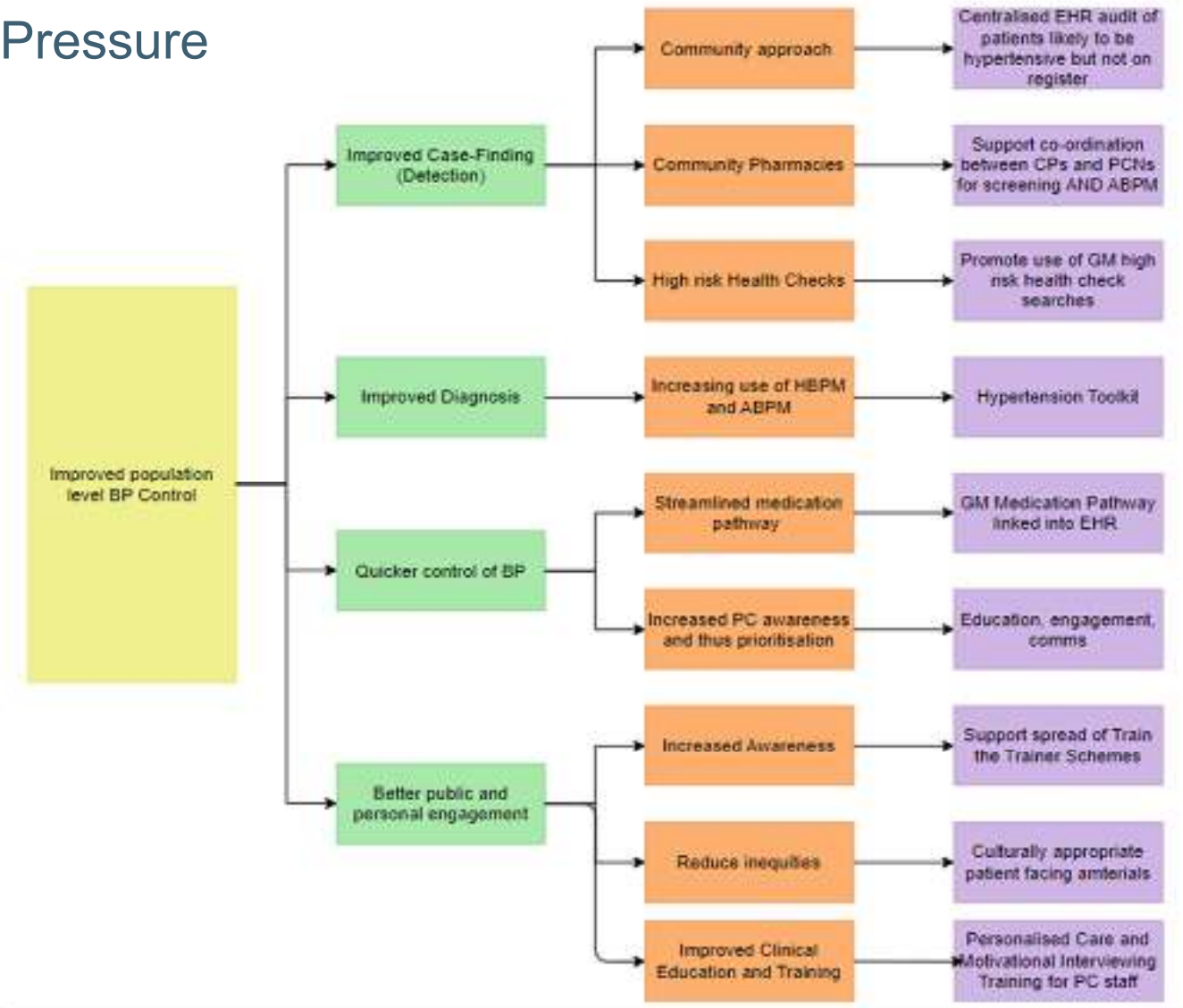
CVD Prevention – Blood Pressure Optimisation

Approach to Optimising Blood Pressure (BP)

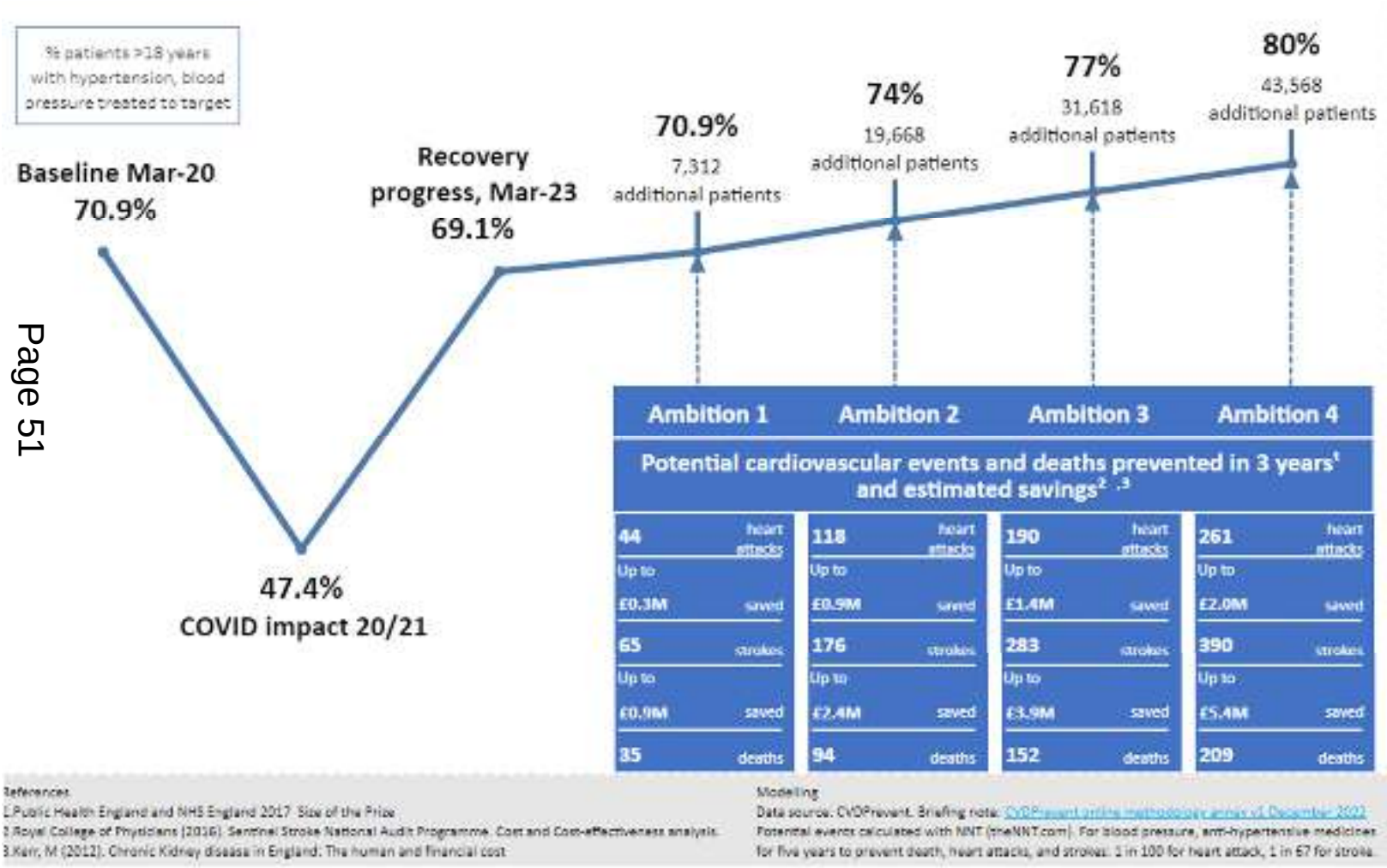
A population health, behavioural and system approach to improving Blood Pressure Control across GM has been taken.

This has led to an implementation that is:

- Community based
- Targets current key barriers
- Tackles health inequalities
- Reduces unwarranted variation



Impact of Optimising Blood Pressure (BP)



Greater Manchester Integrated Care Partnership

If we achieve **Ambition 1**, this will save:

- 44 heart attacks
- 65 strokes
- 35 deaths
- £1.2m

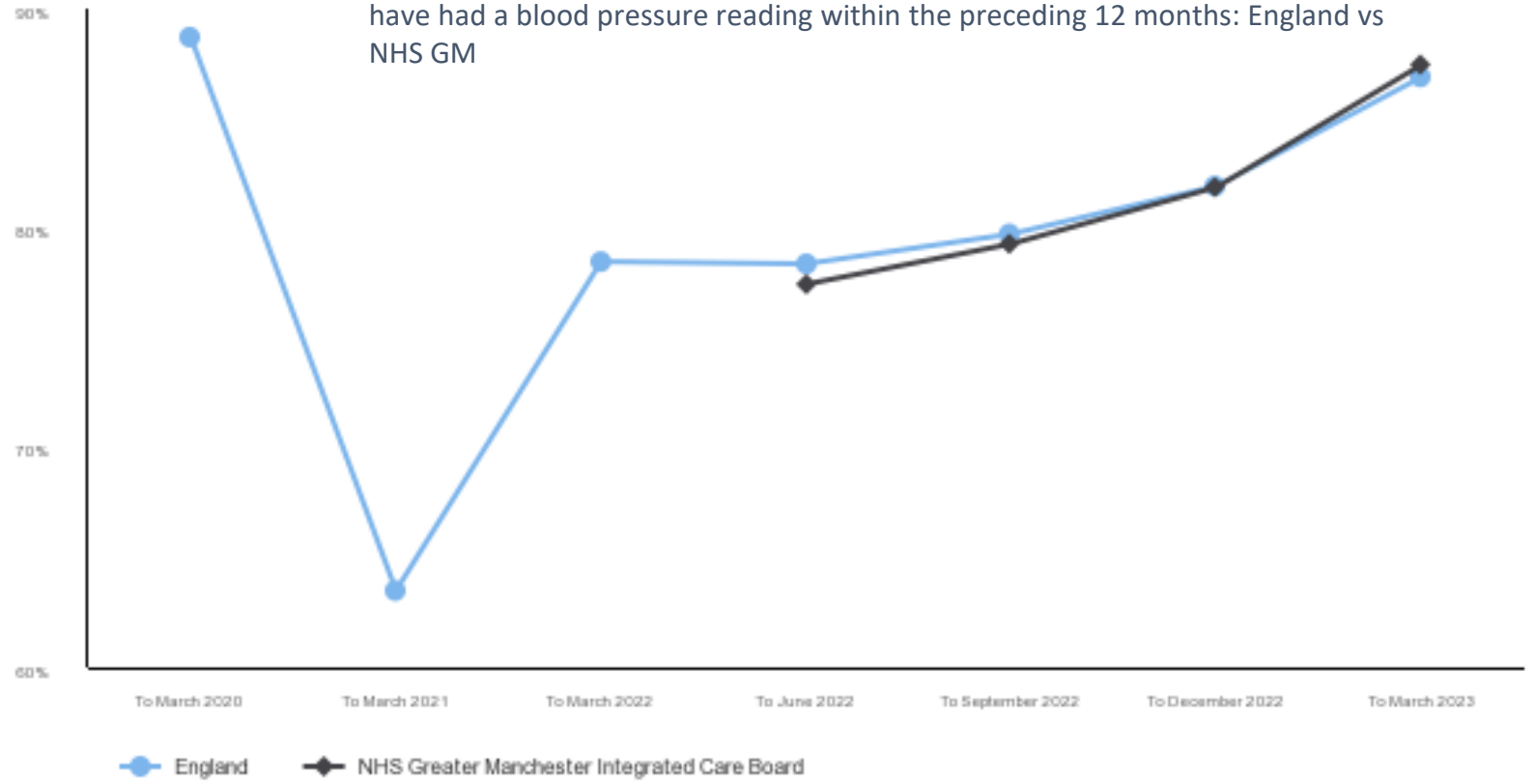
Over 3 years

The aim is to achieve **Ambition 4**

Progress of Optimising Blood Pressure (BP)

Greater Manchester Integrated Care Partnership

Percentage of patients aged 18 and over with GP recorded hypertension, who have had a blood pressure reading within the preceding 12 months: England vs NHS GM



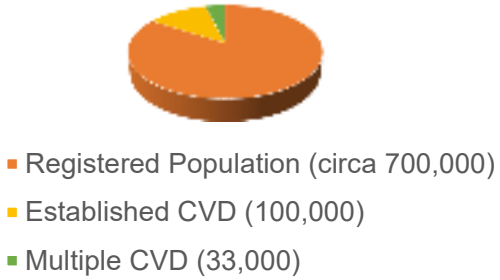
Source: https://www.cvdprevent.nhs.uk/insights?period=6&area=E38000&group=0

A Multimorbidity Approach –
Manchester Locality

Multimorbidity Approach to Diabetes and CVD

Long term Conditions (LTC)

CVD



Our Approach

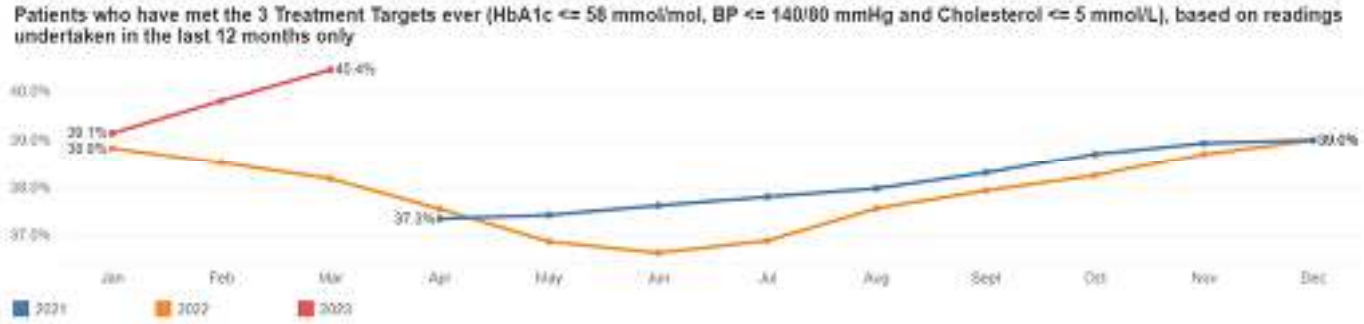
- Data led approach using the GM Analytics and Data Science Platform (ADSP)
- General Practice data innovatively used to produce a set of analytical tools to support population health management approach to identify and reduce health inequalities.
- GP Practices incentivised to prioritise those most *at risk* and to undertake a multimorbidity review to meet all health needs and to identify unmet need
  - Year 1 (2022/23) – incentivised review of people with Diabetes *at risk*
  - Year 2 (2023/24) – expanding to all Cardiovascular Disease *at risk*
- Long term condition dashboards were developed to support PCN-neighbourhoods to take a data-intelligence led understanding of at-risk cohorts by demographics and protected characteristics, thus enabling focused neighbourhood activity in collaboration with Local Authority and VCSE partners.

Multimorbidity Approach – Early Outcomes

Greater Manchester Integrated Care Partnership

A) Chart showing narrowing of the gap between at risk and not at risk groups for achievement of complete diabetes care (the 8 Care processes)

B) Chart showing improvement in achievement of diabetes, blood pressure and cholesterol control in people with diabetes:



Greater Manchester Integrated Care Partnership

The GM Dementia and Brain Health Delivery Plan

Dementia and Brain Health Delivery Plan

Greater Manchester Integrated Care Partnership

Improving connections, quality of care and experience for everyone affected by dementia

- Dementia Wellbeing Plan Digitisation
- Dementia Care Navigation
- Active inclusion of marginalised communities
- Improve quality and experience of being diagnosed with dementia
- Improve detection, treatment and management of Delirium
- Young onset and rarer forms
- Embed quality standards across the Dementia Care Pathway
- Support the provision of good End of Life Care

Promote brain health and help prevent avoidable cases of dementia, supporting wellbeing and independence

- Wellbeing grant initiatives; Big Brain Health Fund and Creativity in Care Homes
- Physical Activity and GM Moving.
- Creative Health, including Music and Dementia.
- Social Prescribing and Dementia support
- Wider determinants of health including finance and housing projects
- Links to new technology for falls prevention
- Brain Health Strategic Development work

Design, develop and facilitate education and training across all sectors

- Support the provision of mandatory dementia training resources
- Undertake training needs analysis to identify and address gaps
- Scope and identify specific locality, sector and project training needs
- Commission dementia and brain health training
- Promote and share broad range of Dementia United training resources
- Promote training for carers and lived experience
- Promote education re Brain Health, Dementia, Prevention and wellbeing
- Support person centred responses to distressed behaviours and complex needs

Increase access to benefits of dementia research through awareness, involvement and participation

- Work collaboratively with new and existing academic partner organisations
- Drive Innovation through Quality Improvement initiatives
- Increase research participation opportunities including through Join Dementia Research
- Horizon scanning and embedding the latest research
- Promote excellence through National and International research links
- Further develop Trailblazer and Proof of Value projects
- Mild Cognitive Impairment programme (Neurology Academy)

Diversity and Inclusion;
Co-production with people with lived experience of dementia and their carers;
Partnership working and the Dementia Care Pathway

Bounce Back Fund Evaluation

Greater Manchester Integrated Care Partnership

"Music and Dance saved my sanity"

"Caring for someone 24/7 can be isolating, lonely and exhausting. Coming along to the Music and Dance gives me a place where I know the other people understand what the situation is...My husband loves the singing, and it is wonderful to see the glimmer of the man that I married."

"I speak on behalf of all the attendees at the lunches when I say many thanks to Dementia United for helping to tackle isolation and keeping people connected"

"The group gives me a chance to stop and relax on a regular basis. This 'me-time' is a chance to catch my breath and gives me energy to continue my caring duties."

"I observed my father come alive. He was smiling, laughing, and chatting in a way I have not seen for many years"

Greater Manchester
Integrated Care Partnership Board

Date: 29 September 2023

Subject: Greater Manchester Primary Care Blueprint

Report of: Rob Bellingham, Director for Primary Care and Strategic Commissioning, NHS Integrated Care and
Dr Tracey Vell, Primary Care Provider Board Chief Officer

PURPOSE OF REPORT:

The attached GM Primary Care Blueprint sets out our 5 year plan for delivery. Our overall aim is to ensure that Primary Care survives and thrives, allowing us to address the needs of our citizens and communities as part of our wider GM Integrated Care Partnership. We will focus equally on the Physical and Mental Health of our citizens, with all elements of the Blueprint focussing on these twin priorities.

KEY MESSAGES:

This Blueprint sets out a vision for a Greater Manchester Primary Care system which will:

✓	Provide timely appropriate access to care delivered by a system which has sufficient capacity to meet the needs of service users, where processes are simple and straight forward

✓	Form part of a wider neighbourhood team, where individuals and communities are supported to take more control over their own health and where providers work together with the shared aim of improving the health of the population
✓	Help to create fairer health and tackle the root causes of inequalities, working in partnership with our communities to create healthier, greener and fairer places
✓	Help people to stay well and focus on the prevention and early detection of ill health, and the effective management of long-term conditions
✓	Be viable for the long term, ensuring that services are available when and where needed
✓	Play a full part in achieving a Net Zero NHS GM Integrated Care Carbon Footprint by 2038
✓	Empower citizens and providers with high quality, digitally enabled Primary Care
✓	Be delivered from facilities which are appropriate for the provision of 21st century Primary Care
✓	Deliver safe, effective services, with a focus on quality improvement
✓	Be recognised as a career destination for a happy, healthy and engaged workforce, trained to a consistent standard with knowledge and expertise to meet the needs of our population and provide timely, exemplar services.

RECOMMENDATIONS:

The NHS GM Integrated Care Partnership Board is requested to approve the content of the Blueprint.

CONTACT OFFICERS

Rob Bellingham, Director for Primary Care and Strategic Commissioning, NHS GM Integrated Care. Email: robbellingham@nhs.net

Dr Tracey Vell, Primary Care Provider Board Chief Officer
Email: tracey.vell@nhs.net

Primary Care Blueprint

Production Version – For Approval

September 2023

Developed by:
NHS Greater Manchester Integrated Care
NHS Greater Manchester Primary Care Provider Board

Contents

Primary Care Blueprint

Executive summary

Executive summary

In the introduction to her national review, published in May 2022, Dr Claire Fuller stated that “left as it is, primary care as we know it will become unsustainable in a relatively short period of time”. This Blueprint describes how we plan to address this risk and sets out our prescription for change. We will focus equally on the Physical and Mental Health of our citizens, with all elements of the Blueprint focussing on these twin priorities.

Our high level vision for Primary Care in Greater Manchester

About Primary Care in Greater Manchester:

In Greater Manchester, as at September 2023, there are circa 1,800 primary care providers, with a workforce of around 22,000. This comprises:

- 639 Community Pharmacies
- 396 Dental Providers
- 411 GP Practices
- 345 Optometry Providers

For 23/24, there is a combined budget of £840m. If we add in prescribing costs, this figure rises to £1.7bn which represents circa 27% of the ICB's total expenditure.

Our Key Aims

We have included a list of headline deliverables at the conclusion of each chapter. These are inclusive of all four disciplines, emphasising that this is a Blueprint for all of Primary Care. Summarised below are some of the key aims and ambitions that the Blueprint describes, all of which are explored in more detail in the relevant chapters:

- Ensuring same day urgent access to General Practice where clinically warranted
- Resolving the so called "8 am rush" in General Practice
- Improving Access to NHS Dentistry and delivery of schemes to improve the Oral Health of our population
- Ensuring ongoing and enhanced access to the Community Urgent Eye Care service in Optometry and a range of initiatives designed to improve and enhance eye care
- Develop pharmacy services to improve access and reduce health inequalities
- All parts of Primary Care to work together as part of Integrated Neighbourhood Teams
- Implementation of a model designed to find and support those most in need which includes a targeted approach to improve outcomes.
- An approach to understanding needs and assets of different communities to support improvements in access, experience and outcomes of care.
- Improvements in the identification and management of long term health conditions
- Increase vaccination uptake, (focusing on COVID-19, influenza, pneumonia, and childhood vaccination)
- To contribute to the achievement of a Net Zero NHS GM Integrated Care Carbon Footprint by 2038

In addition to these main themes, the Blueprint also describes a range of measures relating to the implementation of our four enablers, namely:

- Digital
- Estates
- Quality, Improvement and Innovation
- Workforce

Delivering the Blueprint

We describe in detail our approach to ensuring successful delivery. This includes:

- The establishment of a Blueprint Delivery Unit, a partnership between NHS GM and the GM Primary Care Provider Collaborative
- Describing our approach to maximising the value gained from the existing investment in Primary Care, targeting the use of new funding and making the case for new investment, supporting the delivery of our wider strategic objectives
- Identifying our key strategic risks and setting out our approach to their management
- Setting out our plans for the use of data and intelligence to facilitate delivery and to allow us to track progress on implementation
- Defining our governance arrangements

We will continue to develop the models and supporting products described in this Blueprint and over the next 5 years, look forward to continuing to develop our Primary Care services as a cornerstone of our wider Health and Care system.

Primary care blueprint

Introduction

1.Introduction

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Our vision for Primary Care

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✓	Help people to stay well and focus on the prevention and early detection of ill health, and the effective management of long-term conditions
✓	Be viable for the long term, ensuring that services are available when and where needed
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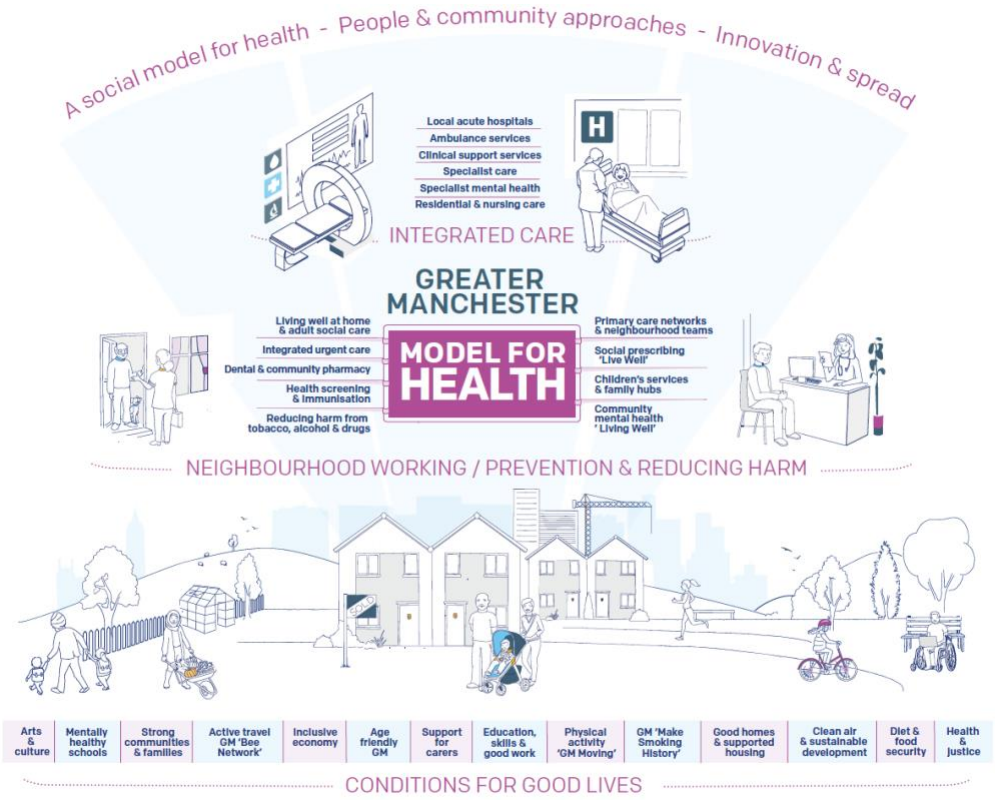
About this Blueprint

Each of the chapters in the document has been developed by a triumvirate of leads drawn from the following areas:

Primary Care Provider Collaborative	Locality Teams	GM ICB Central Team

Alignment to the GM Integrated Care Partnership Strategy and the wider strategic agenda

As well as describing our delivery plan for Primary Care in GM, this Blueprint also represents our response to the GM ICP Strategy and our contribution to securing its delivery. The strategy can be viewed via the following link, https://gmintegratedcare.org.uk/greatermanchester-icp/icp-strategy/., with the graphic below showing the Greater Manchester Model for Health, as described therein.



The strategy describes six missions as shown below. A companion document to this Blueprint sets out in more detail how its content directly relates to the implementation of these missions:

- ✔ Strengthening our communities
- ✔ Helping people get into, and stay in, good work
- ✔ Helping people stay well and detecting illness earlier
- ✔ The recovery of core NHS and care services
- ✔ Supporting our workforce and our carers
- ✔ Achieving financial sustainability

As well as the ICP Strategy, we have also sought to ensure that the Blueprint is aligned with and supportive of, the delivery of other key documents including our GM strategies for Estates, People and Culture, the Green Plan, Digital, as well our 10 Locality Plans.

It is further aligned with relevant national strategies, specifically the Fuller Report published in May 2022 and the Primary Care Access Recovery plan, published in May 2023

The Blueprint and wider Public Service Reform

The Blueprint provides a narrative which clearly illustrates the core role that Primary Care needs to play in the wider ambition for the delivery of integrated public services as described in the GM Strategy, published in 2021, https://aboutgreatermanchester.com/the-greater-manchester-strategy-2021-2031/the-greater-manchester-strategy-2021-2031-summary/ . This is perhaps most clearly expressed in the chapters which we refer to as the "engine room" of the Blueprint, relating to Neighbourhoods, Prevention and Reducing Inequalities.

This commitment is clearly expressed in the headline, shared by the GM Strategy and the ICP Strategy, which states that "We want Greater Manchester to be a place where everyone can

live a good life, growing up, getting on and growing old in a greener, fairer more prosperous city region". We echo and fully support this overall statement of purpose.

More specifically, we will continue to build on the excellent joint working already in place in areas such as tackling homelessness and rough sleeping, supporting people to gain and stay in employment and playing our full role as a delivery partner in the wider programme of work.

The Blueprint and the Voluntary, Community, Faith and Social Enterprise, (VCFSE), Sector

The chapters of this Blueprint contain a recurring theme relating to engagement and joint working with the VCFSE sector. Its publication signals the start of a new phase of this work, with a further deepening and embedding of the relationship that we know is essential to the successful realisation of the deliverables set out in the document.

Engagement in the development process

Following our Primary Care Summit in September 2022, we have conducted a process of engagement and development which has led to the production of this Blueprint.

This engagement has involved attendance and presentation at dozens of meetings, webinars and other settings, including all 10 Locality Boards, our Primary Care Provider Boards and many other forums. We have also received written feedback from a wide range of colleagues and partner organisations.

As well as our Primary Care teams, we have been informed and advised by our Primary Care Assembly, drawn from our wider GM Integrated Care partners. This assembly has met regularly throughout the development process.

Importantly, we have taken into account the clear messages and feedback received via the GM Big Conversation which took place from May – November 2022, as well as wider feedback gleaned as part of our ongoing engagement process. We plan to build on this, using the Blueprint as a catalyst to commence a dialogue with the GM public on getting the best from our Primary Care system.

Primary Care Blueprint

Delivering the Blueprint

This Chapter sets out our plans to create the conditions which will be needed to successfully deliver the aims and ambitions set out in this document. It also sets out the key issues which will need to be addressed and managed to secure a successful implementation.

Establishing a Blueprint Delivery Unit

To oversee and support the implementation process, we will establish a Blueprint Delivery Unit, which is a partnership between the ICB and the Primary Care Provider Collaborative. As well as core Project Management Office type functions, the Delivery Unit will provide a focal point for some of the key supporting project and programme infrastructure. This will include:

- the implementation of a detailed Operating Plan to provide oversight and assurance on delivery
- Creation of a Delivery Assurance Framework and Risk Register to manage strategic and operational risks
- the development and implementation of a programme of organisational development support, building upon the success of existing programmes such as GP Excellence
- support to ensure that we secure the necessary clinical and professional leadership to shape and influence delivery

Finance and Investment

Work is underway on a number of fronts, which broadly described, focus on the following themes:

i. Understanding current levels of investment in Primary Care and achieving maximum value from this, including a review of local quality/ incentive schemes
ii. Maximising the value and benefit to be gained from new investments, e.g. Additional Roles Reimbursement Scheme (ARRS), Primary Care Investment and Impact Fund (IIF)
iii. Setting out the offer and associated investment ask, where investment in Primary Care can assist in the delivery of our wider strategic objectives or the management of strategic risk, e.g. in managing pressures in our Urgent and Emergency Care System, facilitating timely discharge from hospital, supporting people to stay well etc.
iv. Identifying areas where there are material risks to the continuing viability of services and working in partnership with the professions to develop mitigations
v. Supporting maximising core contract delivery and funding. By reducing unwarranted variation, e.g. through QOF – we will bring more resource to General practice

In publishing this Blueprint, we are committing to do all we can to achieve the headline deliverables described therein, wherever possible, via existing resources or from the targeted new investments as described above. For this to be feasible we feel it is reasonable to secure commitments to:

- In return for our demonstrating the value being delivered from our current and planned services, a commitment to maintain current levels of investment in Primary Care and a commitment to using relevant new national investments for the purposes they are intended
- Complete the implementation of the financial flows model previously agreed where money flows to Primary Care providers as directly and smoothly as possible
- Work with us on areas which we believe require additional investment to support themes iii and iv above

Risk Identification and Management

In developing the Blueprint, we have identified a series of strategic risks to delivery. As mentioned in the section above describing the work of the Delivery Unit, we are developing a Blueprint Assurance Framework and Risk Register. This section sets out a high level overview of the key thematic areas which have been identified and will form the basis of these documents:

- Making the case for investment – we recognise that the Integrated Care System in Greater Manchester is facing significant financial challenges and it will be incumbent on us to demonstrate a positive case for investment on any aspects or elements where additional funding is required
- Capacity in our estate – issues re Estate capacity, utilisation and cost figure throughout the analysis done to date and will be a major area of focus
- Workforce – despite the work being done to recruit, retain and develop our staff, there remain significant risks surrounding all parts of our workforce, all of which will require ongoing attention for us to successfully implement the Blueprint
- Information Governance / Data Sharing – our vision for a fully integrated, digitally enabled, intelligence driven Primary Care system must always take into account the related issues in terms of the appropriate usage and security of the data we hold about our citizens.
- Change Management capacity and capability – delivering the changes and improvements set out in this Blueprint, will place additional pressures onto an already stretched system, as well as requiring us to ensure appropriate support is in place to manage the change process
- Issues relating to national contracts and incentives schemes where review and reform is anticipated, e.g. Dental contract, GP contract, GP Quality and Outcomes Framework
- Engagement of our population to facilitate discussions and initiatives to facilitate the best and most effective use of our Primary Care System
- Digital exclusion - Ensuring that we recognise and respect all citizens preferred means of accessing our Primary Care system and ensuring that our moves towards a more digitally enabled Primary Care system do not add to or exacerbate existing health inequalities

Data Insight and Intelligence

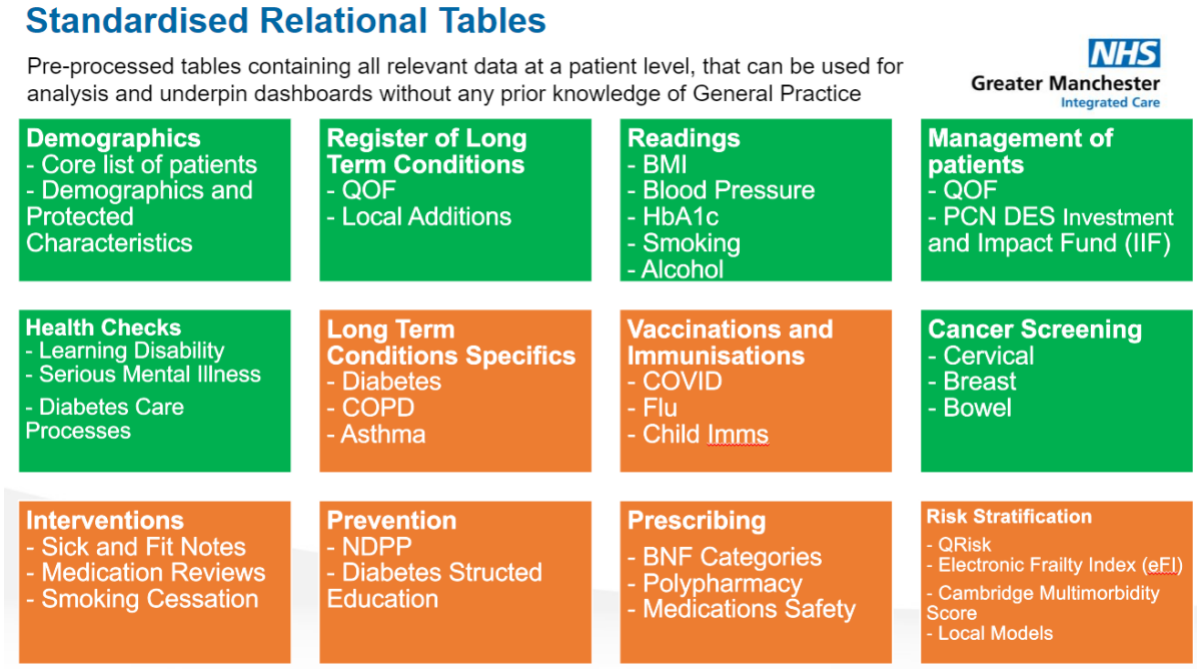
We have identified this as a key area of focus, with Primary Care well placed to benefit from the new technologies and ways of working. The Analytics and Data Science Platform (ADSP) provides the cloud infrastructure suitable to process big data and complex linkages that will enable an approach to analysis that is also timely and up to date daily.

Whilst we have comprehensive plans in plans already in place for some areas of Primary Care data, we also acknowledge that there are gaps which require addressing. We have already commenced work on both aspects of this work programme, which is described in more detail in a supporting document to this Blueprint. Our aim is to work towards an

outcome where all Primary Care data is available within the ADSP to provide a comprehensive and joined up view of intelligence.

Access to patient level GP data from the Greater Manchester Care Record (GMCR) has been long anticipated, with this work now giving rise to a series of analytical products which will be available to support a range of use cases. These will provide both a population overview but also the ability to understand an individual's patient care.

The graphic below gives an indication of the types of analysis that are available to us to support the delivery of this Blueprint:



Governance Considerations

A number of actions or recommendations are set out below relating to the way in which the implementation programme will be governed and to ensure proper engagement of Primary Care in our wider organisational arrangements:

- The role of the Primary Care Committee is to be extended so that, as well as having responsibility for contractual matters, it will provide GM level oversight and accountability for the delivery of the Blueprint.
- Each of the headline deliverables set out at the end of each thematic Chapter, contain a summary of accountabilities. This emphasises the effective links that will need to be established in particular between the GM Primary Care Committee, the Locality Boards and the GM Primary Care Collaborative.

Early Deliverables

We aim to focus on the delivery of some early priority areas, to address issues which have been in train for some time. These issues are all important in their own right but their implementation will also illustrate our commitment to delivery. They include but are not limited to:

- Securing full implementation and visibility of our Primary/ Secondary Care and GP/ Community Pharmacy interface principles which will be important in managing pressures in our system but also in cementing the joint working which will be crucial to the delivery of the Blueprint. This has been identified as a key issue in our local engagement process, as well as in the national Primary Care Access Recovery Plan. In GM, this work is being overseen by a multi-disciplinary group led by the ICB's Chief Medical Officer.
- Occupational Health provision – ensuring that we have an effective, equitable offer in place for all four disciplines, compliant with the relevant national guidance and matching our own local ambition
- Phlebotomy Services – Ensuring that we have a timely, effective service in place in all localities, building on current good practice and addressing gaps where they are found to exist
- Implementation of an updated "Sitrep" pressures management process – providing us with timely information re the current pressures facing our system and triggering appropriate offers of support and mitigation

Primary Care Blueprint

Demand, access and capacity

2. Demand, access and capacity

Providing timely appropriate access to care delivered by a system which has sufficient capacity to meet the needs of service users, where processes are simple and straightforward and operate in a neighbourhood which promotes prevention, self-care and early diagnosis

2.1 Our headline pledges to improve access

It is clear that access to Primary Care is a priority issue for our 2.8m citizens and has also been prioritised nationally, following the publication of the Primary Care Access Recovery Plan in May 2023. The following pledges represent our acknowledgement of and commitment to, this key policy area:

- Ensuring same day urgent access to General Practice where clinically warranted and agreeing an appropriate response at first contact for all non-urgent requirements
- Removing the so called “8 am rush” in General Practice, via a support programme which will include investment in the telephony infrastructure, encouraging optimal use of the NHS App and a programme of development support for PCNs and practices.
- Delivery of a Dental Quality scheme, launched in June 2023, which includes provision to improve access to NHS Dentistry across GM
- Ensuring ongoing and enhanced access to the Community Urgent Eye Care service in Optometry.
- Building on the core Community Pharmacy Contractual Framework, to develop and deliver pharmacy services to improve access and reduce health inequalities e.g, in developing a harmonised GM Minor Ailments scheme

2.2 What do we mean by Demand, access and capacity

DEFINITIONS

Demand:	People wishing to access the service or who would benefit from accessing the service
Access:	The mode of contact into the service
Capacity:	The health and support provision to make the contact and onward associated services work effectively and meet the needs of the person and their carers

When demand, access and capacity, as defined above, are in balance, the result is efficient flow through our system. They are however rarely in perfect harmony and our challenge is to balance all three in a continuous cycle of flexible review and change. When one of the elements comes under pressure, we find services become unbalanced and sometimes unsustainable, resulting in additional pressures for staff and service users reporting their expectations not being met.

In writing this chapter it is important to reflect that demand, access and capacity is different in the four disciplines of Primary Care and in some cases demand and access are merged due to the open-door nature of services. It is also important to acknowledge the role of

preventative, screening, and wellness services which fundamentally change the shape of demand into services, keeping citizens well, supporting early diagnosis and promoting self-care.

The pandemic brought change and in some cases transformation to demand, access and capacity. The Primary Care delivery model had to change overnight, with a short-term reduction in capacity and more access being delivered online. The opportunity to move to digital solutions where appropriate was accelerated and now needs to settle into a more measured way of understanding how digital can support Primary Care services and citizens alike.

Primary Care, and particularly general practice has had the advantage of the Additional Roles Reimbursement Scheme (ARRS) initiative which has brought many more clinicians and support workers into Primary Care Networks, (PCNs), increasing workforce and the opportunity to offer flexible solutions to patients and more capacity into neighbourhoods. For this opportunity to work well we must integrate not only across Primary Care disciplines but also with the wider public sector, voluntary sector, and the business community to make the most of our workforce, local services, and buildings.

2.3 Working across Blueprint chapter headings to realise the vision

The table below sets out how we will work together to create the conditions to deliver our pledges and tackle some of the wider issues relating to demand and capacity, thus delivering optimised access. The linkages to other chapters in the Blueprint are evident here, indicating how this topic cannot be viewed in isolation and must be seen as part of our wider vision for Primary Care transformation. These links are clearly signalled below:

✓	Later chapters describe how integrated neighbourhood teams will work together to help keep people healthy and happy. From the perspective of this chapter, this will help support early identification of illness and encourage uptake of prevention and social prescribing programmes. Integrated neigbourhood teams will also be proactive in supporting people when they are living with long term and life limiting illness. This model of care will help us to manage the demand on our services, supporting people to make good decisions about their health and self-care.
✓	Primary Care disciplines will work together, making every contact count and taking responsibility for those in their care by sign posting and undertaking checks such as blood pressure or giving simple advice. We will seek opportunities to establish this way of working into our contractual frameworks, linking to the work described in the chapters on PC sustainability and service improvement.
✓	As part of our plans for digital modernisation, care records will be interlinked so that, subject to appropriate consent mechanisms being in place, information is available to relevant practitioners.
✓	We work with our further education colleges and universities to create new roles which will emerge to support collaborative working.
✓	We will establish good workforce planning so that we plan our future workforce to reflect our communities and their needs
✓	Websites will be standardised and easy to navigate, telephony will be cloud based to enable calls to be picked up in different places, navigation tools will go hand in

	hand with good customer service and enable people to get to the right place and see the right professional in a seamless way.
✓	We will enable people to access our services in ways that suit them and how they understand, whether that be online, on the phone or face to face.
✓	We will create a data culture where we make the most of intelligence across the elements of demand, access and capacity, ensuring we understand our people and their preferences
✓	People will report a change in the way they experience our services and report a good experience. Where experiences are not so good, we will listen and respond with a culture of continuous improvement

Discipline	Headline Deliverables	Timescales	Accountabilities	Measures
Dental	Promote and expand access to NHS Dentistry via the continuing delivery of our Dental Quality scheme, building on the initial success achieved during 23/24.	Soft launch June 2023, with review of initial implementation by March 2024	Primary Care Committee	Numbers accessing service and quality of patient experience
General Practice	Ensure same day urgent access to General Practice where clinically warranted	2024 onwards	Primary Care Committee Locality Boards	All urgent patients seen on the day (improvement plan measures)
	Agree an appropriate response at first contact for all non-urgent appointments, ensuring all patients are seen within 2 weeks	2024 onwards	Primary Care Committee Locality Boards	Triage and navigation processes in place at practice/PCN level
	Fully implement cloud-based telephony across General Practice to facilitate a more effective patient experience in contacting the practice	2024 onwards	Primary Care Digital Board	Number of practices reporting using cloud based telephony effectively to support triage and navigation.
Optometry	Promote and Increase the number of patients accessing Community Urgent Eye Care Service (CUES)	2024 onwards	Primary Care Committee	Numbers of appointments utilised. Potential A&E avoidance. GP attendance avoidance.
	Expand access to GERS (Glaucoma Enhanced Referral Service)	Soft Launch 2023. Full 2024 onwards	Primary Care Committee	Numbers of appointments utilised.

	including use of a single point of access to support capacity and demand management in GERS practices across GM.			Timeliness of assessments. Avoided Hospital referrals.
Pharmacy	Expand community pharmacy services across GM in line with National Recovery Plan to deliver a common conditions service (CCS) before the end of 2023, offering self-care advice, symptomatic relief and where clinically appropriate, enabling the supply of NHS medicines for seven conditions under Patient Group Directions.	2024 onwards	Primary Care Committee	Number of patients accessing

Case studies: Demand access and capacity

Helping people access the right emergency care: new vision for urgent eyecare services

Urgent Eyecare Services (UES) are now available seven days a week for people across Greater Manchester. The scheme runs across all 10 boroughs and treated 31,000 patients between 2021 and 2022.

Initially, this service is carried out via a telephone consultation followed by a face-to-face appointment if required. The UES provides urgent assessment, treatment, or referral for sudden onset eye problems such as flashes, floaters, vision loss or minor eye injuries.

A network of optometrists provides the service so people can get the care and support they need close to home, relieving pressure on general practice and emergency departments. Most patients (81%) who have used the service since May 2020 have not needed further referrals to hospital. The service helps reduce delays in starting any treatment needed.

The UES makes the best use of optometrists in the community who have the expertise and equipment to assess and diagnose eye conditions. It is provided by Primary Eye Services who have partnered with local optometry practices and NHS Greater Manchester Integrated Care to extend the service across the whole of Greater Manchester.

Child-friendly dental practices spreading smiles across Greater Manchester by reducing hospital visits

Following a successful pilot in November 2020, Child Friendly Dental Practices (CFDPs) are now being rolled out across all areas in Greater Manchester.

The CFDP network was created to reduce the number of children being referred into hospital dental services for specialist treatment, including those provided under general anaesthetic. CFDPs provide quick access to additional and complementary services in primary care from dental teams with enhanced skills to minimise the referral of children and young people (aged 0-18 years) with dental decay to specialist services. Where possible, patients are seen, treated, and discharged back to their regular dental practice.

For people who need onward referral, the service can help to manage dental pain while they wait for operating theatre availability.

This approach also recognises the processes CFDPs have in place to improve oral health in children and young people, by improving attendance at dental appointments and supporting preventative care.

To date, 600 patients have been treated across nine practices and it's the ambition to create a network of 12 CFDPs that will link with other paediatric dental services across Greater Manchester. Greater Manchester was the first area to develop this innovative patient-

focused model and to launch this work as a pilot. Other areas have since adopted similar approaches.

New ways of working are boosting patient experience and improving staff wellbeing at Hawkley Brook practice

This practice in Wigan introduced a single point of access – 'Ask My GP' - with all patients required to contact the practice this way. For those that are unable to use the online consultation system, patients can ring the practice for support, and a member of the administrative team completes the online form on their behalf.

Appointments are allocated equally to each GP partner who triage the referrals and book an appointment with the relevant practitioner – this could be a GP partner, trainee or with another service such as social prescribing or pharmacy.

The practice guarantees that all patients will have contact from the practice on the same day and/ or see a doctor for all routine and urgent requests, with an average turnaround time of 37 minutes from the point of patient contact to receiving a message from the practice.

Patients with multiple health issues have time to discuss their health needs without being limited to a ten-minute appointment.

The new system has allowed for more flexibility, with partners able to stagger start and finish times to suit their needs and spend more time on staff development, with learner tutorials taking place every Friday. They won Employer of the Year at the 2023 Greater Manchester Health and Champions Awards for their commitment to staff wellbeing and career development.

In the 2023 national GP Patient Survey, Hawkley Brook received the second highest overall patient satisfaction result in Greater Manchester at 98%.

Pharmacies save over 63, 000 GP appointments

The Community Pharmacy Consultation Service (CPCS) connects patients who have a minor illness or need an urgent supply of a medicine with a community pharmacy. It aims to lift some pressure off the wider NHS by delivering a fast, convenient, and effective service.

Initially, this launched taking referrals to community pharmacy from NHS 111, with referrals from General Practice being added in November 2020. The national GP Community Pharmacy Consultation Service allows GPs to refer patients to a same day appointment (face-to-face or remote) with their community pharmacist for help or advice with minor illnesses.

The service is helping to make sure people are provided with the right care, by the right person at a time most convenient to them. This helps increase capacity within general practice for the treatment of patients with more serious health problems.

To date, community pharmacies in Greater Manchester have successfully delivered 63,125 patient appointments helping to remove some pressure from General Practice, with the numbers increasing monthly.

Over 97% of all pharmacies and GPs in Greater Manchester are on board delivering this vital service.

How a new shared urgent appointment system is reducing demand in Salford

Eccles and Irlam PCN in Salford introduced a new referral system to provide urgent same day appointments across the PCN. This has increased the number of routine appointments available, reducing pressure on individual practices and improving staff morale.

Like many practices, demand has increased over the last few years due to a combination of factors including the Covid-19 pandemic, rising mental health issues, waiting times for secondary care, population growth and workforce pressures.

In 2021, the PCN, supported by Salford Primary Care Together CIC, used money from the Winter Access Fund to develop a trial urgent appointment system, run through the patient booking system, 'EMIS', which they called Additional Care Today (ACT). The system was used in all seven GP practices across the PCN to provide urgent same day appointments. Due to its success, the system has now been implemented on a permanent basis.

If a patient requiring an urgent appointment is unable to be seen on the same day at their own GP practice, trained reception staff can access the ACT system to book an appointment at another practice within the PCN. Staff run through a few clinical questions generated by the ACT system to check if a same day appointment is necessary.

Depending on demand in the system, the service can offer anywhere between 33 and 99 additional appointments a day. Patients who otherwise may have called 111, or presented at A&E, are now being seen by a GP on the same day.

Primary Care Blueprint

Integrated working in neighbourhoods

3. Integrated working in neighbourhoods

Part of a wider neighbourhood team, where individuals and communities are supported to take more control over their own health and where providers work together with the shared aim of improving the health of the population

3.1 Where are we now

- ("*Our integrated neighbourhood teams work to connect all Primary Care services including GPs, dentists, pharmacists and optometrists with community, social and local acute care, local VCFSE and wider public services (such as housing providers, schools, employment support and the local police and fire and rescue service). We will not miss the opportunity to maximise the enormous potential of community pharmacy…").*

The concept of integrated neighbourhood working is not a new one. Integrated Neighbourhood working is a key building block in our GM architecture. Indeed Greater Manchester is seen as a trailblazer, under GM Devolution harnessing the concept of integrated neighbourhood working, to remove fragmentation between services. The belief that Primary Care is integral to this model, built around populations of circa 30,000 – 50,000 to deliver population based models of care, was a fundamental aspect of the GM Primary Care Strategy, (2016 – 2021). Subsequent national strategy followed with the introduction of Primary Care Networks and the more recent Fuller Stocktake Report.

What we mean by integrated neighbourhood working is connecting communities, working alongside them and understanding their needs. By unlocking skills, expertise, and resources within communities, at neighbourhood level, we can address the inequalities that exist. This is not just about professional Integrated Neighbourhood Teams, (INTs), this is about working in a very different way, with the population rather than to them.

Integrated neighbourhood working has the ability to positively impact on rising demand through reducing avoidable hospital admissions and keeping people at home and more independent for longer. By providing proactive care in local neighbourhoods, seeking out those most at risk and through developing enhanced relationships at an intermediate tier level, working with system partners to enable people to be supported and managed at home and in their community.

Operating in a multi-disciplinary manner facilitates the provision of, and access to place based care with local services responding to local need. Integrated neighbourhood working with partners across VCFSE, community and wider public services is one vehicle with which to tackle inequalities, drive the early intervention and prevention agenda and offer a more sustainable Primary Care with a much broader workforce, across multiple organisations, working with people and communities to deliver care and support at its heart.

We know that there is still variation across localities and across neighbourhoods. This is not necessarily due to a lack of aspiration but because of other factors.

For example, there are varying levels of maturity. There are pockets of innovation, but this is not universal across Greater Manchester. There are also barriers such as workforce, estates and digital. There is evidence of cross sector working to deliver care and strong VCFSE partnerships in some areas but not all. Similarly, there are good working relationships with other clinical teams and providers, but this is not consistent. We engage with other providers as part of integrated neighbourhood working however this is not inclusive of all Primary Care providers.

3.2 Describing the benefits

The benefits and rationale of integrated neighbourhood working include:

✓	People and communities within the neighbourhood are a fundamental part of the delivery model
✓	Greater collaboration between providers can support better decision-making on resource allocation, reduced waste, increased efficiency and return on investment, higher quality, better outcomes and more sustainable services and a reduction of health inequalities
✓	Focus on the wider determinants of health, early intervention and prevention working with wider public sector, voluntary and business partners: • Schools • Employment • Housing • Fire and rescue • Drug and alcohol services • Local police • Criminal Justice system
✓	Utilising population health management tools and data to understand local populations, to proactively anticipate care needs and provide support and preventative care before crises occur. This approach to population health management will drive integrated care for people-especially with long term conditions and those most at risk
✓	Look for hidden communities, and offer tailored support and intervention to meet their specific needs.

Integration opportunities

This is very much aligned to the GM ICP Strategy which sets out the direction for the next 5 years for developing our model for health in Greater Manchester, with strong references to integrated working:

Providing proactive primary care and support and reducing demand on acute services through a comprehensive neighbourhood model spanning public services, local business and community led groups

Our thinking is also aligned to the national direction outlined in the Fuller Stocktake Report and the vision to build **integrated neighbourhood teams (INTs)** to achieve three essential deliverables:

✓	Improved access to Primary Care
✓	Improved **continuity** (and more proactive/personalised care) to people with complex needs
✓	Reduced **health inequalities** and a more ambitious approach to prevention

We also need to take our aspirations further, building on our original vision of more joined up services closer to people's homes. There is so much more that can be delivered through integrated teams, redirecting resources, upskilling our workforce and relieving pressures from other parts of the system, for example Practitioners with a Special Interest, service/pathway redesign and resource to primary/community care, delivered via integrated neighbourhood working.

3.3 How will we do this?

Our collective efforts to date clearly show that the establishment of integrated neighbourhood working does not happen overnight. A recent, GM study[1] has shown that for integrated teams to work effectively, a series of features need to be in place such as consensus, equality, agreement, leadership, structured team building, flexibility, and a system of accountability across partners.

Furthermore, we know from our experience and learning that we need to create the right conditions, such as:

✓	Relationships
✓	Empowering frontline staff and giving permission to act
✓	Developing partnerships with patients, PCNs and VCFSE
✓	Enabling integrated working across health and social care teams and wider public sector
✓	Clinical and managerial leadership / capacity
✓	Interface across sectors
✓	Knowing your population – data and intelligence
✓	Time / Headspace
✓	Organisational Development (OD)
✓	Knowing what services are available within the neighbourhood
✓	Working / thinking differently to support people/communities and deliver improved patient care

Fundamentally, integrated neighbourhood teams are formed, developed and harnessed at a local level, through integrated locality partnerships, provider collaboratives and within neighbourhoods themselves. From a Primary Care system level, we need to consider what is within our gift, where can we add value and how we share the learning. We also need to ensure that we are striving for consistency of offer, that patients and communities have the same experience of the seamless care with fewer handoffs and providers working in an integrated way.

In doing that we want to reaffirm our GM model of care that has early intervention and prevention as an organising principle. We will describe our approach to seeking out those who are most at risk but unseen, and those who are seen and frequently use primary and secondary care services. We will use holistic, strength-based needs assessments through a personalised approach to coproduce care plans that include social, psychological and medical needs. This will be driven through a population health approach targeting those cohorts and conditions that drive demand through integrated working within local neighbourhoods. We will

[1] Primary Care Networks and Voluntary, Community, Faith and Social Enterprise Sector Partnerships Interim Report, March 2023

take learning from models such as proactive care, high intensity users, upstream models of care, focussed care to describe our single Greater Manchester model of care which we will look to mainstream over the next five years.

Our plan therefore is phased over the next five years, with an initial focus to understand the excellent work that has been delivered so far, sharing best practice and identifying barriers and challenges. To determine what can be done once at a GM level and where there can be central support to spread innovation and good practice. To identify where we can we influence and lever at a GM system level, regional level and nationally.

3.4 Outcomes

The benefits to individuals through integrated neighbourhood working will see a less fragmented service; fewer handoffs and a more seamless approach to care and support. The patient benefits are:

✓	To support individuals & communities to take **more control** and navigate their own health
✓	People remain **independent for longer** in their own home through early intervention & prevention
✓	Better experience of more **joined up, personalised care**
✓	People feel more **empowered to manage** their condition and feel more **socially connected** through asset based approaches
✓	**Less duplication and replication**, releases capacity and is more efficient by bringing in a wider range of partners
✓	Provides a focus on **tackling health inequalities** through the contribution of more partners and multi-disciplinary team working
✓	Focus on the **health & wellbeing of a defined population**
✓	**Reducing demand** on all parts of the system

From a Primary Care provider perspective, this will mean a more integrated way of working in the support and management of their patient's care. Being part of a broader integrated team in a joined up way therefore avoiding duplication, more timely intervention and a multi-disciplinary team approach to more complex cases.

Furthermore, working in broader partnerships with the VCFSE and wider public service will also seek to address the wider social determinants which often have a significant impact on the healthcare needs of people, i.e. housing, deprivation, employment.

Discipline	Headline Deliverables	Timescales	Accountabilities	Measures
Dental	To work collaboratively as part of integrated neighbourhood team – each neighbourhood to identify key stakeholders from across the four PC contractors and agree shared objectives	Soft launch June 2023, with review of initial implementation by March 2024	Locality Board Dental Provider Board	Monitoring of agreed shared objectives
General Practice	Each Primary Care Network, (PCN) to identify those patients who do not engage in mainstream health and care or those who are high intensity users of services, often as a result of wider social determinants and produce a multi-agency support plan, designed to meet their clinical and broader needs.	Initial cohorts by March 24, with further cohorts each year thereafter	Locality Board	20 patients per PCN in year one, rising incrementally to 5/1000 patients by March 26
	Ensure outreach/ neighbourhood-based activities are in place,	March 24 and thereafter	Locality Board	Initially, at least one session per month being delivered from a community venue(s), partnership working with the VCFSE.
	Implementation of a model designed to find and support those most in need which includes targeted approach to improve outcomes. Examples already in place in GM include the Focussed Care model,	March 24 and thereafter	Primary Care Committee Locality Board	Relevant models identified and implemented in each PCN.

	Care Co-ordination, Pro-Active care etc.			
Optometry	To work collaboratively as part of integrated neighbourhood teams – each neighbourhood to identify key stakeholders from across the four PC contractors and agree shared objectives	March 24 and thereafter	Locality Boards Optometry Provider Board	Monitoring of agreed shared objectives
Pharmacy	To work collaboratively as part of integrated neighbourhood team – each neighbourhood to identify key stakeholders from across the four PC contractors and agree shared objectives	March 24 and thereafter	Locality Boards Optometry Provider Board	Monitoring of agreed shared objectives

Case studies: Neighbourhoods/ integrated working

Working in partnership locally to reduce inequalities

The city of Manchester is the most ethnically diverse area of Greater Manchester, so making sure everyone across has equal access to healthcare services and addressing inequalities is a key priority.

The city's Covid-19 vaccination programme gave an opportunity to work closer than ever before at a neighbourhood level to meet local needs. Engaging partners across voluntary and community organisations helped identify any barriers to delivering care. Working with representatives from specific communities and inclusion health groups as 'sounding boards' for direction and advice, and as trusted 'messengers' within communities demonstrably closed the gap in vaccination coverage across communities. This approach was evaluated by the University of Manchester.

Manchester has built on this integrated approach, working with local neighbourhood teams, GP practices, community pharmacies, public health, and voluntary organisations to deliver more than more than 2,000 winter vaccines during autumn/ winter 2022/3 in 84 pop-up vaccination clinics. Clinics were based in markets, mosques, community centres, asylum accommodation, sex worker health clinics, supermarket car parks, student centres and warm hubs.

Community volunteers, social media messaging and text messages from GPs brought people through the door with 42% being ‘opportunistic’, and 30% of these saying they would not have had the vaccine had it not been there.

Working together in this way drove forward integration and Manchester is now using this experience to replicate a range of primary care services with a focus on reducing inequalities.

The importance of community organisations for health: VCSE and PCN partnership improving local links

Since January 2023, the Sale Central Primary Care Network (PCN) has worked with local voluntary, community, and social enterprise (VCSE) organisations to run regular drop-in sessions with a community health advisor.

Some people face specific barriers when accessing traditional services and feel unsure what services are available to them and what time and where.

The drop-in sessions for people living locally help tackle health inequalities by offering an alternative way for people to get help and support on health concerns.

The more informal setting removes some of these barriers and help residents feel more comfortable sharing any health issues they have, as well as specific concerns around smoking, weight management and diabetes. People are also supported to book cancer screening and vaccination appointments.

In one instance, an individual attended an appointment to get a blood pressure check but after speaking with the community health advisor, was given help to book vaccinations, and connected to Age UK Trafford who provided advice and support to help them as a primary carer for their spouse.

Working in partnership helps people get the advice needed to improve their health and wellbeing and be linked to services that can support further including cost-of-living advice, help as a carer, befriending and befriending services to combat loneliness.

Partnering with local VCSE organisations to deliver these sessions has helped community health advisors broaden their knowledge of the community services available in the area and build long-term relationships.

Primary Care Blueprint

Health inequalities

4. Health inequalities

We have a system of shared accountability for creating fairer health and tackling the root causes of inequalities, working in partnership with our communities to create healthier, greener and fairer places

What drives Inequalities?

The conditions we are born, grow, live, work and age in, affect our chance of having a long, healthy life.

Factors like our income, housing, jobs, education, relationships, access to green spaces and air quality all impact on our health. widening the preventable gaps between the people with the worst health and the people with the best health.

For example, adults and children who live in cold, damp housing may be more likely to develop respiratory problems over future years because their lungs are affected by the mould spores in their home. If we improved their housing now by working with partners such as local councils and housing associations, they may not end up with various health conditions in the future which can result in poor quality of life (conditions like asthma, chest infections, and other respiratory problems) and could avoid the need for multiple health and care services, helping to reduce health inequalities.

As employers, purchasers and estate owners, primary care providers can positively impact on the health and wellbeing of local communities by choosing to invest in and work with others locally and responsibly to create social value and create the conditions for a healthy life.

We are seeking to develop models where the allocation of primary care resources, is proportionate *to need*, so that prevention, early detection and treatment services are delivered to a scale and intensity that responds to the needs and assets of different communities.

It can be stated that current Primary Care Contractual arrangements and performance incentives do not always actively serve to reduce inequalities and do not always ensure that resources are targeted to communities and neighbourhoods with the greatest need. For example, short term, non-recurrent investment with restricted time for design can limit engagement and opportunities for co-design and co-delivery.

Core 20 Plus 5 and Population Health Management

This Blueprint makes reference to the Core20 Plus 5 construct as a means of defining issues relating to health inequalities and advocates a Population Health Management approach to delivery. For clarity and ease of reference, definitions for both are included below:

Core 20

The most deprived 20% of the national population as identified by the national Index of Multiple Deprivation (IMD). The IMD has seven domains with indicators accounting for a wide range of social determinants of health.

PLUS

Populations identified include ethnic minority communities; people with a learning disability and autistic people; people with multiple long-term health conditions; other groups that share protected characteristics as defined by the Equality Act 2010; groups experiencing social exclusion, known as inclusion health groups.

Inclusion health groups include: people experiencing homelessness, drug and alcohol dependence, vulnerable migrants, Gypsy, Roma and Traveller communities, sex workers, people in contact with the justice system, victims of modern slavery and other socially excluded groups.

5

There are five clinical areas of focus which require accelerated improvement. Governance for these five focus areas sits with national programmes; national and regional teams coordinate activity across local systems to achieve national aims.

- Maternity - Ensuring continuity of care for women from Black, Asian and minority ethnic communities and from the most deprived groups. This model of care requires appropriate staffing levels to be implemented safely.
- Severe mental illness (SMI) - Ensure annual physical health checks for people with SMI to at least nationally set targets.
- Chronic respiratory disease - A clear focus on Chronic Obstructive Pulmonary Disease (COPD) driving up uptake of COVID, flu and pneumonia vaccines to reduce infective exacerbations and emergency hospital admissions due to those exacerbations.
- Early cancer diagnosis - 75% of cases diagnosed at stage 1 or 2 by 2028.
- Hypertension case-finding and optimal management and lipid optimal management

Population Health Management (PHM)

Population Health Management is a way of working to help frontline teams understand current health and care needs and predict what local people will need in the future.

PHM uses historical and current data to understand what factors are driving poor outcomes in different population groups. Local health and care services can then design new proactive models of care which will improve health and wellbeing today as well as in future years' time.

Population Health Management focuses on the wider determinants of health – which have a significant impact as only 20% of a person's health outcomes are attributed to the ability to access good quality health care – and the crucial role of communities and local people.

PHM is a partnership approach across the NHS and other public services including councils, the public, schools, fire service, voluntary sector, housing associations, social services and police. All have a role to play in addressing the interdependent issues that affect people's health and wellbeing.

What will a fairer, greener, inclusive primary care system look like?

- The Fairer Health for All principles (see below) are embedded into culture and ways of working in all primary care organisations and partnerships.

- People working in community settings (primary care providers, VCFSE and wider public sector partners including secondary care) are enabled to work in partnership at neighbourhood level
- Performance, contracting and quality systems focus on improving outcomes for all communities not simply focusing on outputs and population averages.
- Investment in prevention, early detection and in upstream models of care is increased, recognising the requirement to invest in future generations and invest in maternity, early years and creating the conditions for good lives for our children and young people
- Primary care workforce capacity and capability is strengthened in areas of greatest need, and proactive recruitment and retention plans creates a workforce representative of the diverse communities we serve
- Primary care pathways are co-designed with people who are digitally, financially or culturally disadvantaged and excluded
- Tools that promote access and engagement for diverse communities are adequately resourced eg through free GP phone lines or multilingual receptionists and through different delivery models/points of access eg hyper-local community settings that people trust and are familiar with such as schools, community centres etc)
- Mechanisms for continuous learning enable VCFSE and public sector partners to learn and share together about system enablers for prevention, population health management, addressing inequalities and creating social value
- Transparent mechanisms for accountability on Fairer Health for All targets and check and challenge at all spatial levels

How will we create Fairer Health for All in primary care?

1. Utilise a bespoke suite of **Population Health management tools** (Practical tools and intelligence dashboards, developed once at GM level that can be adapted to suit local needs/priorities. These tools will be hosted online (GM Health and Care Intelligence hub) and utilised by neighbourhood partnerships (VCFSE and public sector partners) to combine health service data alongside community insight and use this shared intelligence to plan, deliver, monitor and evaluate primary care. The intelligence hub will curate intelligence about
    a. variation in access, experience and outcomes of care for inclusion health groups including CORE20PLUS5 pathways (for CYP and adults);
    b. modifiable causes of health inequalities and prevention pathways in primary care
    c. social, economic and environmental impact of primary care providers

   A range of tools will be available for use by people planning and delivering care to support risk stratification, reidentification, service improvement, cost benefit analysis and impact assessments and will require data leadership and data champions. This will enable Primary care resource to be distributed according to need in a socially, environmentally and financially sustainable manner.

2. Create the conditions for diverse leadership, workforce and talent to flourish across our public and VCFSE sectors through the Fairer Health for All Academy, including: :
    a. cross-sectoral communities of Practice to share learning on how we are reducing inequalities, enabling inclusion and Net Zero
3. Fairer Health for All Fellowship programme, with 20 Fellows per year from primary care, which will enable cross-sectoral learners from a non-public health background to develop their knowledge and skills in population health, equality and sustainability and to put their learning into practice in their workplace with guidance from professional mentors
4. Develop multimodal approach for primary care and simplify points of access: Standardised and core offer clearly communicated, working with communities to co-design and co-deliver communication and engagement plan
5. Develop a strategic workforce plan that aligns to the health needs of communities (interest, identity and geography) that is adequately resourced for inclusive recruitment, retention and workforce development. PCN/Localities/Local Care Organisation (LCO) /Provider Federation will be enabled to consider workforce constraints - Capacity/capability alongside wider primary care and neighbourhood workforce (including VCFSE) and to implement the real living wage
6. Locality boards to coproduce inequality reduction plan with locality GP/PC boards (advocating nationally when national contracting/funding allocation is not proportionate and being clear what is in scope within GM to change)

Note – Many of the headline actions contained in other chapters of this Blueprint will have a direct impact on reducing Health Inequalities and have not been reproduced here. In addition, we have also developed a significant suite of enabling actions for reducing inequalities, which form part of our Operating plan for the delivery of the Blueprint.

Discipline	Headline Deliverables	Timescales	Accountabilities	Measures
All	Develop and implement GM standards for Inclusion health and agree sustainable funding options (commissioning for Inclusion) and investment in prevention (for all adult and children CORE20PLUS5 pathways)	Standards to be developed during year 1, with implementation ongoing thereafter	PC Committee PH Committee Locality Boards PCNs	Adoption of standards and implementation secured
	Co-design a Population Health Management (PHM) approach to Primary Care that enables primary care providers and partnerships (including VCFSE) to understand needs and assets of different communities of interest, identity and geography and the impact on access, experience and outcomes of care.		PC Committee PH Committee Locality Boards PCNs	Co-design of intelligence, performance, finance, workforce development and governance tools

Case study: Health inequalities

A new way to deliver trans healthcare

Indigo Gender Service, an NHS adult gender service first launched in 2020, as a partnership between gtd healthcare, a not-for-profit organisation with an established presence of primary care and urgent care services in the north-west and the LGBT Foundation, a national charity delivering services, advice and information for lesbian, gay, bisexual, and trans communities.

Indigo Gender Service is NHS England's adult trans healthcare pilot service for Greater Manchester, helping trans and non-binary people to thrive by moving trans health care into a primary care setting.

A team of care navigators with lived experience works with people who access services to help them to get the most out of the service and enable them to connect with local organisations across Greater Manchester.

The Indigo Gender Service includes an all-round assessment of an individual's needs. It offers referrals and signposting to other services, as well as access to in-house counselling, and voice and communication therapy. Within its non-clinical team, the service has trans and non-binary staff at every level of the service. In addition, unique to Indigo, all the care navigator team identify as trans or non-binary, meaning they can offer a truly 'by and for' service.

The key to the success of the service has been the close partnership formed between gtd healthcare and LGBT Foundation. The service also has an ongoing process of coproduction that combines clinical expertise with community understanding. This includes its service user group who meet regularly to feedback and ensure the service is continuously improving .

Working with Mind to increase uptake of Severe Mental Illness checks

TABA PCN (Tyldesley, Astley, Boothstown and Atherton) which has eleven practices in its network has introduced several initiatives to tackle health inequalities, one of which was with the charity, Mind, to increase uptake of Severe Mental Illness (SMI) health checks. Staff from Mind spent two to three weeks in each practice contacting patients on the SMI health check register to discuss general health concerns, whilst encouraging them to come forward for an SMI health check.

Patients were much more open to discussing their health with volunteers and staff from Manchester Mind who used a more holistic approach to tackle problems affecting people, from housing issues to money worries as well as physical and mental health concerns. This led to further discussions about the benefits of SMI health checks resulting in an increase in the uptake of health checks across the PCN.

The project with Mind also coincided with the purchase of two new point-of-care (POC) blood test machines which rotate around practices in the PCN. The blood test machines provided two types of blood tests - hemoglobin A1c (HbA1c) and lipid testing - both important elements of a health check. Historically, the PCN found it difficult to get patients to have these blood tests as they were only done at Leigh Infirmary which for many patients felt difficult to access, often resulting in no-shows and this part of the SMI health check being incomplete.

Primary Care Blueprint

Prevention

5. Prevention

"In Greater Manchester, we aim to deliver a primary care system which helps people to stay well and focuses on the prevention and early detection of ill health, and the effective management of long-term conditions."

The Current Position

In GM, people become ill earlier, spend more time in poor health, and die earlier than the national average. Life expectancy and healthy life expectancy for people born in GM is significantly lower than the England average. There are also significant health inequalities within the city-region. For example, a male born in Manchester can expect to live an average of almost 5 years less than a male born in Trafford. For healthy life expectancy there is almost 10 years difference between individual local authority areas.

Much of the burden of poor health and early death in GM can be attributed to conditions that are preventable (including many cardiovascular and respiratory diseases, type 2 diabetes, and some cancers). It is estimated that 42% of morbidity and premature mortality in England is attributable to modifiable risk factors such as smoking, hypertension, high glucose, obesity, unhealthy diets, and alcohol use. Inequalities in health, and in the prevalence of these risk factors, are driven by inequalities in the social determinants of health (e.g. housing, education, income, employment, violence); the circumstances in which people are born, grow, live, work, and age. It is estimated that these social determinants of health may account for 30-55% of health outcomes.

There has been significant progress since devolution in helping people across GM to start well, live well, and age well (including scaled, multi-component approaches to some of our main modifiable risk factors). However, health inequalities and access to preventative services were impacted during the pandemic, with some services being slow to recover. As we continue to work towards pandemic recovery, we have the opportunity to re-focus, build on previous work, and create a primary care system that supports residents in GM to stay well for longer; working alongside patients and communities to build healthy lives and places.

Our goals for improvement

The World Health Organisation (WHO) defines prevention as: "approaches and activities aimed at reducing the likelihood that a disease or disorder will affect an individual, interrupting or slowing the progress of the disorder or reducing disability"[2].

Aligning with the GM Framework for prevention and work outlined within the GM Joint Forward Plan, our goals are to:

- Support individuals across the city region to protect, maintain and improve their mental and physical health, wellbeing, resilience, and social connections.
- Create a culture where prevention is seen as 'everyone's business' across the primary care workforce (including GP, pharmacy, dentistry and optometry), and neighbourhood teams, and enable staff to take action.

[2] GFIV_fr_e.indd (who.int)

- Work with the wider system partners (including the VCFSE sector) to support people to reduce health harming behaviours.
- Detect illness at an early stage and ensure it is proactively managed to reduce the risk of progression.
- Ensure that long-term conditions are effectively managed with a low carbon approach to reduce their impact on individuals, the wider system, and the environment.
- Tackle health inequalities by working with system partners to address the wider determinants of health and wellbeing through integrated neighbourhood working.
- Work in partnership to prevent violence and create supportive and cohesive communities, in accordance with the Serious Violence Duty.
- Expand culturally appropriate, locally led preventative services that better reach into all communities, and those not in contact with NHS services.
- Continue to work with the VCFSE sector to ensure that engagement, co-design and co-production are integrated into programmes of work to improve equity of access, experience and outcomes, and to enable the VCFSE sector to act as catalysts and connectors for communities in GM.
- Shift the focus of activities and resources away from urgent and emergency care and towards prevention.
- Achieve widespread implementation of upstream models of care, which means delivering care that is: person-centred, health promoting, integrated with wider welfare and social support, trauma responsive, targeted/ proportionate to need, and environmentally and socially sustainable.

Areas of Focus

Our areas of focus are outlined below. However, several aspects of our work on prevention are covered in other chapters (including the important role primary care plays in environmental sustainability, tackling health inequalities, and integrated neighbourhood working).

1. **Prevent** or reduce the risk of ill health.
    - Increase vaccination uptake, especially among target populations (focusing on COVID-19, influenza, pneumonia, and childhood vaccination).
    - Ensure equitable access to high quality contraceptive services, and support system work to reach zero new transmissions of HIV and hepatitis B and C.
    - Work with system partners (including the VCFSE sector) to develop pathways, tools and resources to support primary care staff to provide care that is person-centred, trauma-responsive, health promoting and integrated with broader welfare, financial, emotional, and social support
    - Maximise the availability, reach and impact of social prescribing and allied approaches so that people can access a wide range of ways to manage their health and wellbeing that are ‘more than medicine’.
    - Optimise primary and secondary prevention programmes to improve oral health.
    - Optimise primary and secondary prevention programmes, to support system work to Make Smoking History.
    - In accordance with the Serious Violence Duty, share intelligence on serious violence, and work with system partners to prevent it.

2. **Detect** conditions, or risk factors for disease, at an early stage.
    - Increase the uptake, reach, quality, and impact of NHS health checks across GM, with an initial focus on high-risk and inclusion health groups.
    - Work in partnership to improve hypertension/AF case finding and diagnosis pathways in wider primary care (building on the current work in community pharmacies), and non-NHS settings, with a focus on CORE20+ groups.
    - Optimise the SMI and LD Health Check programmes.
    - Support identification and referral of people experiencing (or who are at risk of experiencing) serious violence, or in whom there are safeguarding concerns.
    - Increase the proportion of cancers diagnosed at an early stage through optimisation of the early cancer diagnosis DES.
3. **Protect** people from worsening ill health by effectively **managing** long-term conditions or risk factors for disease at an early stage.
    - Support high quality, evidence-based, equitable management of cardiovascular risk factors (lipids, hypertension, AF) across all patent populations.
    - Through proactive care and the Aging Well Programme, work with the GMCA (the Aging Hub), and Falls Collaborative to prevent falls through early intervention.
    - Support high quality, evidence-based, equitable management of long-term conditions across all patient populations, using a low carbon approach.

This work will be enabled through:

- Strengthening relationships at place between primary care, Health and Wellbeing Boards, Community Safety Partnerships, and locality public health teams.
- Using data and insights and partnering with the VCFSE sector to co-develop interventions and models of care that better target and engage people at higher risk of illness and those not in contact with healthcare services.
- Mapping current provision and agreeing appropriate standards across all ten localities, which can be flexed according to local assets and need.
- Ensuring all primary care staff have access to appropriate training on topics such as MECC, trauma-responsive care, the links between health and climate change and person-centred care.

Benefits

There are significant potential benefits of this work, which reach across the whole health and care system. In the short-term, we might expect to see a reduction in unwarranted variation in care, improvements in wellbeing, stronger, more connected communities, and a reduction in health-harming behaviours (such as smoking, unhealthy diets, physical inactivity and alcohol excess). In the medium and longer term, we would expect to see a reduction in the prevalence and exacerbation of long-term conditions and an associated drop in the demand for urgent and routine care, along with a reduction in health inequalities. This will lead to cost savings for the NHS, increased productivity, and wider economic growth.

Discipline	Headline Deliverables	Timescales	Accountabilities	Measures
Dental	Build on previous work to roll-out Healthy Living Dentistry programmes across GM.	2024 - 2029	Primary Care Committee Primary Care Provider Board	Increased participation in programme, including at the enhanced level of participation, (level 2)
	Optimise primary and secondary prevention programmes to improve oral health via: • Delivery of an Oral Health improvement with dental access programme for 0–5-year-olds. • Delivery of an Oral Health improvement with dental access programme for customers of the Working Well (Work and Health) programme for unemployed people with health conditions or disabilities, and those in long-term unemployment.	2024 - 2029	Primary Care Committee Primary Care Provider Board	• Decrease in 5 year olds with dental decay. • Increase the number of children participating in the GM Oral Health Improvement Programme
General Practice	Improve the early detection and management of risk factors for illness (focusing on CORE20+5 populations and conditions, and including the VCFSE sector as a delivery partner), for example, by increasing the uptake, reach, quality and impact of Learning Disability, Severe Mental Illness and NHS health checks across GM.	2024 - 2029	Locality Board	• Improved uptake and quality of NHS health checks (including a reduction in inequalities in uptake among target groups). • Improved uptake and quality of LD and SMI health checks • Improved CVD outcome

				measures (admissions, prevalence, mortality) • Improvements in the main modifiable risk factors for CVD
	Improve the management of long-term health conditions (with a particular focus on CORE20+5 populations and conditions) including: • Improving the diagnosis of COPD and asthma by improving access to quality assured spirometry at a neighbourhood level.	2024 - 2029	Locality Board	• Increase in diagnostic spirometry for children. • Increase the number of people who have been diagnosed with Asthma/COPD and have a quality assured spirometry on record
Optometry	Build on previous work to roll-out Healthy Living Optical practice and programmes across GM.	2024 - 2029	Primary Care Committee Primary Care Provider Board	Increased participation in programme, including at the enhanced level of participation, (level 2)
	Improve the management of long-term health conditions (focusing on CORE20+5 populations and conditions) including: • Promote and enhance access to the Easy Eye Care Learning Disabilities Service pathway • Agree referrals routes for people	2024 - 2029	Primary Care Committee Primary Care Provider Board	Increased number of people with LD having appropriate eye care. Increase the number of people who have been diagnosed with Hypertension and/or AF

	presenting to optometry with suspect falls into appropriate falls services. • Scope out the potential to pilot an optometry falls service. • Explore options to pilot and roll-out AF and hypertension case finding within optometry (building on the learning from other schemes across the country in optometry and pharmacy).			
Pharmacy	Improve the management of long-term health conditions (focusing on CORE20+5 populations and conditions) including: • Commissioning of Structured Medication Reviews and /or other services within Community Pharmacy to build on integrated working with PCNs, including stop smoking support (subject to change according to national commissioning arrangements).	2024 - 2029	Primary Care Committee Primary Care Provider Board	Increased levels of medicines reviews conducted and increased evidence of joint working with PCNs to deliver a wider range of initiatives

	Consider commissioning CVD health checks to further extend the hypertension case finding service offer (dependent on available funding)	2024 - 2029	Primary Care Committee Primary Care Provider Board	• Improved uptake of NHS health checks (including a reduction in inequalities in uptake among target groups). • Improved CVD outcome measures (admissions, prevalence, mortality) • Improvements in the main modifiable risk factors for CVD
Pharmacy/ General Practice	Increase vaccination uptake, especially among target populations (focusing on COVID-19, influenza, pneumonia, and childhood vaccination)	2024 - 2029	Primary Care Committee Primary Care Provider Board	• Achieve and sustain ≥ 95% coverage with two doses of the MMR vaccine in the routine childhood programme (<5 years old) and reduce inequalities in uptake in specified cohorts. • Increase the proportion of people over 65 receiving a seasonal flu vaccination to ≥ 85 and reduce inequalities in uptake in specified cohorts. • Demonstrate improvements in flu and

				COVID-19 uptake and reduce inequalities in uptake in specified cohorts.

Case studies: Prevention

Community connections: taking health and wellbeing support on the road

The health and wellbeing team for Denton, Audenshaw and Droysden (DAD) Primary Care Network (PCN) is taking their care into the community to encourage people to look after their own health and embrace self-care.

Over the last two years, the team has grown from one to eight care coordinators, first introduced to help run the Covid-19 vaccination programme, but now supporting lots of health promotion activities, including hypertension (high blood pressure) workshops in the community.

The coordinators have a rolling diary of 15+ groups they attend such as coffee mornings, luncheon clubs and playgroups. Through GP records, they identify who's had a high blood pressure recorded and do a free follow-up check. If it's still high, people are given advice, a monitor, and a diary, along with a follow-up appointment. Those who are not registered with a local GP practice are offered support and advice on how to lower and prevent heart disease and other related problems.

The coordinators also attend weekly sessions at the Tameside Wellness Centre and Matlock Sports Centre where they partner with sports coaches who offer patients free gym sessions, whilst the DAD team give health and wellbeing coaching to support individual needs and goals towards a healthier lifestyle.

The next step is to build on this success and introduce a cancer care coordinator to join the health and wellbeing team at their community groups to promote screening awareness, increase attendance and signpost to local cancer support services.

Tackling high blood pressure through community champions

Big Life's Living Well service designed the 'Community Champions' project in Rochdale to deliver blood pressures checks at local events and raise awareness of cardiovascular disease. They wanted more people to be alert to the dangers of high blood pressure and know where they can go to measure it, such as a pharmacy or GP. Heart attacks and strokes can be associated with high blood pressure, with many people not realising their blood pressure is high.

Between February and August 2023, 1480 blood pressure checks have been carried out with over 29% of people (430) found to have a high blood pressure. 418 people received a follow up call, of those who answered (260), 89% of people accessed support from their GP, which for some included home monitors or medication. Others received urgent or hospital care.

Following a successful rollout, Living Well have created two new roles for community workers from South Asian communities to increase attendance at GPs for cholesterol checks. On street engagement has taken place to identify any barriers to attendance and improve uptake.

Primary Care Blueprint

Sustainability

6. Sustainability

Primary Care which is viable for the long term, ensuring that services are available when and where needed.

Achieving a Net Zero NHS GM Integrated Care Carbon Footprint by 2038

6.1 Viability of our PC System

High quality Primary Care is a critical and cost-effective part of the health care system. Patient satisfaction, while variable, is generally high. Although escalating demand and resource pressures can lead to growing dissatisfaction, especially around access to services.

We currently face significant challenges to the long term viability of elements of our Primary Care system in a number of areas, with recent examples including:

- The potential withdrawal from the market of a significant community pharmacy provider, including the closure of many branches situated within a major supermarket chain
- A significant reduction of a major dental provider's portfolio and a number of other providers moving away from NHS provision of dental care
- GP practices "handing back the keys" on their contracts

Unprecedented demand and workforce supply issues both contribute to the current pressures and are explored elsewhere in this document.

We recognise that, without tackling these issues head on, the delivery of the ambitions set out across the course of this document will be severely restricted and in many cases, will simply become unachievable.

6.2 Securing our future

The introduction to this document sets out our ambition to "ensure that Primary Care survives and thrives". To deliver on this ambition will require some concerted joint working including work to:

- Work across our health and care system with a view to the rebalancing of our investment models, with Primary Care making material contributions to the delivery of our wider strategic goals.
- Secure funding which enables longer term planning and delivery, with less reliance on short term, non-recurrent investment models
- Complete our GM wide review of quality and incentive schemes, initially focussing on existing schemes but moving into all four disciplines, which aims to align such schemes with the delivery of this Blueprint, as well as seeking to ensure appropriate and equitable levels of investment across GM.
- Creating and using an infrastructure which means that Primary Care is in a position to respond as equal partners to opportunities to secure new investment and has

arrangements in place to oversee delivery and gain the most value from its funding allocations

- In support of the above, ensuring that Primary Care is properly represented and is heard appropriately at locality and GM level to ensure that it has the opportunity to be present at all stages of development and allocation processes
- Working at regional and national level to influence and shape developments, for example, work on updated contracts for General Practice and Dental or in describing new models of care, emphasising the potential role and contribution of wider primary care
- Working closely with individual providers and wider organisations or representative bodies, e.g. Local Representative Committees, PCNs, Community Pharmacy GM, Provider Federations, Local Professional Networks and others, to provide support where needed and to ensure that opportunities for investment are being maximised, eg via ARRS funding etc.

6.3 Developing new ways of working

We recognise that to achieve a viable and flourishing Primary Care system for the future will require a programme of change management including support for:

✓	Development of outcome based information as evidence for commissioning decisions
✓	The mobilisation of a large collection of individuals, groups, and organisations towards an integrated model of care
✓	The creation of a culture where citizen involvement and engagement is the norm, where health and care is responsive to what is important to citizens and where there is a real feeling of working together
✓	Sharing good practice and spreading what we know works across neighbourhoods and localities

We will create a **Primary Care Delivery Model** for the needs of the population in 2025 and beyond, recognising the potential to broaden the role of Primary Care, as part of a wider redesign of our public service delivery model

6.4 A Sustainable Primary Care System

We are taking the opportunity, via the Publication of this Blueprint, to commit to playing a full part in delivering the aims of the NHS GM Integrated Care Green Plan:

- To achieve a net zero NHS GM Integrated Care Carbon Footprint by 2038 – this target is the science-based approach outlined in the GMCA 5-Year Environment Plan. We will seek assurance that providers are delivering against their own plans, whilst focusing on priorities that we can deliver most effectively by working together.
- To achieve a net zero NHS GM Integrated Care Carbon Footprint Plus by 2045 – this is a national NHS target to eliminate the carbon impact of the goods and services we buy. We will work closely with national and regional partners to achieve this

Primary care is responsible for 25 per cent of the NHS's carbon footprint, so it is clear that we have a central role in delivering on the above objectives. A 10-step plan to greener primary

care https://gmpcb.org.uk/sustainability/sustainability-10-step-plan/ has been developed to provide a starter guide to help primary care teams start to reduce their environmental impact. The headline themes from the 10-step plan are shown below:

Talking about sustainability

1. Declaring a climate and ecological emergency
2. Engage and educate the whole primary care team
3. Engage your patients

Prescribing

4. Focus on inhalers
5. Optimise prescribing

Business

6. Calculate your primary care organisation's carbon footprint
7. Decrease energy use, improve practice energy efficiency and consider switching to a renewable energy supplier
8. Active travel
9. Think about sustainable procurement and use of resources

More ideas

10. Upping your game

Discipline	Headline Deliverables	Timescales	Accountabilities	Measures
All	To **achieve a Net Zero NHS GM Integrated Care Carbon Footprint by 2038** – this target is the science-based approach outlined in the GMCA 5-Year Environment Plan. We will seek assurance that providers are delivering against their own plans, whilst focusing on priorities that we can deliver most effectively by working together. To achieve a net zero NHS GM Integrated Care Carbon Footprint Plus by 2045 – this is a national NHS target to eliminate the carbon impact of the goods and services we buy. We will work closely with national and regional partners to achieve this.	2024 – 2038/ 2045	Primary Care Committee	Progress towards the relevant trajectories described in the GMCA Environment Plan and the NHS GM Net Zero Strategy
	To **ensure a viable Primary Care system in Greater Manchester**, equipped to deliver the wider vision and deliverables set out in this Blueprint, including: • Influencing national contractual review processes • Creating investable propositions which will secure	2024 - 2029	Primary Care Committee	Reductions in numbers of closures or handing back of contracts across all of our contractor groups. Read across to the overall success of the implementation of this Blueprint and the associated deliverables.

	necessary funding injections and where necessary, shifting investment into Primary Care from other parts of our system • Ensure regular reviews of tariffs and funding arrangements for services commissioned under NHS standard contracts			
	Transformation: Develop new clinical delivery models in order to meet demand, altering the way in which primary care operates and interacts with individuals, families and local communities. Work together as primary care providers within an Integrated Care System and at a locality level with colleagues in social care and the voluntary sector.	2024 - 2029	Primary Care Committee	Reductions in numbers of closures or handing back of contracts across all of our contractor groups. Read across to the overall success of the implementation of this Blueprint and the associated deliverables.

Case studies: Sustainability

Greater Manchester Dental Quality Scheme improving access to dentistry

A new dental quality scheme was introduced in June 2023 with the aim of improving patients' experience of access to dentistry. It's the only quality scheme of its kind run by an integrated care system in the country. It was set up in response to lots of feedback from

people that are finding it difficult to see an NHS dentist locally, whether they are in pain or not.

Around 22,000 new patients have been able to access NHS dental practices since the launch of the scheme, with 175 dental practices now signed up.

Practices signed up to the scheme are expected to:

- Be open to new patients and ensure their details on the NHS website (www.nhs.uk) reflects this, showing that they are accepting new adult and child patients.
- See and treat an agreed number of new patients.
- Be part of the wider urgent dental care system, which provides treatment for dental problems that cannot wait, when dental practices are closed or for those who do not have a regular dentist.

Reducing the carbon footprint of inhaler prescribing

Metered dose inhalers (MDIs) are the most common type of inhaler used in the UK, commonly used to treat asthma, COPD, and other respiratory conditions. When patients press the metal canister of the MDI into its plastic case, a gas is released that helps get the medicine to patients' lungs. When this gas is released, it stays in the atmosphere trapping the sun's heat, like glass in a greenhouse. This warms the planet which is a problem for the climate. Climate change also increases air pollution which can worsen lung conditions.

There is growing awareness and concern from health care professionals and patients alike about the impact of MDI inhalers on our environment. With over 300, 000 inhalers prescribed each month in Greater Manchester, with the equivalent climate impact of 28,000 cars; GP practices, pharmacies, hospitals, and patients have started making a difference through working together towards greener inhaler choices.
For many people, this can involve a switch to a dry power inhaler, or a combination inhaler. For all patients, it is ensuring they have the most appropriate treatment to get the best control of their illness; and when their inhalers are empty, returning to their pharmacy for proper disposal. So far, this has resulted the equivalent of 3,000 cars being taken off the road in Greater Manchester.

People should only make changes once they have spoken to health care professional and should continue to take inhalers as prescribed until then.

Pencycle Recycling Initiative

Greater Manchester local pharmaceutical committee (GMLPC) and Novo Nordisk identified a need for community pharmacies to engage with initiatives to reduce the sector's carbon footprint, in line with the Greener NHS agenda. Novo Nordisk, who make pens for diabetes and weight management treatments, approached GMLPC to work on and help launch PenCycle, a first-of-its-kind recycling initiative for insulin pens, with the aim of reducing landfill plastic waste. The scheme has led to greater awareness of the environmental impact

of disposable pens and provides an easy way for patients to reduce their carbon footprint. PenCycle has enabled partnership working across the healthcare sector and has established community pharmacy as a key partner to contribute to a Greener NHS.

228 community pharmacies in Greater Manchester, almost 40% of all pharmacies have joined the scheme to reduce plastic waste in the healthcare sector. As pens cannot be thrown into the plastic recycling along with common household products, most pens end up in landfill, with a small number burnt in a process called incineration. Landfill uses a lot of space and is unsustainable, while incineration uses a lot of energy and leaves some plastic waste behind.

People with diabetes, obesity and other conditions are asked to return their empty pens in a dedicated PenCycle return box to pharmacies so they can be recycled and given new purpose. Pharmacies arrange for these to be collected when they have a full box. Over 20, 000 pens have so far been returned locally with plastic from these pens being reused in furniture and lightbulbs.

New Jackson Medical Centre opens to community with green credentials

New Jackson Medical Centre, located across the ground and first floors at Elizabeth Tower on Chester Road, houses new additional practice sites for Cornbrook Medical Centre, Vallance Centre in Ardwick and the Docs, in Bloom Street. It is the first GP medical centre to open in Manchester city centre since the City Health Centre in the Arndale shopping centre in 2009.

Funded with the help of a £2.6m grant from Manchester City Council and £1m from NHS England, and having taken four years to complete, it houses 16 clinical rooms and will eventually be able to serve more than 20,000 patients.

With a school and park also being built in the vicinity, the medical centre will be able to cater for an influx of new and existing residents in and around Manchester city. It will also free up capacity in Cornbrook, Vallance and the Docs, and offer more appointments.

A wide range of community health services will also feature, along with ultrasound and dermatology services. Thanks to the NHS Additional Roles Reimbursement Scheme (ARRS), GPs will be able to call on care coordinators, pharmacists, social prescribing link workers and physiotherapists in the new building.

The building's green credentials are consistent with NHS Greater Manchester Integrated Care's commitment to achieve a net zero carbon footprint by 2038. It expects to achieve a 'BREEAM' environmental rating of 'excellent' with its focus on waste management, energy efficiency, transport (proximity to Metrolink stops) and pollution reduction.

The creation of the new Jackson Street neighbourhood by Renaker also supports Manchester City Council's wider ambition of continued population growth within the city and the demand for quality and low-carbon homes, close to transport hubs and new local services.

Primary Care Blueprint

Digital

7. Digital

Empowers citizens and providers with high quality, digitally enabled Primary Care.

7.1 Context

In Greater Manchester, we aim to deliver a Primary Care System which empowers citizens and providers with high quality digitally enabled Primary Care.

Digital technologies have been ubiquitous in nearly all our daily lives for many years now and Primary Care is no exception to this. Effective utilisation of digital tools can improve efficiency and experience for the users and workforce of Primary Care, recognising that digital tools are not always the most appropriate interface for everyone in the population. As an enabler to Primary Care, digital has a role across all the themes in this blueprint however there are both foundational requirements and aspirational goals to be achieved.

This chapter is structured around four pillars that must be considered to leverage digital as an effective enabler for Primary Care. They are: inclusion, engagement and communication; workforce, training and skills; hardware and infrastructure.

7.2 The current situation

Digital tools are widely deployed but there is considerable variation in both what is in place and how the tools are deployed.

i. *Inclusion, engagement & communication*
    a. Inconsistencies in adoption of digital across people and places
    b. Digital inclusion has not been at the forefront of design of tools
ii. *Workforce/training/skills*
    a. Not currently getting the most out of digital tools
    b. Rapid adoption at start of the pandemic was not pre-empted with robust training
    c. Lack of investment in training workforce with digital skills across Primary Care
iii. *Hardware and infrastructure*
    a. Inequity in hardware available within and between Primary Care disciplines in GM
    b. Digital hardware funding is available for General Practice but not for other Primary Care disciplines
iv. *Software*
    a. Inconsistency in deployment and use of different software available for Primary Care
    b. Rapidly evolving ecosystem of products in use in Primary Care
    c. Lack of consistent interconnectivity and interoperability between Primary Care providers
    d. Limited funding for software is available for General Practice but not for other Primary Care disciplines

7.3 Our aims

Digital tools when deployed effectively will make Primary Care work better for users and the workforce, enabling more efficient and effective care that is experienced positively by all.

i. *Inclusion, engagement & communication*
    a. Accessible and usable tools
    b. Digitally inclusive services, recognising that digital exclusion does not always follow standard patterns of exclusion and health inequality
    c. A population that is knowledgeable about how and when to access care digitally.
ii. *Workforce/training/skills*
    a. Robust training plan for the whole GM Primary Care workforce to enable digital tools to be deployed to maximal effect
iii. *Hardware and infrastructure*
    a. Appropriate hardware in place to make Primary Care fit for purpose now and to be flexible to ensure this is kept fit for purpose in the future
iv. *Software*
    a. Appropriate software in place to make Primary Care fit for purpose now and to be flexible to ensure this is kept fit for purpose in the future

7.4 Our plan to deliver

The digital tools currently available to Primary Care are plentiful, with new tools constantly in development. We will need to take a collaborative approach as a Greater Manchester Primary Care system, ensuring a minimum level of digital capability and functionality across the region, whilst allowing flexibility to account for nuances in local variations in need.

i. *Inclusion, engagement & communication*
    a. Effective use of data e.g. Digital Environment Research Institute (DERI)
    b. Digital inclusion must be a fundamental consideration in all developments.
ii. *Workforce/training/skills*
    a. Create training standards and provide support to Primary Care to achieve them
iii. *Hardware and infrastructure*
    a. Agree a minimum standard of digital hardware for all Primary Care within an appropriate financial envelope to enable Primary Care to achieve its desired outcomes
iv. *Software*
    a. Agree a minimum standard of software functionality for all Primary Care within an appropriate financial envelope to enable Primary Care to achieve its desired outcomes

7.5 Describing the Benefits

There are significant benefits of enhancing our digital capabilities and functionality in Primary Care. When our human resources are stretched as they are now and have been for some time, digital tools can enable Primary Care to work more effectively and efficiently. Patients will benefit from Primary Care delivering a more effective service, enabling them to have better access to their health information and promote prevention and self-care.

i. *Inclusion, engagement & communication*
    a. Support Primary Care to meet the needs of the population
ii. *Workforce/training/skills*
    a. A digitally enabled workforce can be deployed in a more agile way
    b. Opportunities for new career pathways will support a more sustainable workforce
iii. *Hardware and infrastructure*
    a. Appropriate hardware to meet the needs of Primary Care to achieve their desired outcomes.
iv. *Software*
    a. Appropriate software to meet the needs of Primary Care to achieve their desired outcomes
    b. We can optimise user experience through deployment of fit-for purpose software

7.6 Issues for management through the implementation process

We must ensure that the deployment of digital tools does not worsen any inequalities that exist in Greater Manchester and must not create new ones. It is important to acknowledge that digital tools come at a cost and demonstrating return on investment is essential, however we acknowledge that this is not always easy to quantify due to the complexity of Primary Care.

i. *Inclusion, engagement & communication*
    a. Huge task to effectively engage the population, specifically those at risk of digital exclusion and health inequalities
    b. Digital inclusion must be considered from the outset of any development and deployment plans for digital tools
ii. *Workforce/training/skills*
    a. Cost of ongoing training and development of the workforce
    b. Workforce turnover and continuity of knowledge and skills must be continuously considered
    c. Ongoing digital transformation requires organisational cultural change
    d. Effective deployment of digital tools at scale requires some standardisation of processes, which is challenging when needed across the numerous providers of Primary Care in Greater Manchester
iii. *Hardware and infrastructure*
    a. Investment across Primary Care in digital hardware will be required and funding across the breadth of Primary Care is currently lacking
iv. *Software*
    a. Understand levels of standardisation and potential controversy of standardisation
    b. Ongoing costs of licensing should be continuously monitored
    c. As software available to enhance Primary Care continues to grow, funding may not be available to purchase new products across all Primary Care disciplines

Discipline	Headline Deliverables	Timescales	Accountabilities	Measures
All	Work in collaboration with local authorities and clinical providers to tackle digital exclusion, collating and building on existing work done across localities and PCNs . Each locality to build on existing delivery of projects in collaboration with local authority and VCFSE colleagues to improve digital inclusion, with learning and case-studies shared via the Centre of Excellence described in 6.6.	2024 - 2026	Locality Primary Care Teams/Locality Digital teams	Evidence provided by localities
	GM Care Record to be functioning as a live and dynamic tool, with data integration across all Primary Care, Secondary Care and Community providers to facilitate a live and integrated view of a patient's care journey in GM.	2024 - 2026	Primary Care Digital Board GM Digital Transformation Board	Measurement of access instances for GMCR in Primary Care
	Alignment with GM Combined Authority, (GMCA) pledge to make GM a 100% digitally enabled city region, including improvement of GM-wide internet connectivity and data availability.	2024 - 2029	Primary Care Digital Board GM Digital Transformation Board	Compliance with the relevant GMCA measures and metrics

	Electronic prescribing availability to all prescribers	By 2029	Primary Care Digital Board GM Digital Transformation Board	% of prescribers using electronic prescribing
Dental	GM Care Record access for Dental Practices across GM	2024 - 2026	Primary Care Digital Board GM Digital Transformation Board	% of GM Dental Practices with access to GMCR % of Dental Practices actively using GMCR
General Practice	Facilitate enhanced digital access to general practice, via the rollout of the NHS App and enhanced telephony support, supported by the delivery of a communications campaign to patients on how and when to access care digitally.	Year 1	Digital First Primary Care Programme	NHS App data - number of appointments booked, number of repeat prescriptions ordered, number of new downloads of NHS App. Practice and PCN telephony data, including average wait time, call failure rate, patient satisfaction. NHSE website audit tool outputs.
	Digitisation of paper GP “Lloyd George” records	2024 - 2029	Primary Care Digital Board	% of GP Practices with digitised Lloyd George records Audit of estate space saved as a result of digitised Lloyd George records

	Fully implement cloud-based telephony across General Practice to facilitate a more effective patient experience in contacting the practice		Primary Care Digital Board	Number of practices reporting using cloud based telephony effectively to support triage and navigation.
Optometry	GM Care Record access for Optometry across GM	2024 - 2026	Primary Care Digital Board GM Digital Transformation Board	% of GM Optometry practices with access to GMCR % of Optometry practices actively using GMCR
	Ongoing availability of Electronic Eye Care Referral System across GM	2024-2029	Primary Care Digital Board GM Digital Transformation Board	% Optometry practices with access with EeRS % Optometry Practices actively using the EeRS
Pharmacy	GM Care Record access for Community Pharmacy across GM	2024 - 2026	Primary Care Digital Board GM Digital Transformation Board	% of GM Community Pharmacies with access to GMCR % of Community Pharmacies actively using GMCR

Case studies: Digital

Transforming care through digital eye care referrals

A new referral process across eyecare services in Greater Manchester is improving patients' care experience by making it easier for all referrers to send directly to the right service first time round.

Optometrists can now refer patients directly to hospital for treatment rather than asking the GP to make a referral. This saves time between referral and appointment, reduces the risk of lost referrals and is more efficient.

With over 55, 000 referrals made via the Electronic Eyecare Referral Service (EERS) over 2022 to 2023, and 99% of Greater Manchester practices signed up, the benefits have been felt by patients and professionals alike.

Ophthalmologists (eye-care consultants) can access the results of eye-care imaging tests, when available, at the point the referral is received. This means patients may not need to visit the hospital for a physical assessment.

Patients receive better care, as the service allows optometrists to share more information and high-quality images with the hospital to inform a patient's treatment.
GPs are still informed when a referral is made, and their time is better used for more appropriate appointments.

The project is continuously evaluated for key learning areas, staff training and potential expansion into other areas.

Beating the 8am rush at Cheadle Medical Practice

Recognising the long call waits on a Monday morning, and patient frustration when appointments quickly ran out due to capacity, one practice has opted for total digital triage and is seeing improvements to satisfaction all round and a drop in phone calls, approx. 10% so far.

Every patient contacting the practice first provides information on their symptoms in a short questionnaire, so care can be provided by the right healthcare professional with the right level of urgency.

No one is excluded as the highly trained reception team support those unable to use the internet to complete the questionnaires, which identify red flags to help the GP make the most appropriate decision.

With over 60 custom questionnaires covering common symptoms, these keep practice productivity high by helping the GP identify any red flags early in the process, empowering them to make better decisions. A service directory embedded into the

practice clinical system complements this with receptionists able to suggest appropriate referrals such as a community pharmacist. These referrals have increased from 8 to 19 per week, freeing up appointments for those in need.

One GP each day triages the incoming requests, freeing others to do routine appointments which there is now space for. The practice now sees 96% of patients within two weeks, up from 82% beforehand. Patient feedback has improved with numerous positive reviews and 'Friends and Family' responses.

The practice is keen to help other practices going through the same journey and involve patients in its next steps through reviewing what's worked well and room for growth.

Widening access to patient information from the GM Care Record for Community Pharmacists

Health Innovation Manchester is developing a project to provide community pharmacists access to a patient's full medical record to improve the quality and safety of prescribing in the community.

Community pharmacies currently access patient information through a system called the National Care Record (NCR). The NCR is an electronic record that contains limited information about a patient's health.

This project aims to provide community pharmacists' access to a patients' full health and care record through the GM Care Record. This will provide the following benefits:

- Improved patient care ¬– community pharmacists can make more informed decisions about the medications they prescribe when they have access to a patient's full care record.
- Increased patient satisfaction – most patients expect healthcare professionals to have access to their data and feel more confident in the care they are receiving when they do.
- Improved medication safety – community pharmacists can use a patient's care record to identity any potential adverse reactions between existing medication and new medication.
- Increased efficiency ¬– access to a patient's care record will help community pharmacists dispense medications more quickly and accurately – in some instances without having to wait for responses from the GP, alleviating the pressures on both pharmacists and practices.
- Increased communication – community pharmacists can communicate more effectively with other members of the health and care teams when they have access to a patient's full care record. This helps improve the overall coordination of care a patient receives.

Primary Care Blueprint

Estates

8. Estates

Delivered from facilities which are appropriate for the provision of 21st century Primary Care

8.1 Our Current Estate

An estate which is fit for purpose and is consistent with our objectives for net zero, as set out elsewhere in this document, represents a critical success factor for us. The current position presents us with a series of issues and challenges, many of which are set out below:

- There are access challenges, particularly in areas with significant health inequalities and deprivation.
- There are challenges and variation across GM in the condition, compliance, and fitness for purpose of primary care estate.
- Some premises do not meet contractual standards for primary care service delivery and some significantly fall short.
- It is difficult to assess and quantify the baseline utilisation of existing estate as very little data on actual use is available for demise and bookable.
- There are challenges with regard to the level of usage of clinical rooms in many areas
- The cost burden for voids and unused accommodation lies with NHS GM which indicates significant wasted underutilised estates resource which could otherwise be invested in estates improvements.
- There are lease issues in many NHS Property Services and Community Health Partnerships buildings with unclear documentation on responsibilities, requirements and occupational costs.
- There are undocumented primary care estate occupiers which put the provider at risk of that occupation being terminated i.e. in GP owned buildings where the GP owner retires, this puts practice at risk of eviction where there is no lease agreement in place
- Implications and restrictions of the LIFTCo funding models that add a layer of cost to any premises variations
- The property companies have indicated that there are debt issues with some NHS tenants which unless resolved / cleared will mean property companies will not consider variations on those tenanted areas or expansion in occupancy
- There has been variation in the level of estates investment over time across the different Localities.
- There is inequitable contribution by practices to premises costs with differing levels of historic subsidies.
- There are national requirements to meet sustainability & BREEAM targets by 2038/2040, including the NHS Net Zero Building Standard, and there has been limited national funding routes for primary care.

8.2 Addressing current issues and building a vision for the future

Whilst the list of current issues is a long and complex one, we recognise that we must do all we can to address them, allowing us to provide a platform from which to deliver the vision set our in this Blueprint. We therefore plan to:

- Seek to ensure that all primary care premises, as a minimum, meet statutory compliance requirements and be configured to support optimal flow.
- Facilitate the implementation of efficient and effective ways of working across Integrated Neighbourhood Teams, and PCNs, supporting delivery of new models of care and delivering a more efficient use of estate, particularly patient facing estate.
- Develop clear prioritisation criteria, aligned to national guidelines, providing a clear understanding of the prioritised premises schemes for improvement and investment.
- Establish clear agreements to enable property companies to charge effectively and reduce occupancy, lease and debt issues.
- Facilitate effective collaboration between Local Authorities, Place and Community to develop robust integrated system plans and facilitate actions to deliver our strategic priorities.
- Improve utilisation of our estate
- Reduce voids to an absolute minimum.
- Achieve a high level of utilisation mid-week and increased utilisation at weekends and evenings
- Increase utilisation of community buildings to support social value for VCFSE and community groups.
- Develop a better understanding of the estates opportunities under the various contracts ensuring that responsibility for estates is known whilst making sure patients have access to services.
- Ensure all primary care providers in Community Health Partnerships, NHS Property Services and third party owned premises are within a lease agreement; and all GP partner owned premises have a lease agreement with the GP practice.
- Have a clear primary care premises subsidy policy and processes to access support on a fairer and more reasonable basis.
- Ensure that there is a clear and transparent process to enusure a fair contribution by all GP practices towards premises costs.
- Be in a position to address estates sustainability, develop a forward plan and be ready and in a position to apply for potential national funding that may be available with partners
- Strive to secure energy efficient Primary Care estates with high EPC/DEC ratings, saving money and reducing environmental impact
- Seek opportunities for renewable energy generation for Primary Care sites

8.3 Actions towards delivery

We have identified a series of enabling measures to facilitate the delivery of our objectives as follows:

- Completion of the GM Estates Infrastructure Strategy in 2023/24.
- Completion of the Locality Asset Review refresh to enable local system Strategic Estates Groups (SEG) to identify use of surplus estate or estate for disinvestment.
- Prioritisation criteria developed to enable fair and transparent prioritisation of estate to access the limited funding based on most effective use of resource.

- Completion of PCN clinical and estates plans and the development of ten prioritised Locality plans and an overarching ICB prioritisation plan by the end of 2023.
- Relaunch the SEGs ensuring consistent and effective strategic estates arrangements in place including primary care representation.
- Provide assessment of current premises compliance and actions that are needed for example, through the 3 & 6 facet surveys collation and PCN estates toolkit implementation.
- Progress development of an overarching GM utilisation framework to include utilisation principles to be adopted across GM e.g. in relation to protocols for block bookings.
- The utilisation of existing estate including internal reconfiguration of premises with longer term occupational commitment.
- Removal, or where not possible, mitigation against barriers to improved use e.g. understanding LIFTCo covenants vs model flexibilities including lifecycle costing.
- Collecting data on use and sharing this with Localities and Strategic Estates Groups to enable actions to deliver improvements.
- Identify specific buildings to target utilisation studies / manual data collection.
- Plan for the conversion of former patient records storage footprint to clinical rooms and secure use of NHS England, NHS Property Services and Community Health Partnerships capital for reconfigurations.
- Continue to bid for external funds to support investment and for other use such as towards achieving improved utilisation and increasing clinical capacity e.g. One Public Estates funding and s106 monies.
- Review current position and consider options for GM policy approach for tenant subsidies.
- Develop disposal pipelines to dispose of underperforming estate

8.4 Projected Outcomes

In setting out the issues and our planned actions, we are aiming to deliver a series of outcomes which will contribute to the wider delivery of this Blueprint, including:

- Delivery of plans that will deliver most effective use of resource to provide maximum outcomes for patients and investment prioritising areas to tackle health inequalities.
- Effective system working to facilitate best use of public estate resource – improving utilisation and access to clinical services, and disinvesting in surplus premises.
- Enable additional clinical activity to be undertaken in the funded estate including bringing service delivery out of hospital.
- Enabling access to services in locations which are convenient to their users and facilitate their safe and effective delivery
- Provide physical configuration to maximise service flow and efficiency for primary care providers ultimately enabling greater productivity.
- Implementation of a consistent policy to enable consideration of applications for non-mandatory financial assistance and provides resilience and clarity to providers
- GP practices are in appropriate leases thereby providing security of tenure and clear reimbursement in line with the terms and conditions of the Premises Cost Directions.

- Primary care providers making progress towards net carbon zero targets in estates and benefiting through improved financial resilience

Discipline	Headline Deliverables	Timescales	Accountabilities	Measures
All	Maximise use of the wider public sector estate to promote integrated working and to deliver improved efficiency re building usage	2024 - 2029	GM Strategic Estates Group (SEG) and Locality SEGs	Reduced void costs and increased estates usage statistics
	Agree ICB estates utilisation principles, processes and procedures, with the aim of improving accommodation utilisation levels to achieve financial efficiencies and more effective and appropriate use of the estate	2024	GM Strategic Estates Group (SEG) and Locality SEGs	Reduced void costs and increased estates usage statistics
General Practice	Completion of PCN Clinical Plans & Estates Strategies	Summer 2023	GM Strategic Estates Group (SEG) and Locality SEGs	
	Plans for the conversion of former patient records storage footprint in GP Practice premises to increase clinical capacity with no revenue consequence	2024 - 2029	GM Strategic Estates Group (SEG) and Locality SEGs	

Primary Care Blueprint

Quality, improvement and innovation

9 Quality, improvement and innovation

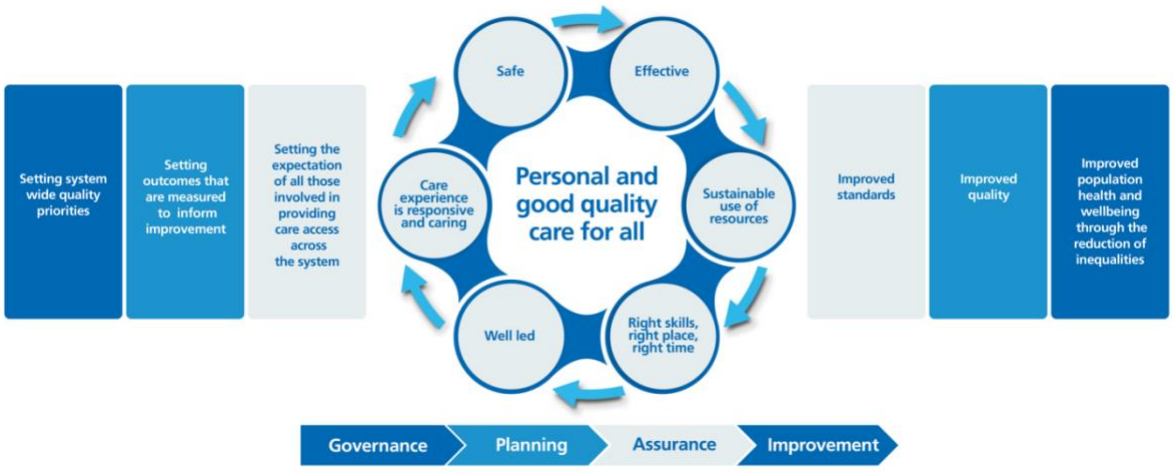
Delivering safe, effective services, with a focus on quality improvement

We recognise that there is variation in the way that services are delivered to patients, across our 1800 Primary Care Providers. This variation may be warranted, particularly where the outcomes and experience for patients is consistent and of an expected level. However, where there is variation there is also potential for this to be unwarranted, evidenced in the relative health outcomes within communities, individuals' experiences in accessing services

Across the four primary care disciplines there are different ways of operating and regulatory frameworks, however we are working in the context of a clear willingness to work together to improve quality, reduce unwarranted variation and reduce health inequalities. Our overriding aim is to deliver a primary care system that provides safe care. Primary Care plays a key role in safeguarding the population, and individuals are facing increasingly complex vulnerabilities. Ensuring that the most vulnerable patients (children and adults) are protected from harm requires robust internal primary care safeguarding processes, along with primary care contribution to statutory multi agency safeguarding processes and procedures.

This chapter sets out how an embedded culture of delivering quality across primary care, will support the drive for levelling up aspirations through continuous sustainable quality improvement, reduction of health inequalities and an ethos for shared learning. It is important to note that whilst this chapter focuses on Primary Care, the ambition is clearly aligned to the GM system quality strategy which reinforces the development of a single, cohesive quality approach across Primary Care in Greater Manchester.

The diagram below illustrates the shared purpose for quality.



This chapter also describes how innovation plays a role in how our quality improvement ambitions are achieved.

How will we deliver quality, improvement and innovation for Primary Care in Greater Manchester?

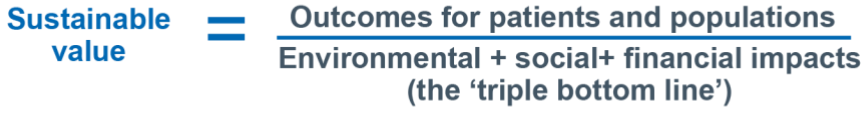
Building on the opportunities presented through the Greater Manchester Integrated Care Partnership, the overarching principles that underpin delivery of this plan are:

- Quality standards will be applied across Greater Manchester Primary Care Providers, to improve patient outcomes and experience
- Embed a culture of supportive improvement through shared learning and peer-based improvement
- Central data dashboards will be available to a range of stakeholders
- Assigning resources will be managed with evidence-based decision making through clear governance
- The use of data to provide the evidence-base for flexible and innovative commissioning as a key enabler to improvement, with continuous improvement at the heart
- Ensure strong connections with service users through patient and public engagement

There are already many examples of good quality in primary care across Greater Manchester, however the Primary Care Blueprint sets out the ambition over the next five years to continuously strive to find ways to improve and innovate. A series of tangible deliverables are set out below; the delivery plan will be inclusive but not limited to these activities and workstreams:

- An ambition to implement of the Patient Safety Incident Reporting Framework (PSIRF) across Primary Care, in line with relevant national requirements
- Development of a consistent set of GM Primary Care Quality Standards, applied to all four disciplines as appropriate to the relative commissioning opportunities and regulatory frameworks that exist, following the 'SusQI' approach to deliver the best possible health outcomes with minimum financial and environmental costs, while adding positive social value at every opportunity.

  'SusQI' is defined below:



- In conjunction with the GM Quality Directorate, establish a clear process for reporting, escalation and assurance to support patients, providers, localities and GM teams.
- Establish a 'go-to' data repository within tableau, to enable reporting and analysis across the many data and information sources that are available.
- Establish and embed shared learning forums through in-person and online forums, where needed to facilitate good communication, relationship building and sharing of good practice.

- Develop a robust process for risk management at GM and locality level.
- Continuous improvement through shared learning with a supportive, assurance-based approach

Quality has been identified as an enabler within the blueprint, as improving quality of health and care for our population runs through everything that we do. We are 'values-based' rather than 'standards-based' and we value the delivery of high quality care for all based on the Institute of Medicine definition of quality care (Safe, Effective, Timely, patient-centred, efficient and equitable) with the addition of 'with high staff-well-being'.

A culture of continuous improvement is required as we strive to deliver quality provision, for the benefit of our population. This will come from understanding unwarranted and warranted variation between providers and across our population. Working with system partners, regulatory bodies and a range of wider stakeholders, we will build a shared understanding in order to engage, supporting innovation through application of quality improvement and quality assurance. All of which will be supported by systematic reporting through robust governance and decision-making processes.

We will continue to develop and refine how we will measure the success of our activities in this area of work but these will include:

- Staff being aware of how to raise concerns, with confidence, about quality and safety of care and evidence that these systems are being used effectively
- Improved patient satisfaction across all primary care (for example, friends and family test, GP Patient Survey etc)
- Reporting and data capture seen through established reporting routes and governance
- Culture of shared learning embedded to improve patient outcomes and experience
- Reduced carbon footprint from care pathways

It is intended that outcomes will be measured using a range of metrics with equal weighting, given to the experience of people using the service which will be prioritised alongside measures for health Inequalities and long term condition management. This approach is set out in the table below:

Year 1	• Mapping of all quality related activities and services across Primary Care for Greater Manchester • Develop a GM quality contract for General Practice • Establish clear governance for primary care quality within the ICB
Year 2	• Implement GM quality contract for General Practice (with annual process to review impact, outcomes and value) • Establish LFPSE reporting across all Primary Care as standard, linked to PSIRF implementation • Data and intelligence available to enable reporting and analysis to identify opportunities for improvement and innovation • Robust quality reporting relating to safeguarding and patient safety and patient experience in place across all primary care
Year 3	• Annual review of quality contracts (impact, outcomes and value) • Developed mechanisms for all primary care quality to be understood at GM and place level
Year 4	• Review of blueprint priorities in readiness for future strategic planning
Year 5	• Robust quality assurance embedded for primary care within GM ICB

Quality Matrix

Our quality matrix is reproduced below, setting out in more detail the areas of work and associated actions:

Area ⟹ / Action ⇩	Safety and safeguarding	Staff and patient experience	Continuous quality improvement and assurance	Reducing unwarranted variation	Innovation	Regulatory Frameworks	Risk management
Data and reporting	Patient safety strategy, PSIRF implementation, LFPSE, Complaints management SEAs, Serious Incidents, Datix Locality arrangements i.e. MDT meetings	FTSU, FFT, PPGs, Big Conversation, annual reports from commissioned services e.g Pride in Practice Patient and Public Advisory Group (PPAG), CHEM (Manchester)	QI approach, consistent indicators of quality Locality Quality Schemes (primary medical care) Dental Quality Scheme Pharmacy Quality Scheme EWS	Population Health perspective, patient cohort identification Locality Quality Schemes	Use of data to identify areas for improvement and measure/ evaluate Collating of pilots, projects within primary care	CQC (GP and Dental), CPAF and QiO Improvement plans	Responding to immediate and longer term reported pressures Risk Registers
Stocktake/ mapping	Review of existing locality arrangements	Understanding the extent of activity already in place, opportunity for shared learning and good practice GM shared database as information repository (Horizon?)	Review of existing quality schemes	PCN Health Inequaities leads (ARRS)	Understanding what innovations are already taking place across primary care in GM	Processes for managing contract sanctions including in relation to quality related matters; establish consistency where	GM/ locality level risks and/ or mitigations

						appropriate (GMS)	
Shared learning	LFPSE Datix PSIRF	Staff survey pilot - opportunity to rollout Healthwatch feedback	Protected learning time for all Facilitated sessions ALS (action learning sets)	Evaluation of Local Quality Schemes Outcomes from PCN DES TNHI work	shared learning for good practice - spreading good work and ideas Example - PCB programmes PCN development programme PCN collaboration network	Processes for managing contract sanctions including in relation to quality related matters; establish consistency where appropriate (GMS)	GM/ locality level risks and/ or mitigations
Escalation	Raising concerns - 'understanding how to'	Links to staff retention FTSU Whistleblowing	Early warning score and sitrep CQC national benchmarking reports	Working with population health and using data to identify unwarranted variation and assessing risk and prioritisation to address .e.g. proactive care workstream	Proactive approach to using benchmarking data/early warning metrics	Contractual levers/ formal actions	Responding to immediate and longer term reported pressures

Support and relationships	Multi-disciplinary team meetings, Mandatory safeguarding training	Health and wellbeing resources, 'you said, we did' Healthwatch engagement Alternative Provider Federation VCFSE groups	QI training available through GP Ex programme - clinical lead Healthwatch HWB programme	Integrated neighbourhood working - chapter link	Build community of practice Establish central data/ information repository	Stakeholders: Primary Care teams (GM and localities) System-wide quality teams CQC	
Governance structure	Quality and nursing	Quality	Locality quality leads (is there a network)	Population Health	Enabling timely decision making and priority setting Example - locality GPB development opp through PCB (external facilitation offer)		GM/ locality level risks and/ or mitigations

Discipline	Headline Deliverables	Timescales	Accountabilities	Measures
All	Development of a consistent set of GM Primary Care Quality Standards, applied to all four disciplines as appropriate to the relative commissioning opportunities and regulatory	To be developed for review in 24/25	Primary Care Committee	Standards agreed and implemented

	frameworks that exist.			
	Establish clear governance for the escalation and reporting of PC quality matters for NHS GM	2024	Primary Care Committee Quality and Performance Committee	Escalation Framework agreed and in use
Dental	Develop our quality contracting arrangement options for Dental, building on the learning from the 23/24 implementation	2024	Primary Care Committee	Development of a model which will materially facilitate the delivery of the ambition set out in this Blueprint
General Practice	Seek to ensure that all GP Practices are CQC rated Good or Outstanding	2024 - 2029	Primary Care Committee Locality Boards	Year on year increase in %age good or outstanding ratings
	Conduct a comprehensive review of current 'quality contract'/ Locally Commissioned Service, (LCS) arrangements, inc. baseline data collection, option appraisal with preferred option / recommendation for commissioning to be identified	Initial implementation to commence in 24/25, with full implementation from 25/26	Primary Care Committee	
Optometry	Explore future quality contracting arrangement options for Optometry	24/25	Primary Care Committee	Development of a model which will materially facilitate the delivery of the ambition set

				out in this Blueprint
Pharmacy	Explore future quality contracting arrangement options for Community Pharmacy	24/25	Primary Care Committee	Development of a model which will materially facilitate the delivery of the ambition set out in this Blueprint

Case studies: Quality improvement and innovation

Preparing General Practice for CQC inspection

Between March 2020 and April 2021, the Care Quality Commission (CQC) suspended all routine inspections so healthcare providers could prioritise the increased demand from the pandemic.

When inspections resumed, GP practices having focussed all their resources on managing the impact of the pandemic and stepping up a new vaccination programme, felt vulnerable with regulatory inspection, as their evidence had not been fully maintained. The inspection process had also changed considerably, including virtual meetings, with evidence shared online. Practices were therefore keen for support to prepare for their next inspection.

The GP Excellence Programme, a partnership between the Royal College of GPs and NHS Greater Manchester to help practices improve and also meet CQC requirements, ran a series of webinars to reach as many practices as possible, with expert advisers covering the main requirements of inspection. The package also included a detailed evidence plan template as a resource for practices to work through, using a traffic light (red-amber-green – RAG) rating against the essential criteria of the CQC's five key questions. The questions, also known as Key Lines of Enquiry, help inspectors answer if services are safe, effective, caring, responsive and well-led.

More than 330 people joined the webinars. Out of thee 27% who completed an evaluation, 95% stated they found the webinar very useful; and 80 out of 93 respondents reported that their confidence levels had improved.

Since then, the GP Excellence team identified several common themes from CQC inspections where Greater Manchester practices were struggling to demonstrate the required standard. This led to another bespoke webinar series focusing on these themes including medicines management, general policies and procedures, and complaints.

The GP Excellence team's next step is to explore the possibility of providing similar training webinars to dental practices, who are also subject to CQC inspections.

Practice alert system helping manage pressures in primary care

The Primary Care SitRep was first introduced in response to the Covid-19 pandemic for all practices to centrally report their levels of pressure – initially this was on capacity, workforce and PPE supplies - and help identify where support and resources were needed.

As the NHS moved out of pandemic response, back to a changed new normal, the SitRep evolved to produce a Greater Manchester Operational Pressures Escalation Levels (OPEL) score, producing a weekly report to the Primary Care System Board for each of the four primary care disciplines showing where the pressures were and the local area.

In 2022/23, the SitRep process was reviewed, working with primary care colleagues to improve the design and presentation that made it more relevant and meaningful. Significant engagement was undertaken to coordinate a single approach across primary care. A series of workshops were delivered to support those working directly with primary care providers to access and interpret the data; and provide a consistent, supportive response where needed using a clear escalation framework.

By taking a collaborative approach, the SitRep is now more user-friendly with a clearer purpose. The data produced by the SitRep allows proactive planning and helps predict where the pressures in the system will be, which leads to a response by the appropriate teams to manage those pressures.

Primary Care Blueprint

Workforce

10. WORKFORCE

Greater Manchester Primary Care is recognised as a career destination for a happy, healthy and engaged workforce, trained to a consistent standard with knowledge and expertise to meet the needs of our population and provide timely, exemplar services.

10.1 The Current position

In common with other parts of the country, we face risks of a growing workforce crisis, linked to individuals not choosing Primary Care as a career destination, workforce not growing fast enough to support demands, attrition of existing staff leaving a workforce shortage across general practice, community pharmacy, dentistry and optometry. These issues present across a number of thematic areas as shown below:

- **Recruitment** – It is recognised that there are significant challenges related to working in Primary Care. These include but are not limited to rising public expectations, increasing demands on services, both in terms of demand and regulatory requirements, variation in standards of employment. These, coupled with the employment options available in other sectors, all impact on our ability to recruit and retain.

- **Retention –** The issues described immediately above, also present challenges relating to our ability to retain staff once in post. These can be further exacerbated by other factors, particularly around pay and conditions (for example dental nurses leaving in favour of better paid roles elsewhere or leaving the profession entirely). Our data also highlights certain roles (for example general practice nurses) being disproportionally affected due to aging workforce

- **Education and development** - Priority is rightly given to clinical skills based education and development, but it is also important for us to focus on areas such as leadership, wellbeing, resilience and personal development. We also recognise that further work is needed to develop a consistency of approach to succession planning and building the workforce of the future. There is currently some disparity across GM in the investment of funding to support the education and development across all four Primary Care disciplines (for example business / practice managers)

10.2 Our vision for improvement

We aim to ensure that Primary Care is recognised as a preferred career destination, with a happy and healthy workforce, trained to a consistent standard with enough knowledge and expertise to meet the needs of our population and provide timely, effective services.

To facilitate this, we plan to deliver across the following themes as follows:

- **Recruitment** - Flexible, inclusive recruitment models at all levels which attract and respond to both individual career aspirations and the needs of the population, ensuring

the workforce is reflective of the population it serves. Clear understanding of the breath of roles, both clinical and non-clinical to ensure Primary Care is valued as a career destination for all. Understanding priorities, and the need to align both short and longer-term workforce planning, service development and cross sector working, including VCFSE organisations

- **Retention** - All providers demonstrate the value they place on workforce by committing to good management practice including, talent management, inclusion and engagement, support for health and wellbeing, consistent terms and conditions (e.g. becoming members of GM's Good Employment Charter) and succession planning

- **Education and development** - Equitable access to training and development which is appropriately funded which include ambitions to meet role specific objectives and personal aspirations

10.3 What are the risks and potential barriers?

A summary of high-level risks has been identified in the table below; these will be reflective across several chapters, varying in impact, influence and GM control.

Risk (High level)	
✓	Political environment and public expectations of NHS services
✓	Limitations of National contracts
✓	NHS reputation and perception of NHS as an employer
✓	Uncertainty of future supply
✓	Time required to grow workforce
✓	Competition for roles across health economy
✓	Lack of parity of employment contracts

**The risks below have been identified as high level and affect all three themes Recruitment, Retention and Training & Development*

10.4 Our Plans to deliver

Following on from the themes set out immediately above, we aim to work across the areas of Recruitment, Retention and Development, to create a workforce ready to deliver better population health outcomes. Our plans include:

- **Recruitment** - Engagement and influencing across all areas of workforce supply (e.g. schools, colleges, educational institutes, Department for Work and Pensions (DWP), local population aligned to GM Creative Health Strategy. Ensuring there are career pathways promoting GM Primary Care roles which are available to all, including influencing the use of the GM apprenticeship levy

- **Retention** - Encourage all organisation to adopt the GM Good Employment Charter and support Primary Care organisations to achieve the standards, set out therein - https://www.gmgoodemploymentcharter.co.uk/ . Identifying and sharing best practice on workforce health and wellbeing terms and conditions and good leadership

- **Education and development -** Development of the Primary Care workforce across general practice, community pharmacy, dentistry and optometry, enabling the workforce to deliver health in a changing, innovative, and digital environment to provide better population health outcomes. Optimizing the benefits and use of the GM Training Hub and focus on supervision, mentorship and prioritizing access to learning and development

Discipline	Headline Deliverables	Timescales	Accountabilities	Measures
All	Deliver consistent up take of the GM Good Employment Charter across all of PC.	Aim for all providers to be signed up by 2026	Primary Care Committee Locality Boards	Trajectory towards full sign up
	Deliver a comprehensive plan to create a sustainable workforce for the long term including initiatives to: • "Grow our own" future workforce • Secure international supply where necessary • Deliver a "bring back" programme, designed to attract people back into PC • Create a central careers page for all GM job opportunities	2024 - 2029	Primary Care Committee Locality Boards	Increased recruitment of staff Reduction in vacancies across GM Trainees in GM deciding to work and live in GM Continuity of patient care Collaborative working
	Implement initiatives relating to the retention of our workforce including: • Taking regular "Temperature Checks" including via a workforce survey • Promoting the use of Joint Appointments / Flexible roles • Including development of hybrid roles across pc disciplines e.g. Community Pharmacy & GP	2024 - 2029	Primary Care Committee Locality Boards	Reduction in attrition of staff. Workforce staying in role for longer Integrated teams across PC neighbourhoods Work/life balance Increased job satisfaction

	Deliver a comprehensive development, education and support offer including: • Creating accredited learning environments across neighbourhoods to support all disciplines • GM Passport rollout • Recognised and equitable access to training • Equitable access for workforce health and well being offer across all 4 disciplines of primary care • Fellowship opportunities to support all new to or newly qualified staff understand GM and access peer support/mentorship	2024 - 2029	Primary Care Committee Locality Boards	Reduction in attrition of staff. Workforce staying in role for longer Work/life balance Increased job satisfaction

Case studies: Workforce

More support for international GPs to stay in practice

Attracting and retaining doctors to work in general practice in Greater Manchester is a key priority for the primary care workforce programme.

Under the current system, international doctors are sponsored by NHS England, formerly Health Education England, during their training, and must wait five years to apply for the right to remain in the UK for five years. Once qualified, a doctor needs to find a GP practice who holds the relevant licence. This was previously a challenge with only four practices in Greater Manchester holding a licence and over a third of locally qualifying GPs being international doctors.

The primary care workforce team introduced a scheme that supports international doctors and GP practices to navigate the application process, access the right legal advice via a helpline, and even cover the cost of the licences.

Now, over 90 GP practices hold a licence which has enabled many of our international trainees to stay in Greater Manchester since 2019. Through professional word-of-mouth, it has also helped with attracting other international doctors to work in the area.

How Middleton Primary Care Network increased access by opening a health hub in a shopping centre

The Additional Roles Reimbursement Scheme (ARRS) gives PCNs the ability to create bespoke multi-disciplinary teams through national funding. 17 different roles can be claimed for to meet the needs of local communities making it easier for people to access a wider range of help.

Middleton PCN consists of seven GP practices serving a population of around 46,600. It recently recruited 38 ARRS staff to provide more services across the PCN such as physiotherapy, social prescribing, mental health support, phlebotomy and pharmacy but didn't have space to house new colleagues.

The idea to rent a space in the local shopping centre was developed by PCN Clinical Director, Dr Mo Jiva. Once approved, monies were pooled together by the PCN, Rochdale Health Alliance, and Public Health to rent a unit based in Middleton shopping centre.

With six consultation rooms, a daily footfall of approximately 50,000, free parking and proximity to the local bus station, the hub is an ideal location to create a centre from which routine appointments can be offered to patients from all seven GP practices. It also provides an opportunity to promote public health campaigns and signpost residents to other services.

Routine appointments for blood tests, physiotherapy and pharmacy are available daily at the hub. This has resulted in reduced waiting times across the PCN and freed up approximately 100 GP appointments per week.

Significantly, the hub provides a space for staff across disciplines to work together to support patients and have important health conversations with people who may have otherwise been missed by their GP.

There are further plans to use the space to promote wider public health initiatives such as HIV testing and stop smoking services.

Over 1600 staff have now been recruited into new roles in Greater Manchester as part of the Additional Roles Reimbursement Scheme and they have already made a significant impact in general practice and in the community delivering care to patients.

Budget class cooks recipe to beat loneliness

A slow cooker course in Westhoughton, Bolton has been a huge success after it helped people eat healthily for less and provided much needed social interaction for residents who felt lonely over the winter months.

The course was organised by social prescribing link workers at Bolton GP Federation, in association with Westhoughton Assist, which runs a local community food shop. The sessions were designed to promote health and wellbeing, and a sense of togetherness to combat social isolation and improve people's mental wellbeing. Cooking simple, tasty meals that can be recreated at home challenged misconceptions that healthy eating had to be expensive.

GPs and other professionals can refer patients to link workers, who in turn can connect people to a variety of community groups and activities for practical, social, and emotional support. This helps to address wider determinants of poor health such as stress and loneliness, something the team at Westhoughton see first-hand.

With an emphasis on healthy eating and cooking on a budget, people felt the course developed their confidence and helped with their mental health. With steep energy costs, a slow cooker is cost effective too as it uses less energy. The course helped with cooking skills and tips. On completion, participants came away with a file of recipes and ideas for easy meals to make at home, plus their own slow cooker.

Eating regularly and having at least one hot meal a day can help people to keep warm and stay well during the winter. The group has continued to meet socially even after the course finished, to share new recipes and friendship.

Boost for practice nurses in Oldham

In September 2020, in response to a shortage of practice nurses in Oldham, the then NHS Oldham Clinical Commissioning Group, recruited five nurses to participate in a pilot that saw nurses take up six-month placements at five Oldham practices. The scheme aimed to reduce the barriers for nurses entering general practice and provide a structured education programme to develop the skills needed to work as a practice nurse.

The pilot was successful, and a decision was made to run a second wave in September 2022. Incorporating lessons learned, a further six qualified nurses were recruited, who were placed in Oldham practices that hoped to employ a practice nurse. The programme was based on a simple premise that the nurses would take up a fixed-term placement in

GP practices and learn core skills from experienced staff across the borough. The locality funded a proportion of the nurses' salaries at AfC Band 5, as well as supporting training where required.

The nurses were employed full-time and spent four days per week in practice, with one day of formal training or self-study. At the end of the placement period, the intention was for nurses to complete their existing employment arrangement, and take up permanent roles, preferably at the practice where they were initially based.

The second wave of the programme has been very successful, and all nurses are still employed within Oldham practices, with five on permanent contracts and the sixth due to finish an extended placement in the autumn. It is hoped to run a third wave of the programme in late 2023.

NHS

Developed by:
NHS Greater Manchester Integrated Care
NHS Greater Manchester Primary Care Provider Board

Part of Greater Manchester Integrated Care Partnership

Greater Manchester Integrated Care Partnership Board

Date: 29th September 2023

Subject: Greater Manchester (GM) Mental Health and Wellbeing Strategy Refresh

Report of: Prof. Manisha Kumar, Chief Medical Officer and
Lynzi Shepherd, Head of Mental Health, Learning Disabilities & Autism

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PURPOSE OF REPORT:

The purpose of the report is to present the latest version of the five-year GM Mental Health and Wellbeing Strategy (Appendix 1), which sets how, as a city-region, we will improve the mental health and wellbeing of people in GM, better support those with mental ill health, and reduce mental health inequalities across GM. The ICP Board has been involved in shaping the strategic vision and objectives, when the strategy was shared at previous meetings, and this report provides a brief recap of the process to co-design the strategy as well as the next steps relating to evaluation, action planning and delivery and governance.

KEY MESSAGES:

- The five-year GM Mental Health and Wellbeing Strategy sets out the priorities which have been agreed in consultation with stakeholders, public service partners, the VCSE sector and communities. They identify the priorities that we, as a city-region, need and want to focus to achieve a step change in mental health and wellbeing outcomes for GM residents. The ambition and vision are summed up in the strategy's strapline: *'Doing mental health differently'*

- This GM Mental Health and Wellbeing Strategy sits as a subcomponent of the Integrated Care Strategy and progress reports will align directly with the GM Joint Forward Plan reporting arrangements.

RECOMMENDATIONS:

The Integrated Care Partnership Board are requested to:

a) note the content of the report;
b) endorse the vision, objectives and five strategic missions of the GM Mental Health and Wellbeing Strategy, subject to any additional comments the GM Integrated Care Board have following feedback; and
c) endorse the GM Mental Health and Wellbeing Strategy as a key aspect of the GM ICP Strategy.

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1.0 BACKGROUND

1.1 Whilst there are many great examples in Greater Manchester already in place to support the mental health and wellbeing needs of GM residents, we know we can do more, and it is important we do so. The findings of the *Build Back Fairer in Greater Manchester: Health Equity and Dignified Lives* report and the *Measuring Mental Wellbeing in Greater Manchester Report 2023* gave sharp focus to the already widespread understanding that mental health problems affect certain groups of people more than others, and that there is inequality of access and opportunity for some communities across GM.

1.2 We also know that no single agency, body or organisation can solve the mental health and wellbeing challenges faced by our residents. We must work together as an integrated public service system (including the Voluntary, Community, and Social Enterprise sector (VCSE) in partnership with residents and communities.

1.3 This strategy is takes an all-age, system-wide, population health view, recognising that mental health and wellbeing can be affected by a complex range of environmental and medical reasons including access to care, social and economic conditions faced by residents and community, individual and family circumstances.

1.4 This strategy is therefore about more than how we deliver NHS services and allocate NHS resources. One of the clear findings of the engagement and co-design of the strategy was mental health needs to be everybody's business and good mental health and wellbeing should be actively promoted across a range of strategies, policies, and programmes throughout the system.

1.5 The strategy foregrounds a co-designed vision for mental health and wellbeing in GM as a **mentally healthy city region where every child, adult and place matters.** The vision will be delivered through five strategic missions:

1. People will be part of mentally healthy, safe and supportive families, workplaces and communities
2. People's quality of life will improve through inclusive, timely access to appropriate high-quality mental health information, support and services.

3. People with long-term mental health conditions will live longer and lead fulfilling and healthy lives.

4. People will be comfortable talking about their mental health and wellbeing and will be actively involved in any support and care that they receive.

5. The mental health and wellbeing system recognises the inequality, discrimination and structural inequity people experience and are committed to developing more inclusive services and opportunities that people identify with and are able to access and benefit from.

1.6 The development of the Greater Manchester Integrated Care Partnership provides us with an exciting opportunity to take a very different approach to responding to mental ill health as part of a whole system, whole society approach.

2.0 Data, insights and consultation

An extensive programme of consultation, engagement and co-design has been undertaken to develop the strategy, spearheaded by a Mental Health and Wellbeing Strategy 'writer's group' which included representatives from the VCSE, Mental Health Trusts, Localities and the Greater Manchester Combined Authority (GMCA).

2.1 The group drew on the rich data available across the system including

- Review of the findings of:
  - Build Back Fairer in Greater Manchester: Health Equity and Dignified Lives report
  - Measuring Mental Wellbeing in Greater Manchester Report 2023
  - #BeeWell survey
  - Review of the 2019-2022 Greater Manchester Children and Young People's Plan
  - Mental Wellbeing and Disability report
- Data about service delivery, demand and impact from GM providers, GM localities and GM system leaders who are already involved in

designing and delivering existing mental health and wellbeing services and provision.

- Data from NHSE and the Office for Health Improvement and Disparities (DHSC) to enable an overview of national trends and benchmarking.
- Population and public health data, segmenting population by communities of interest and place.
- Survey data from:
  - The GM Big Conversation
  - Greater Manchester Residents' Surveys
  - The Big Mental Wellbeing Conversation

2.2 We supplemented this desk research with engagement with stakeholders across the system, using system leads to ensure there was wide engagement across the region. This has included an interactive event in October 2022 with over 80 stakeholders from across the system, and engagement with members of key forums including:

- the Violence Reduction Health and Wellbeing Delivery Group
- GM LD & Autism Programme Board
- GM MH Blue Light Mental Health Response
- GM Population Health Board
- GM VCSE leadership Group
- MH Adult and Childrens Commissioners Meeting
- GM Reform Board
- GM Directors of Public Health
- GM Aging Well Meeting
- GM Gambling Harms Group

- individual locality meetings i.e. All-Age Mental Health Salford Board Meeting, local housing forums
- individual communities of interest groups, reflecting the diverse communities of GM. This has included further engagement undertaken with both adults and young people's lived experience groups.

2.3 Key findings from the engagement, consultation and co-design process that has shaped the strategy included:

- The system needs to be flexible to work with people on their terms in a place, time and manner that works for them.
- The system needs to be accessible, person centred, and service user led.
- We need to instil resilience in people and communities and make sure we are not set up simply to respond to people after they get worse or reach crisis point.
- We need to actively support and mainstream provision of more joint up support including the VCSE offer, finding ways to ensure that initiatives are not siloed and short-term.
- We must bring resources together and test new ways of commissioning with people and communities.
- We need to have a shared language around how to address the mental health challenges we face as city-region.

3.0 DEVELOPING AN APPROACH TO MEASURING STRATEGIC IMPACT

3.1 The development of the strategy has also encompassed mapping our approach for evaluating the impact of the strategy evaluation. Following a steer from the ICP board, we are holding two metrics workshops that bring together representatives across the GM system to develop an approach to evaluating the strategy and measure success.

3.2 The first workshop was held on 21 June, and the second is taking place on 4 October. The outputs from both sessions will identify some key metrics we will use

to measure progress from point of launch. This will form the last two pages of the current strategy document (left blank in the version in Appendix 1).

3.3 Our plan is to agree with stakeholders at the workshops a headline metric for each of the five mission areas and these will be tracked in the first year of the strategy. As our knowledge about what works grows, we will review the metrics used, expanding or changing them as appropriate.

3.4 In addition, the workshops are building a shared system understanding of the impact each part of the system, each sector or individual organisation can have on headlines metrics for mental health and wellbeing and allow the exchange of insight and learning from different sectors.

3.5 Once identified, reporting of progress against key indicators will align directly with the GM joint forward plan annual reporting arrangements.

4.0 ACTION PLAN DEVELOPMENT

4.1 An action plan detailing specific commitments and timeframes for delivery will be developed following strategy sign off.

The action plan will encompass the services, projects and activities already in place across the system (across the continuum from early intervention and prevention through to specialist services). Developing the plan will also enable the team to re-connect with the many stakeholders and communities that co-designed the strategy to consolidate further co-design of delivery plans, and to harness the system enthusiasm for a new approach for mental health and wellbeing.

As previously agreed, the action plan will be framed across an initial two year period, to enable review and ‘course correction’ as momentum grows. The action plan will be codeveloped, co-owned and co-delivered by the system.

5.0 RESOURCE

5.1 The GM Mental Health and Wellbeing Strategy refresh and action plan will not have a specific separate associated budget. Instead, the strategy and accompanying

action plan set out action that is taking place already in the city-region through the current funding streams including NHS services such as specific early intervention; Thrive; mental wellbeing and trauma-responsive programmes, but also goes beyond NHS mental health core and transformation funding allocations.

5.2 By taking an approach of wide-scale co-design and reaching consensus across a range of partners, we have laid the groundwork to enable new and innovative ways of working which will have both social and wider economic benefits.

5.3 The NHS Long Term Plan clearly signals the need to improve services and provide wider support for people with mental ill health, underpinned by a commitment to addressing mental and physical health inequalities through a focus on prevention and through integrated approaches. The NHS Long Term Plan also brings with it some funding, some of which will already be earmarked specifically for mental health developments over the next few years. The five missions within the Mental Health and Wellbeing Strategy will further help inform where such streams of funding could be targeted.

6.0 Governance arrangements

6.1 Implementation of the strategy and delivery of action plan milestones will be overseen through the GM Mental Health Partnership Board which is chaired by the GM ICB Mental Health SRO.

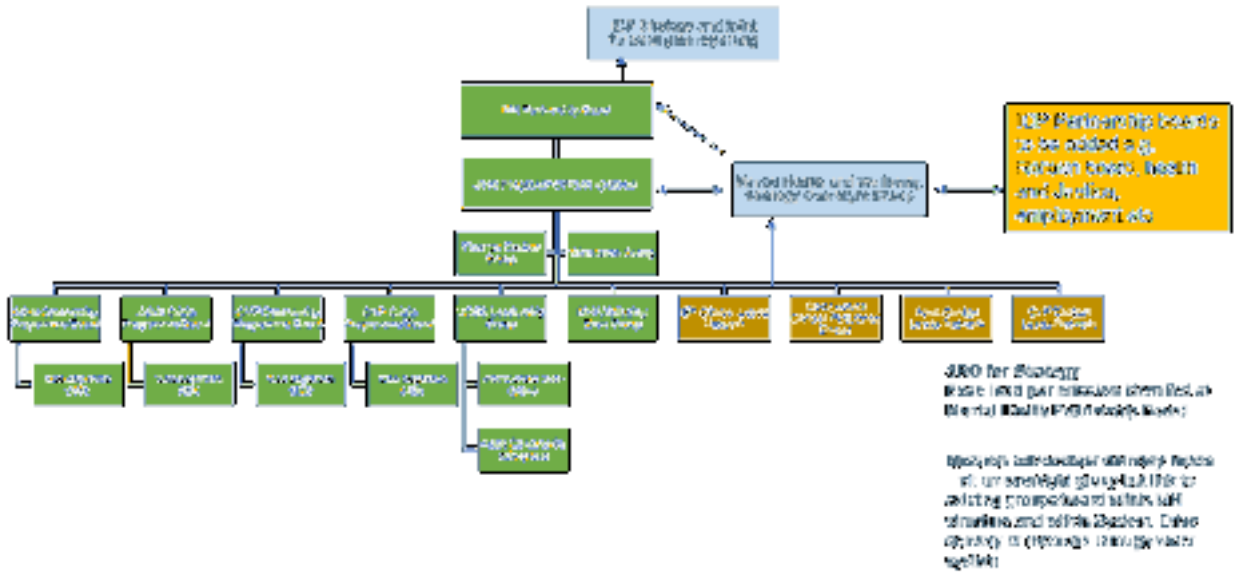
6.2 Where key decisions are required about resource allocation including future investment, these will be progressed through the ICP's governance arrangements.

6.3 Progress on the strategy will be reported to the GM Integrated Care board. As highlighted in the below diagram the GM mental health and wellbeing strategy delivery will be underpinned by a clear system governance with organisational and system accountability, executive sponsorship, and a support framework.

6.4 Recognising because of the scope and breadth of the strategy, successful implementation of the strategy and action plan will only take place with concerted effort from all partners. To ensure oversight, strategic expertise and focus on delivery, we plan to identify and approach an executive sponsor from the system for each of the five missions.

6.5 These leads will include representatives from the VCSE sector, GMCA, MH Trusts and ICP staff at a GM and locality level. These leads will form part of the membership of the Mental Health and Wellbeing Strategy Oversight group and report progress and risks to the GM Mental Health Partnership Board. Adult and young people's lived experience representatives will also sit on the oversight group, and support mission leads in monitoring progress.

Governance proposal to monitor delivery against five missions and success indicators



7. RECOMMENDATIONS

7.1 The Integrated Care Partnership Board are requested to:

a) note the content of the report;
b) endorse the vision, objectives and five strategic missions of the GM Mental Health and Wellbeing Strategy, subject to any additional comments the GM Integrated Care Partnership Board have following feedback; and
c) endorse the GM Mental Health and Wellbeing Strategy as a key aspect of the GM ICP Strategy.

Greater Manchester Integrated Care Partnership

Doing Mental Health Differently

Mental Health and Wellbeing Strategy

2023 - 2028

Draft

Foreword

This is our updated five-year Greater Manchester Mental Health and Wellbeing Strategy. It sets out what we will do together as a city-region to improve the mental health of people in Greater Manchester, to better support those with mental ill health and to reduce mental health inequalities across our city region.

This Mental Health and Wellbeing Strategy sits alongside the overarching strategy for the Integrated Care Partnership (ICP) in Greater Manchester – and its delivery plan – the Joint Forward Plan. ICP Strategy. What we do to improve the mental health of our residents will contribute to our achieving all six of the missions we have set out in the ICP Strategy.

Considerable engagement with stakeholders across Greater Manchester has shaped the development of this strategy. The engagement work led to the agreement of five shared missions to achieve our vison that 'Greater Manchester will be a mentally healthy city-region where every child, adult and place matter.'

We know that no single part our system can solve the mental health and wellbeing challenges we face as a city-region. This strategy is an all-age strategy, recognising that mental health is influenced by various issues from formal health services to social and economic conditions, to community, individual and family circumstances.

We all have a part to play in Greater Manchester becoming a mentally healthy city region. Achieving our shared vision is dependent upon a strong partnership approach. This means working in partnership with the public, voluntary sector, local government and other public services so that each part of civic society in Greater Manchester can contribute to improved mental health.

This strategy builds on the many examples of excellent partnership working in Greater Manchester – but we know we can do more. We all have a part to play, and the realisation of our united vision requires investment, championing, and action in a variety of different ways across the city region.

We must go on making sure that our services work with people on their terms in a place, time and manner that works for them. We must tackle the deep inequalities relating to mental health. We must do more to increase investment in mental health. We invite you to join us and play your part in 'Doing Mental Health Differently' for Greater Manchester.

This Strategy will be supported by an action plan co-developed, owned and delivered by the system. We will put this in place shortly after this Strategy is published.

Sir Richard Leese
Chair, NHS Greater Manchester Integrated Care

Paul Dennett
Chair, Greater Manchester Integrated Care Partnership

Dr Manisha Kumar
Chief Medical Officer,
Greater Manchester Integrated Care Partnership

Introduction

We all have mental health – in the same way we all have physical health. Sometimes our mental health is good and sometimes our mental health is not so good. Sometimes we become ill.

As an Integrated Care System we have a responsibility to deliver the clear targets of NHS England's 10-year plan for mental health. However, we know that simply delivering that would not change the way people experience and understand their mental health and wellbeing.

We understand that mental health and wellbeing is impacted by far more than the services we provide through the investment given to us by NHS England. Tackling poor mental health involves improving mental wellbeing for the whole population as well as preventing and reducing mental illness.

We all have roles and responsibilities in improving mental health and wellbeing and we want this strategy to be developed and actioned jointly, alongside people who live and work in Greater Manchester.

We understand that the mental health and wellbeing of those who live in Greater Manchester is also impacted by the many different organisations and support offers that exist across the city region.

We know we need to do more in prevention and early intervention. However, we need to balance this with the fact that we know people will continue to require specialist mental health services. This is where the NHS focuses its financial resources.

This Mental Health and Wellbeing Strategy for Greater Manchester is all-age and builds on our previous Mental Health and Wellbeing Strategy 2016-21. Many of our aspirations and objectives have not changed, but we are aware that the world we exist in has.

This refreshed strategy seeks to join the dots and looks at how we can tackle together, head on, some of the greatest challenges we face as a city region and ultimately improve the mental health and wellbeing of people living in Greater Manchester.

Improvements can only be made once the whole system understands the problems

Our services need the infrastructure or flexibility to provide practical help to people experiencing mental health problems in their own lives. To achieve this:

- Systems need to be flexible to work with people on their terms in a place, time and manner that works for them. This is a particular issue for people who are experiencing a range of issues at the same time.
- Staff working with people in formal mental health and broader public services want to work in a person-centred way; we need to give staff the confidence, time, training or freedom to do this.
- We need to ensure that the responses to mental health issues are not simply driven by risk, remit, thresholds or convention but by peoples' needs in the context of their own lives.
- We need to make sure we are not only set up to respond to people after they get worse or reach a crisis point.
- We must move away from relying solely on emergency or referral routes rather than proactive and open engagement. We need to respond to people in a manner, time, and place which suits them.
- There is limited integration with or support for complementary offers in the Voluntary Community and Social Enterprise (VCSE) sector or within the community. We need to actively support and mainstream these offers.
- Individual initiatives have been developed to act as stopgaps to meet this need. However, we need to find ways to ensure that these initiatives are not siloed and short-term but are used as good practice examples that feed into universal services.

The commissioning process can create complexity through a lack of integrated budgets and commissioning processes across health services, other public services and the VCSE sector. We must bring resources together and test new ways of commissioning with people and communities.

- We need to bring together leaders across services for the public, which enables the system to focus on the needs of individuals and communities rather than the needs of organisations and programme areas. We need to have a shared language around how to address the mental health challenges we face as a city region.

Estimated spectrum of mental health need across Greater Manchester population

This is not a one-way street. A person will move backwards or forwards along this continuum at different points in their life.

Estimated number of people (adults and children) in each group based on their mental health state over 12 months
People categorised as having a mental health problem (mild/moderate/severe) if they had an episode in a calendar year
Categorised at risk if they had an emerging symptom within a 12 month period, an episode in the year before or were children/parents of a person presenting with mental health problems

Based on the Productivity Commission Issues Paper into the Social and Economic Benefits of Improving MH (Jan 2019)

Mental Health in Context

Around 80,000 people in Greater Manchester are in contact with mental health services each month.

1 in 5 working-age adults

are economically inactive, more than the national average.

£££££

Greater Manchester still invests 8.5% less money in mental health per head overall than the England average (£192.88 compared with £210.86).

On March 31, 2020

3,304

households were in temporary accommodation across Greater Manchester. Of these, 63% were households with children.

37% of Black secondary school pupils in Greater Manchester **experience discrimination because of race, skin colour or where they were born.**

More children in Greater Manchester live in poverty. More children are in the looked-after system, a number that is increasing.

School readiness for all pupils has been improving steadily in Greater Manchester but is still behind the national average.

Covid mortality rates were 25% higher in Greater Manchester than in England at the height of the pandemic.

The population of Greater Manchester grew to 2.8million in 2021. A rise of 6.9% from 2011.

The number of people living in the City of Manchester has grown 36.3% over the last 30 years.

X3

Older people who self-harm are at three times greater risk of suicide than younger people who self-harm.

Those with serious mental illness are experiencing inequality in life expectancy, dying on average 17 years earlier for men and 15 years earlier for women than the general population.

What we are doing is good, but more is needed.

While there are many great examples in Greater Manchester of our work to respond to various mental health and wellbeing issues, we know we can do more. We know that mental health problems affect certain groups of people more than others. Providing access to support and appropriate treatment that meets the needs of people is important. Given the centrality of mental health and wellbeing to everything, this strategy is purposefully ambitious, not just in setting out what we need to do but also in how we need to do it.

The challenge is to ask how we can bring all our expertise, knowledge, resources and relationships together to improve all citizens' mental wellbeing and respond to mental health issues in a flexible, person-centered way designed around people's needs.

The NHS, in its many forms, can only do so much. We can provide services and entry to opportunities but we need more than that to achieve our vision. We need to think optimistically and more broadly about solutions. This is about more than how we spend NHS money. We have to think differently about how we access all available budgets and work together as an integrated public service system (including the VCSE) in partnership with residents and communities.

Link to NHS National Plans – to add

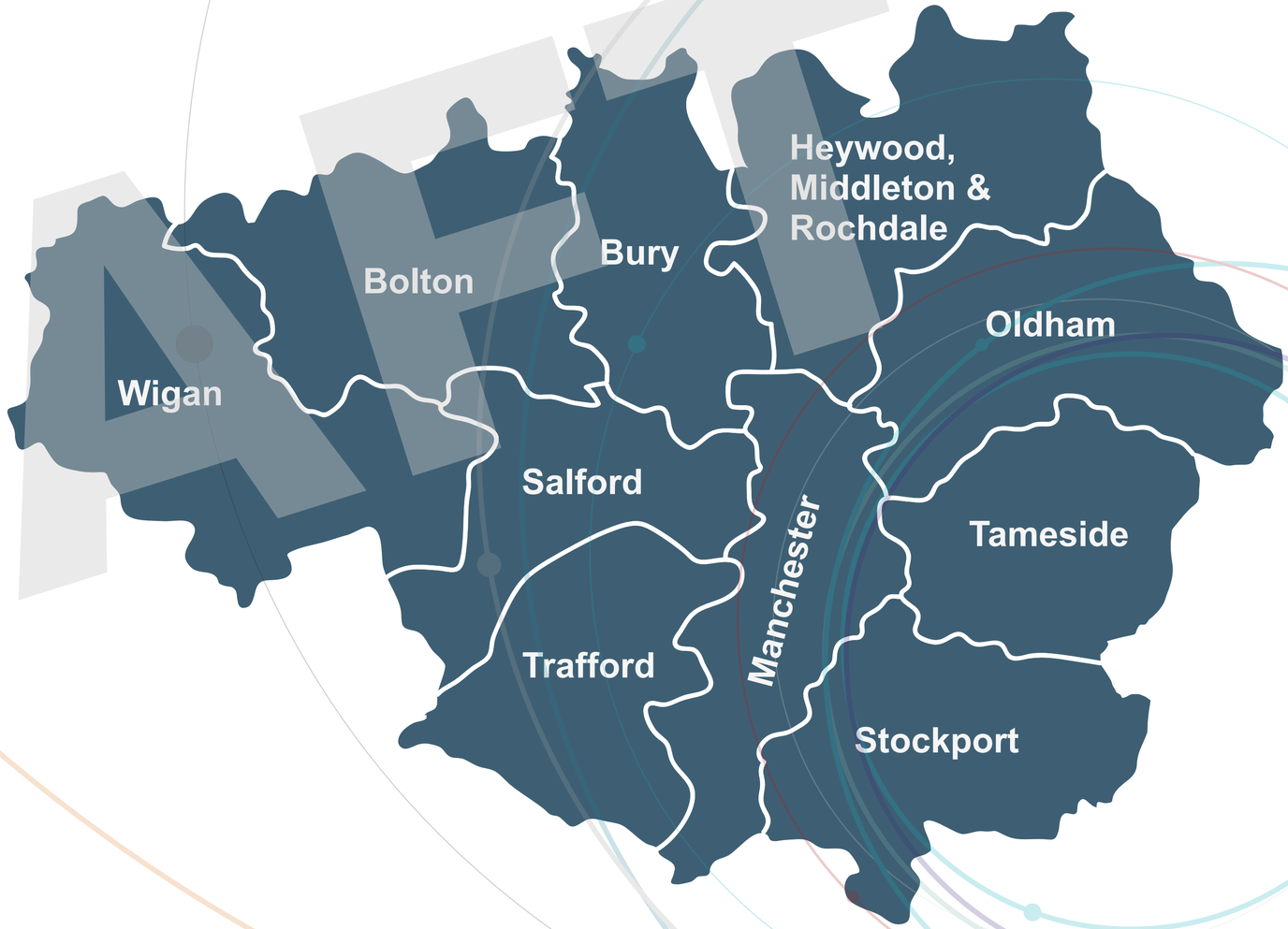
Link to NHS National Plans – to add

We have to take a whole system, whole society approach.

No single agency, body or organisation can solve the mental health and wellbeing challenges we face as a city region. This strategy is a 'system-wide' strategy, recognising that mental health is influenced by various issues from formal health services to social and economic conditions, to community, individual and family circumstances. Mental health and wellbeing must span and balance the medical and social models without subscribing to one or the other. It also recognises the value of statutory, formal and informal support.

The development of the Greater Manchester Integrated Care Partnership provides us with an opportunity to take a very different approach to responding to mental ill health as part of a whole system, whole society approach. We know that to rise to the challenges and pressures on the health system, we will need to significantly change how we operate in Greater Manchester.

We want to use this refreshed strategy to unite the different approaches to improving mental health in Greater Manchester. Some solutions will include better provision of services for those who have distinct mental ill health. Still, some solutions can be broader, involving all working closer and harmoniously with partners in building community health through housing, education, lifestyle and cultural bases. It is not just about sharing budgets. It is about sharing ideology, sharing outcomes and sharing aspirations.



Our overall approach for the GM Mental Health and Wellbeing Strategy will be fuelled by:

Vision: **A mentally healthy city region where every child, adult and place matter**

At the heart of our strategy, we have five shared missions we want to focus on as a unified, integrated, and equitable system.

1. People will be part of mentally healthy, safe and supportive families, workplaces and communities.
2. People's quality of life will improve through inclusive, timely access to appropriate high-quality mental health information, support and services.
3. People with long-term mental health conditions will live longer and lead fulfilling and healthy lives.
4. People will be comfortable talking about their mental health and wellbeing and will be actively involved in any support and care that they receive.
5. The mental health and wellbeing system recognises the inequality, discrimination and structural inequity people experience and are committed to developing more inclusive services and opportunities that people identify with and are able to access and benefit from

1 People will be part of mentally healthy, safe and supportive families, workplaces and communities.

Commitment by all sectors to work together on a delivery plan focused on missions to improve the mental health and wellbeing of citizens.

Areas to include – (Presumption towards community and integration provision)

- All agencies support and enable a comprehensive and consistent, community-led 'Live Well' offer in all communities across GM (regardless of the postcode and including alternative, psychosocial, creative and active offers).
- Development of evidence-based interventions in early years settings supporting social and emotional development. Building upon approaches including 'Think Equal.'
- Further integration of mental health offers into both Early Help, family support, housing and schools (in the vein of 'mentally health schools').
- Employees in areas outside of mental health services have a good understanding of mental health and wellbeing issues and can offer enhanced responses to communities (equally, those in mental health services can offer an enhanced response and connection to contextual issues, e.g. Trauma-Informed, Poverty awareness, fundamental issues – housing, finance, relationships, etc).
- Further integration of mental health support available through community spaces into a neighbourhood to 'blue-light' policing as part of place-based working (e.g. cost of living, food/warm banks, ageing well-related offers).

Living Well Tameside Services

Getting the correct mental health support is vital, and for residents of Tameside accessing the right care at the right time has been a huge priority.

Living Well Tameside is a new mental health system designed to help empower the individual, by offering open door integrated services that includes medical, clinical, and wider social support.

Working collaboratively enables different services to support individuals at the same time focusing on what matters to the person and not driven by their diagnosis. The mental health system collaborates with a wide range of partners both formally and informally which have huge impacts on the lives of people living with mental illness. This includes relationships with housing providers, the local authority, drug and alcohol services, local police, and physical health.

The new way of working ensures no one 'falls between the thresholds'. The offer is built around each person having 'My Story' which collates their support, care, and recovery plan in one place. This fresh approach looks at individuals as a 'whole person', so any situation or issue is looked at in the wider context of their lives, to be able to provide the most effective service.

The Living Well Tameside Services team understand what it is like to have a mental health condition and walks with anyone accessing the services side by side. Since the set up of the service it has seen over 9,171 people and has been recognised nationally for leading the way with new ways of working to support people with their mental health.

Living Well Tameside is a formal partnership made up of The Big Life group; Pennine Care NHS Foundation Trust; Tameside, Oldham and Glossop Mind; The Anthony Seddon Fund; Tameside Local Authority and CGL (drug and alcohol provider), commissioned by Tameside Integrated Care Board.

2 People's quality of life will improve through inclusive, timely access to appropriate high-quality mental health information, support and services.

Commitment by all sectors to work together on a delivery plan focused on missions to improve the mental health and wellbeing of citizens.

Areas to include – (Presumption towards community and integration provision)

- Provide clear, accessible care pathways for people, integrating mental wellbeing, social care and physical health.
- Adopt a 'no wrong door' approach, which means no rejected referrals.
- Create a system that provides integrated, 24/7, all-age access for service users, including those with multiple complex needs. No person should fall through the gaps between services or their operating hours.
- Ensure we have a sustainable workforce that is supported to provide the best possible person-centred care that is recovery focused.
- Ensure that all our services recover from the effects of the pandemic as effectively and fairly as possible, including further development to ensure adequate workforce capacity across GM to deliver mental health and wellbeing support.

I-Reach 7 Day Follow Up Service

I-Reach is a 7 Day Follow Up service which ensures that children and young people get the right level of support at the right time, aiming to reduce the number of schools that send young people, or direct parents, to take their children to A&E which may not always be the most appropriate place. The service educates and supports seeking earlier help via the school Mental Health Lead or Child and Adolescent Mental Health Service (CAMHS). It empowers people and schools to make better use of resources to provide a faster response to concerns.

Since launching, the service has seen 35 high schools and 13 primary schools that are registered as 'Emotionally Friendly Schools', benefit from the offer. The I-Reach team contacts schools 7 days after a young person presents at A&E, to offer advice, discuss issues around safeguarding and signpost to websites and other relevant services.

I-Reach is building collaboration and pathways between the Thrive in Education team, schools, A&E, Mental Health Liaison team and core CAMHS and helping to improve understanding of the Salford mental health system.

In the first three months of 2023, the service prevented 37 schools from sending young people unnecessarily to A&E. The service is constantly developing as the message is communicated about the offer ensuring that there is a focus on making the pathway even more robust listening to the children and young people as well as the schools involved.

3 People with long-term mental health conditions will live longer and lead fulfilling and healthy lives.

Commitment by all sectors to work together on a delivery plan focused on missions to improve the mental health and wellbeing of citizens.

Areas to include – (Presumption towards community and integration provision)

- Complete the transformation of community mental health support for adults.
- Develop our system, services and staff to ensure we can empower and equip people to receive integrated, flexible and multi-agency responses that reflect their individual complexities. These will specifically address those who experience multiple disadvantages and co-occurring conditions.
- Work collaboratively across organisational and service boundaries to ensure young people have a smooth and supported service, including age-appropriate support at transition points.
- Create opportunities for facilitating learning, collaboration, innovation and research to reduce stigma, raise awareness around mental health and drive continuous improvements in availability, access and quality of care.
- People with long-term mental health conditions will be supported to achieve their best physical health status, ensuring services identify and equip people to address health-risky behaviours in a human and holistic manner.

Building the Foundation: community rehabilitation and supported housing partnerships in Greater Manchester

Forging new partnerships with housing partners can lead to new life and opportunities for people with complex mental health needs. These partnerships can open the door for people to move on from expensive and restrictive inpatient units, sometimes many miles away from friends and family, to living more independently closer to home.

Gore Avenue is one such example in Salford - accommodation with a support service delivered by Sanctuary Supported Living - a 24/7 double staffed, waking nights offer, aiming to support people who need a higher level of support. A package of Enhanced Intensive Housing Management and Support was put in place with ForHousing, (commissioned by Greater Manchester Mental Health NHS Trust), supporting people to move into independent social housing, with wrap around housing and individual support.

Strategic partnerships - in this case between health and housing and between the NHS and Social Care – can allow Greater Manchester to build a better future for many more people who need a higher level of support tailored to their needs. Developing sustainable pathways with shared investment enables people to ‘step down’ from inpatient wards into supported accommodation and in some cases to move into their own homes. It allows us all as a system to continue shifting the balance away from costly inpatient care and instead reinvests our resources into Greater Manchester’s communities, homes and people.

4 People will be comfortable talking about their mental health and wellbeing and will be actively involved in any support and care that they receive.

Commitment by all sectors to work together on a delivery plan focused on missions to improve the mental health and wellbeing of citizens.

Areas to include – (Presumption towards community and integration provision)

- Peer support and advocacy opportunities available for all those within the mental health and wellbeing system.
- Lived experience leadership embedded across the system(s) with a practical and integrated offer developed and implemented.
- Roll out targeted campaigns and literacy programmes promoting mental health knowledge and support available to empower people to have greater control over their mental health and support needs.
- Build capability, capacity and confidence of the wider public to enable them to have mental wellbeing and suicide prevention conversations.
- Working with the Good Employment charter, all GM employers will be provided with an offer to promote a psychologically safe culture, including providing mental-health-literacy training to all employees and training leaders as well as managers to recognise signs of distress.

Refugee football project in Manchester

Football connects people no matter what their ethnic or cultural background. The game turns strangers at the start of the match into friends when the final whistle blows. A new sports initiative, The Football Freedom Project is using the sport to bring over one hundred refugees and asylum seekers living in Greater Manchester together for weekly matches.

The games are improving their physical and mental health as well as creating a sense of normality and helping players feel more connected to the new community, they now live in. Taking place in Ardwick the sessions attract mainly women, but men and children from the Ukraine and African, Middle Eastern and Asian countries are also being drawn to play. Many of the refugees have struggled with their physical and mental health, so football provides a safe space where they can integrate and get a better sense of belonging and healing.

The chance to improve their fitness by running and moving around, particularly for the children, provides the perfect opportunity to forget their struggles and make new friends.

The ground-breaking project has been co-created by charities Football for Humanity and Refugee and Asylum Participatory Action Research (RAPAR). GMMoving has helped to fund the sessions, through Sport England's 'Together fund'. The Freedom Football Project is helping refugees from all over the world to feel happier, more settled and use sports to break down cultural and language barriers.

5 The mental health and wellbeing system recognises the inequality, discrimination and structural inequity people experience and are committed to developing more inclusive services and opportunities that people identify with and are able to access and benefit from

Commitment by all sectors to work together on a delivery plan focused on missions to improve the mental health and wellbeing of citizens.

Areas to include – (Presumption towards community and integration provision)

- Support historically excluded groups and people with expertise through experience into employment opportunities to create a workforce that represents and is better able to support the population it serves.
- Invest in a system that embraces and learns from partners and experts. The system should be open to challenge and support as we adapt to more inclusive approaches and services.
- Expansion and integration of culturally appropriate services across the system that better tackle structural inequity.
- Create the ability to respond effectively to continual change in the social and political landscape and coherently in a co-designed manner to continual change in the social and political landscape.
- Make sure that people with complex and intersectional needs can access and get support from all services by adapting them to meet their cultural, social and economic conditions.

Greater Manchester LGBTQ+ Youth Led Project

Findings in the #BeeWell data 2022, show inequalities in wellbeing for LGBTQ+ young people. This has prompted a collaborative project between 42nd Street, The Proud Trust and The LGBT Foundation- all 3 organisations have a long history of working with LGBTQ+ young people across Greater Manchester but this is the first time they will have collaborated in this way.

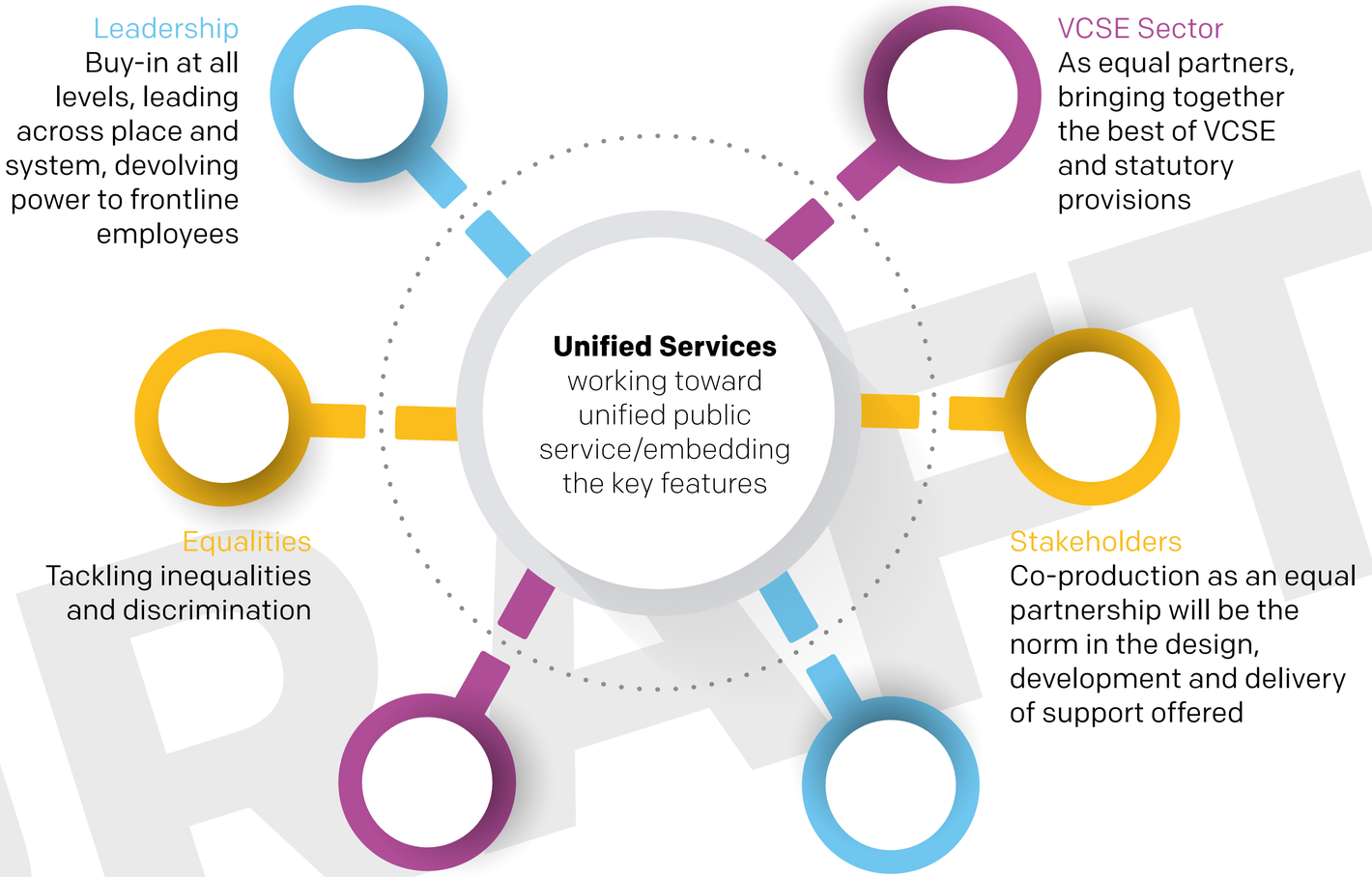
This project aims to understand the impact of the inequalities and discrimination experienced by LGBTQ+ young people, the impact on their mental health and wellbeing and the barriers that they experience to getting support. The partners will engage with young people to unpack what is driving the data. A critical part of engaging with LGBTQ+ young people will be for the project to give a voice to young people who often feel marginalised and who do not necessarily identify with or have the confidence and support to visit obvious places of support for curious, questioning and out LGBTQ+ young people. The project will focus on young people across Greater Manchester aged 13-19year olds and the partners will work alongside young people to co-produce approaches which aims to reach out to all LGBTQ+ young people across the city-region wherever they are in their journey and geography. As part of this work, young people will be offered the opportunity to participate in a young leaders course, which will enable them to lead peer workshops within schools, youth organisations, sports and faith clubs and other environments they feel are important to talk to young people in.

The partners will measure improvements in wellbeing for the young people involved in the co-design aspect of the project and as approaches are co-designed and adopted across the city region we will also monitor the wider impact on wellbeing for young people and their families. Overall this project will give us a greater understanding of the barriers faced by LGBTQ+ young people and the approaches required to address this critical area of inequality, discrimination and structural inequity across the health and social care system in Greater Manchester and beyond.

Enablers and ways of working:

The building blocks for achieving our goals and how we work across the system are as important as what we are trying to achieve. Without certain enabling conditions in place, we will not be able to achieve our goals. Ways of working are central to the Greater Manchester Strategy - the diagram on the right illustrates the areas most relevant to our Mental Health and Wellbeing Strategy.

Governance/Accountability – shared across the system



Capacity and resource – shared across the system

Our Missions

Our missions are for every person in Greater Manchester; they are not limited to a group or specific cohort of people.

This strategy aims to provide us with a set of missions that can be applied to remove barriers where we know marginalised and underserved populations have previously suffered and lacked support. While developing this strategy, we have undertaken an exercise to engage with a large number of the groups we are aware of and have enabled people to contribute to 'What does this mean to us?'

This, by no means, is reflective of every group/community which exists but is a commitment from Greater Manchester to build on this as we bring the strategy to life. It provides a minimum expectation of what everyone in GM should have when it comes to their mental health and wellbeing, regardless of their background, circumstances or complexities. We will continue to explore our citizens and ensure that our system, services and staff are equipped to do what it takes to adapt and meet people's needs rather than trying to provide the same to everyone.

We all have a part to play in Greater Manchester becoming a mentally healthy city region. Achieving our vision is dependent upon a strong partnership approach that takes positive action across the areas highlighted within the five missions. This means working in partnership with the public, VCSE and private sector to enable them to continue to take responsibility and provide leadership on aspects of the Strategy.

System engagement and board sign off

To be populated following sign off

Governance

The GM Mental Health Partnership Board will take overall responsibility for, and provide leadership on, reporting all progress relating to the GM Mental Health and Wellbeing Strategy back to Integrated Care Partnership Board.

Working with partners, a delivery plan and reporting framework is being produced to enable progress tracking against the five missions outlined within this strategy. The intention with the delivery plan is to give structure and meaning to each of the principles that sit under the missions, to ensure co-production throughout implementation, building on the co-production that led to the development and publication of the strategy.

Our Evaluation Approach

Our Evaluation Approach

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NHS GM Integrated Care Partnership

Forward Work Programme:

15 December 2023

- Mission 3 - Health & Employment (Warren Heppolette)
- Care Quality Commission System Assessment (Mandy Philbin, Anita Rolfe and Joanne Chilton)

22 March 2024

- Mission specific update tbc

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Greater Manchester Integrated Care Partnership Board

Date: 29th September 2023

Subject: GM Health and Care Digital Transformation Strategy 2023-27

Report of: Warren Heppolette, Chief Officer for Strategy & Innovation, NHS Greater Manchester Integrated Care

Gareth Thomas, Digital Innovation Director, NHS GM and Health Innovation Manchester

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PURPOSE OF REPORT:

To share the GM Health and Care Digital Transformation Strategy 2023-27.

KEY MESSAGES

- The Strategy is underpinned by the GM Digital Maturity & Investment Framework (elements of which have been adopted by NHSE and rolled out to all NHS Providers).
- The Strategy has been developed through extensive engagement with system representatives and public representative.
- The integrated annual delivery plans are overseen by GM Health and Care Digital Transformation Board.

RECOMMENDATIONS:

The Integrated Care Partnership Board are requested to:

- Note the engagement and socialisation completed to date (Appendix 1).
- Note the approach to delivery planning.
- Consider and support the strategy.

CONTACT OFFICERS:

Warren Heppolette, Chief Officer for Strategy & Innovation, NHS Greater Manchester Integrated Care
Email: warrenheppolette@nhs.net

Gareth Thomas, Digital Innovation Director, NHS GM and Health Innovation Manchester
Email: Gareth.Thomas@healthinnovationmanchester.com

1. BACKGROUND

To deliver on GM's integrated care system strategic plan and support the broader ambition for Greater Manchester to become a world-leading digital city region, we recognise the importance of embracing digital transformation to deliver new models of care, improve outcomes and efficiency.

We have made considerable digital and technological advances – from the acceleration of the Greater Manchester Care Record for all citizens, to the development of a secure data environment (SDE) to support world leading research and planning. But there are still large parts of our system that do not have the basics in place.

A new GM health and care digital transformation strategy has been developed through significant cocreation to outline our ambition to optimise digital approaches, data and technology across all care settings. It includes an assessment of our digital maturity as a system at both foundational and aspirational levels, to inform a framework of 47 digital priority activities to take forward over the next five years. The GM framework is actively used for investment planning and decision making across the system, at organisational and ICS levels.

2. STRATEGY

Extensive engagement (see appendix 1) has been undertaken to develop the GM Health and Care Digital Transformation Strategy, led by Health Innovation Manchester and NHS GM in partnership with Providers.

The strategy sets out 5 ambitions, with 3 layers of activity (to digitise, integrate and innovate):

1. We deliver integrated, coordinated and safe care to citizens
2. We enable staff and services to operate efficiently and productively
3. We empower citizens to manage and their health and care needs
4. We understand population health needs and act upon insights

5. We accelerate research and innovation into practice for the above, as a globally leading centre

The strategy includes the priority digital & data capabilities in each care setting and across care settings. The strategy itself is not a business case or delivery plan but sets the context for delivery plans and business cases as required at the programme level.

3. DELIVERY PLANNING

The strategy sets the context for annual costed delivery plans with programmes targeted at the priority capabilities, with detail of funding sources. The digital transformation delivery plan has been aligned to ICB Join Forward Plan priorities, and is included in the JFP delivery framework.

Delivery plan oversight, assurance and benefits realisation are monitored at a system level by GM Health and Care Digital Transformation Board (DTB).

The 23/24 delivery plan, structured according to the ambitions and priority capabilities defined in the strategy is available upon request via gmdigital@healthinnovationmanchester.com, and an extract is found in appendix 2.

4. RECOMMENDATIONS

a. To note the engagement and socialisation completed to date (appendix 1)
b. To note the approach to delivery planning
c. To consider and support the strategy

.

APPENDIX 1 - ENGAGEMENT AND SOCIALISATION

The strategy has been built upon 1,700 digital maturity data points and engagement in care setting ‘deep dives’ with 250 staff and 250 patients conducted predominantly during 2022, including with system governance groups including:

- GM Health and Care Digital Transformation Board
- Provider CIOs; Provider DoFs
- Primary Care Digital Board
- Locality Primary Care IT Leads
- Locality GP Digital Leads, PCN CDs and managers
- Adult Social Care Digital Steering Committee; Adult Social Care Digital Network
- DASSs
- Social Care providers (including service mangers)
- Local Authority IT & Transformation Leads
- Integrated Pharmacy & Medicines Optimisation Group – Digital
- GM Community Provider Board - and nominated representatives
- Patient & public representatives

In 2023, the learning from the deep dives was brought together into a single strategy, which has been developed and approved by GM Health and Care Digital Transformation Board with socialisation and support gained through the following groups to date:

- GM Digital Delivery Executive, plus additional engagement with
    - Provider CIOs
    - Locality Primary Care IT Leads
    - Adult Social Care Digital Steering Committee
    - Primary Care Digital Board
    - Integrated Pharmacy & Medicines Optimisation Group – Digital
    - Deputy Directors of Place

- Provider CCIOs and CNIOs, NHS GM Clinical Effectiveness Group
- Digital Inclusion Action Network
- HInM Board
- GM Primary Care System Board
- GM Provider Federation Board
- Patient & public representatives (public facing version)
- GM Integrated Care Partnership Board – planned for 29 Sept

Appendix 2 - annual delivery plan extract

Ambition 2: We enable staff and services to operate efficiently and productively

Lead Organisation	Project	Care settings in scope	Pipeline Stage	Digital & Data Capability	Key Dependencies	Cost	Funding source	Funding status	System governance	Major milestones/ deliverables for 23/24	Outcomes (including quantified impact)	Date expected	Anticipated benefits	Date expected	Project Closure
Providers	Electronic Patient Record	Secondary Care and Mental Health	Delivery – Roll out at Scale	TS_11 - EPR for each care setting	Future year funding	(Varies per trust)	NHSE Frontline Digitisation	Funded	DTB	Detailed trust-level milestones	80% Trusts with EPR meeting minimum digital foundation by end 2024	Q2 24/25	Improved Digital Maturity Scores	Q2 24/25	Q2 25/26
Providers / NHS GM	GM Cost Efficiency Opportunities workstream - Digital	All	Qualification	(Multiple)	Resourcing - funding / time	TBC	TBC	TBD	ICB Board	Q2 23/24 Confirm list of priority areas	Focus for provider organisations to focus on to deliver cost efficiencies in Digital	Q4 23/24	Greater efficiency in digital spend cross-providers	Q4 23/24	TBC
NHS GM	GMCR - RBAC Access Reconfiguration	Primary Care	Delivery - proof of value	DD_8 - Integrated Shared Care Record & Care Plans		Service Resources	N/A	Funded	GMCR COG	Ongoing Service activity	Secure, appropriate access to GMCR	TBD	Improved access to GMCR support patient care	TBD	
	GP IT Futures Retendering	Primary Care	Qualification	TS_11 - EPR for each care setting		£5.2m	GPIT Futures Central allocation	Funded	PCDB	New GPIT Futures Framework needs to be released (was due 31/3/23) All Vision sites must retender by 31/12/23 all others by 31/3/24	Practices on new contracts	Vision Q3 23, EMIS/TPP Q4 23	Practices will have supplier managed clinical systems in line with GPIT Futures requirements	Vision Q3 23, EMIS/TPP Q4 23	
	EMIS Spoke Servers	Primary Care	Delivery - rollout at scale	TS_11 - EPR for each care setting		£119K	NHSE DFPC & Primary Care SDF/Revenue	Funded	PCDB	64 servers scheduled to be replaced this FY. TO completed	All practices will have fit for purpose servers	Q4 23/24	Spoke servers will be fit to support EMIS Practices	Q4 23/24	Q4 23/24
	Telephony uplift	Primary Care	Solutioning	TS_23 - Unified communications		£700K	NHSE DFPC & Primary Care SDF	Funded	PCDB	Complete procurement process to identify approved suppliers	Fit for purpose telephony services	TBD	Users will have fit for purpose telephony services	TBD	TBD
	Migration to Enomen (EDT) Connect Service	Secondary Care	Delivery - rollout at scale	TS_0 - Integration Engine		TBC	FT's	TBD	GM CIO's	3 FT On Prem servers remain to be transferred	All Cerdden EDT Hubs on Cloud based services	TBD	On prem servers can be closed down. Improved resilience and functionality	TBD	
HInM	GMCR Training and Comms for clinicians	Primary and Secondary Care	Solutioning	DD_8 - Integrated Shared Care Record & Care Plans	TBD	£238,000	HSLI	Funded	GMCR COG	Q2 23/24 - Design and development of content Q3 23/24 - Reporting on KPI's Q3 23/24 - Delivery of content Q3 23/24 - Development of ongoing/future training approaches	- Clinicians have greater awareness and understanding of use of the GMCR. - Greater number of clinicians access and utilise the GMCR - Increased information sharing across clinical settings and organisational boundaries to inform care.	Q1 24/25	- Staff time saved - less time spent contacting other areas for relevant patient information that could be accessed through the GMCR (staff in which healthcare setting does this impact?) - staff satisfaction	Q2 24/25	Q4 23/24
	ICS Digital Workforce Joint Plan	TBC	Qualification	Strategy		£75,000	NHSE Digital Strategy	Funded	DTB	TBD	TBD	TBD	TBD	TBD	TBD

Quarterly reporting to GM Health & Care Digital Transformation Board from NHS GM, Providers and HInM will include RAG status per project, risks/issues for escalation by exception and benefits realisation reporting as relevant.

GM Health and Care
Digital Transformation Strategy

2023 - 2027

Greater Manchester Integrated Care Partnership

Contents

Summary

We want Greater Manchester to be a place where everyone can live a good life, growing up, getting on and growing old in a greener, fairer more prosperous city region

Summary

To deliver on Greater Manchester's strategic vision to become a world-leading city region, we need to embrace the digital transformation opportunity across the health and care system.

The health and care system in England is now embracing digital as a powerful driver for transformation, improving care, productivity and experiences. There is increased investment in technologies, talent and skills – there is much more to do to achieve the levels of experience and expectation in other digitally transformed industries.

In Greater Manchester, we are advancing to be a truly digital health and care system with an aspirational learning environment, leveraging the partnerships across academia, with one of the largest life sciences clusters in the country, and across industry. This, powered by the established integrated health and care system (ICS), gives Greater Manchester the ability to envision and drive digital transformation across the health and care system.

We have made considerable digital and technological advances – from the acceleration of the Greater Manchester Care Record for all citizens, to the development of a secure data environment (SDE) to support world leading research and planning.

However, there are many areas of our health and care system which remain paper-based or operate on clunky, outdated systems that are not connected to each other. This impacts on the quality and standard of care and the experience of people using our services. There is an urgent need to get the basics right, alongside our ambition to develop leading-edge approaches.

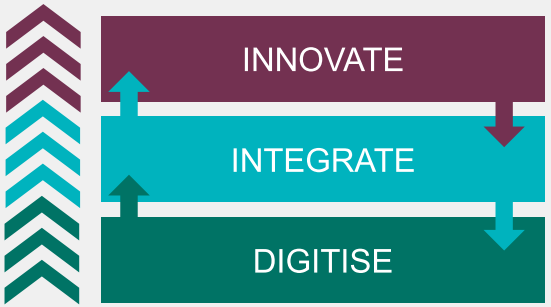
We have much more to do to see the benefits of the global digital revolution, accelerated by the Covid-19 pandemic, underpinning transformation of health and care services. During the pandemic, our workforce and citizens were forced to react quickly and adopt different, digitally-enabled ways of working, alongside handling extreme clinical and operational pressures. In 2023 – 2027 we must embed digital ways of working to drive benefits for our citizens.

What are our digital transformation ambitions?

1. We deliver **integrated**, **coordinated** and **safe** care to citizens.
2. We enable staff and services to **operate efficiently** and productively.
3. We **empower citizens** to manage their health and care needs.
4. We understand **population health** needs and act upon insights
5. We accelerate **research and innovation into practice**, as a globally leading centre

How will we meet our 5 ambitions?

We developed and rolled out the GM Digital Maturity & Investment Framework in each care setting to understand our current status and next priorities. This strategy presents three layers of activity required - to **digitise**, **integrate** and **innovate**.



What does this strategy include?

In this strategy, we discuss the **context of Greater Manchester** with its immense opportunities for **effective partnership working.**

Driven by outcomes for citizens, we have set out the GM health and care **digital vision, ambitions and priority capabilities** for a delivery roadmap for 2023 – 2027, in line with the GM Integrated Care Partnership Strategy.

This strategy is developed in **close collaboration with partners** across the Greater Manchester health and care system – with engagement throughout 2022 with leaders, staff and citizens.

On the basis of this engagement we present our ambitions, **underpinned by our methodology** for how we approach digital transformation across GM: getting the basics right with **digitisation** for all services, enabling the **integration** of care and connecting people, and **innovating** to allow new digital approaches and partnerships to flourish.

We are passionate about understanding particular problems faced by staff and citizens, and codesigning solutions with health and care professionals and the public – **solutions that work in practice**. We have learned a lot about the skills and abilities required to deliver sustained digital transformation effectively, and we are focused on wholistic change incorporating **people, process, culture, tools and technology**.

We understand the financial, operational, structural and technical **challenges** to be overcome to deliver transformation within a system under huge pressure.

We recognise that our **workforce have a critical part to play** in digital transformation – from articulating issues and solution codesign through to adoption of digital technologies into daily use. A further digital workforce strategy is to follow in 2023.

We also recognise the **importance of codesigning solutions with staff and citizens** to ensure that our health and care system is **inclusive, accessible and usable** by our population, whatever our cultural background, language or age. A further digital inclusion strategy is to follow in 2023.

We **reflect on the outputs** from our engagement in each care setting and service area, which includes over 1700 data points from **our digital maturity assessment**. Our assessment is focused on **how technology is being used by staff to deliver better care for citizens** and is now being adopted by NHSE across all Providers and ICSs.

We provide context for local organisation strategies and planning, as well as providing the **mechanism for investment prioritisation decisions** at ICS and locality/organisation levels.

Our Context

Greater Manchester is now an Integrated Care System – a partnership of organisations that come together to plan and deliver joined up health and care services, and to improve the lives of people who live and work in GM

Context

Our Integrated Care Partnership (ICP) has a collective vision - we want Greater Manchester to be a place where everyone can live a good life, growing up, getting on and growing old in a greener, fairer more prosperous city region. A GM where everyone:

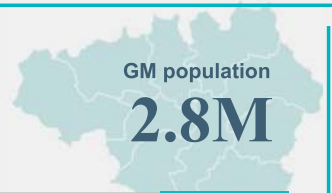
- Has a fair opportunity to live a good life
- Experiences high quality care and support where and when they need it
- Has improved health and wellbeing
- Works together to make a difference now and for the future

In the ICP strategy, this vision is underpinned by six missions:

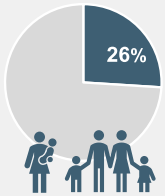
1. Strengthening our communities
2. Helping people get into, and stay in, good work
3. The recovery of core NHS and care services
4. Helping people stay well and detecting illness earlier
5. Supporting our workforce and our carers
6. Achieving financial sustainability

There are **multiple inequalities** experienced in Greater Manchester:

GM has some of the **lowest life expectancy** in England



In some of our localities, the **disparity** between the shortest and longest life expectancy is as big as 17 years.



GM is **relatively deprived** compared to other ICSs in England

Low income levels underpin **high levels of child poverty (26%) in GM**, which is 8% higher than the national rate (**18%**)

Working-age people in GM with **no qualifications** is disproportionately high **9%**

The skills deficit reinforces the **predominance of lower value, low pay employment in the city-region** compared to the south of England and GM's international comparators.

There are strong correlations between **employment levels and health conditions**

75% **75%** of the variance in employment rates across the neighbourhoods of GM is **accounted for by health** (correlations for mental and physical ill-health were similar)

10% **Employment rates of people from minority ethnic groups** in GM are **10% below** the average working-age employment rate.

50% **Only half** of GM working-age residents with a **disability** are in employment

We now live in a world where technology is part of our daily lives, from paying bills, to online shopping to keeping up with news – the way we do things has been completely transformed because of digital technology. Most of us are connected through technology most of the time – to each other and to people who provide products and services.

Digital, data and technology have a fundamental role in improving care for everyone to achieve these missions and addressing health inequalities. Sharing data and information is vital to providing integrated, whole person care, helping people stay well and detect illness earlier.

We want to bring this level of digital advancement into our public services to give people greater control over their own health and wellbeing and transform the way in which we engage with services.

What have we done?

Since launching the 2019 GM health and care digital strategy, we have faced and risen to multiple challenges.

We were able to accelerate digital transformation during the COVID pandemic. Whilst COVID-19 had devastating impacts on the citizens and health and care workforce of Greater Manchester, we were able to unblock barriers to delivering patient care. Through new governance models we enabled critical data sharing for the first time across localities and care settings in GM.

We have delivered multiple projects of new digital functionality across GM since 2019, including:

- Data sharing across localities and care settings via the GM Care Record to enable safer and more timely care
- Remote monitoring for people with Covid-19, including symptom tracking in care homes to identify those who need acute care earlier
- Picture archiving communication system to share images
- Covid-19 vaccination booking system

While there are many examples of advances in digital technology in health and care across the UK and in Greater Manchester, things are not good enough. We know that health and care professionals are unable to access or contribute to the same patient record and are often operating across multiple clunky and outdated systems, using sub-standard equipment, which prevents them from being able to enable high quality care and impacts on operational efficiency. We need to digitally transform how people engage with health and care services by bringing in new technologies and using data to provide more accurate and effective care and treatment. We need to enable people to better monitor their own health and plan their care, alongside professionals.

We developed the GM Health and Care Digital Maturity & Investment Framework to gain consistent understanding of current maturity and enable digital investment decisions to be driven by patient outcomes. The digital maturity assessment embedded within our framework is now being rolled out by NHSE across the country.

Deep understanding of the **digital maturity of the organisations in the ICS**

35 **Digital Maturity Assessments** completed by organisations across all care settings

1700 **Digital maturity data points** received

Deep understanding of the **investment required**

Over £40m secured in 2021/22 for **digital transformation**

Over £35m secured in 2022/23 for **digital transformation**

Through our engagement…

…**we've listened** to over **250 citizens** to understand what matters to them

…**we've listened** to over **250** **clinical, social care, operational and digital professionals** to understand what matters to them

Advancing our digital health and care system

Greater Manchester has a global reputation as a pioneer and partner of choice. We have led the way in establishing ICSs, and we have learned through GM devolution that it takes time to deliver change and make a difference. We all have a role to play in improving health across the region, and the NHS, wider public services, the VCSE sector and GM citizens will work together to achieve this.

We acknowledge that we are progressing on a journey toward achieving difficult things at pace and scale, with determination to be a healthcare system that truly embraces the use of digital technology in all we do. We have learned a lot about the skills and abilities required to deliver sustained digital transformation effectively, and we are focused on wholistic change incorporating people, process, culture, tools and technology.

Building on the strength of partnership across the city region, we are in a unique position to deliver transformation and improve outcomes for our citizens. However, in order to be a place where everyone can live a good life, growing up, getting on and growing old in a greener, fairer more prosperous city region, we must maximise our capability and capacity through wider partnerships.

In addition to collaboration with wider public services, we must develop the right relationships with the technology industry, to leverage resources and insights, and embed GM as the place for leading-edge tools to be deployed to improve patient care. In order to harness our data assets to deliver real world evidence studies and evidence-based innovations, we also partner closely with academic institutions across the life sciences and evaluation.

Through these partnerships we will move further and faster toward our ambitions. We will cultivate a culture of learning and collaboration, with technology solutions which are flexible to local needs and digital maturity.

To improve care and outcomes for citizens in Greater Manchester, we must accelerate the development and deployment of digital innovation. There is tremendous potential for Greater Manchester to become a world-leading digital city region. Through close collaboration with citizens and partners across the Greater Manchester health and care system, we have a strategy that will meet our ambitions for digital transformation, leading to enhanced efficiency and integration across services, greater understanding of our population's needs, and improved care for everyone."

Dr Gareth Thomas,
Digital Innovation Director at Health Innovation Manchester and NHS Greater Manchester Integrated Care

Spotlight: GM wider public sector opportunities

For the GM Health and Care digital transformation strategy to have the greatest impact, it must be enabled through collaborative working with partners across Greater Manchester. It is key to our ambitions that we consider wholistically the needs of citizens and wider determinants of health outcomes.

Through collaborative working with public sector colleagues, we can create a greater impact for citizens – particularly recognising the shared goals in digital inclusion and digitally developed workforce - of empowering individuals to access and benefit from the opportunities digital brings if they want to.

Representatives from health and care work with colleagues in the Greater Manchester Combined Authority and Local Authorities at senior leadership and operational and delivery levels.

The following GMCA Digital Blueprint priorities and strategic enablers are common to this health & care strategy:

Priorities

- Empowering people and communities to thrive
- Building responsible, data driven public services
- Strengthening our position as a global digital influencer

Enablers

- Building digital skills and literacy for life, education, work and business
- Strengthening our Digital Talent Pipeline
- Harnessing academia, testbeds and research

There are many examples to demonstrate the importance of collaborative working across the wider public sector in GM, for example:

The Mayor's Digital Inclusion and Action Network recognises the benefit of working together to share best practice, opportunities and connections. It has a focus on enabling all Young People, Disabled People, and Over 75s to get online safely and benefit from the internet. This is a key enabler for citizens to realise benefits from digitally enabled healthcare too. Applying these priorities will be developed further in the GM Health and Care Digital Inclusion Strategy.

The Early Years Platform has been developed to support Health visiting and Early Years services in order to improve School Readiness in Greater Manchester. With over 40,000 digital assessments now completed, it gives parents, guardians and professionals a mobile solution that replaces paper-based processes, enabling more effective support of families, helping deliver a more joined up child support journey from pre-birth to school age."

As discussed in the **GM Green Plan 2022** and GMCA Digital Blueprint, we know that the impacts of digital technology reach further than patient care, for example into the net zero agenda, particularly with the increase of services delivered virtually.

Our operating environment

Our operating environment presents numerous opportunities and challenges. Our delivery strategy must reflect this to promote partnership working, collaboration and flexible solutions which are consistent with local needs.

Governance

Digital governance and delivery accountability in GM has been significantly developed since 2019 to ensure system-wide representation, with clinical, digital and financial understanding and ownership of key issues. Transparent, effective and efficient decision making mechanisms at the right levels are critical to shape programmes, provide assurance of delivery, and ensure compliance with technical, clinical safety and data sharing standards. These governance models must be blended with the emerging ICS environment.

Funding model

In a fiscally constrained environment, we are reliant upon annual funding streams that emerge late in the financial year. This significantly limits our ability to plan for and deliver wholescale digital transformation; whilst we are in a strong position to respond to opportunities, we must work with funders to proactively ensure funding cycles support delivery of our strategy.

Supplier management

Most of the technology relied upon in health and social care is supplied by independent companies, with whom our teams work to ensure that the products we buy, and develop with them, are meeting our requirements. We must have robust supplier relationships to ensure value for public monies.

Operating model

Digital transformation is not about adding IT to existing ways of working. Digital transformation is about enabling new ways of working underpinned by digital technology. The technology must be subservient to the ways of working (the operating model), rather than the other way around. This means that our teams are focused on a deep understanding of the current clinical operating models and working with colleagues to redesign the models to better meet the needs of patients and staff (and making sure the technology helps rather than hinders this).

Information Governance

Sharing data responsibly saves lives. It is critical that we govern data in the way that our citizens expect – to ensure access by the right people at the right time to support the best patient care. In GM, we engage with citizens, via public panels and engagement groups, about their data so that everyone can understand how their data is being used, and can make informed decisions about having their data shared. We also engage fully with data controllers as early as possible within our digital transformation projects to ensure the appropriate agreements are put in place – in this way Information Governance becomes an enabler rather than a barrier to better patient care.

Technology

Organisations across GM have variable digital maturity and varied architecture. Interoperability between systems is limited. Our strategy promotes convergence around a limited number of interoperable products where clinically and operationally warranted.

Data Sharing

By analysing de-identified data, we can better review and plan services based on accurate information. It also supports groundbreaking research into new cures and treatments that could save lives here and around the world. Good use of data really does save lives.

There are strict rules about how patient data is used in research to ensure people's information is protected. Researchers are only ever given the minimal amount of information they need to conduct a particular study and a person's name, date of birth and address are removed so they cannot be identified. Citizens can opt-out to their information being shared for reasons beyond their individual care.

Workforce

We have a workforce with variable digital skills, and varied levels of digital clinical leadership and limited capacity in the technical workforce. Training needs must be addressed at all levels.

Developing our workforce matters

Our workforce are our biggest and most precious asset. With ever-evolving technology and expansion of its applications in the planning and delivery of services, our frontline health and care workforce are increasingly dependent on digital skills and confidence to perform their duties. We want to harness technological benefits for staff to improve the quality and safety of care delivery.

We are excited about the new ways of working that our workforce will shape through use of digital technology. We must aim to incorporate the digital mindset into strategic planning and business processes at all levels. Developing further, we must cultivate the learning environment that fosters leaders who scan the horizon, prioritise the use of emerging technology, being able to pivot service provision and models of care for a digital age.

The GM Health & Care Digital Workforce Plan will be developed in 2023, in line with the GMCA's vision to create a critical mass of digital talent, positioning GM as the key place for businesses seeking a digitally-skilled workforce to invest in. It will be codesigned with frontline workers to set out the priorities and approach for empowering and equipping our workforce to embrace digital ways of working and transform care.

Our whole health & care workforce need the skills, knowledge and confidence to use and make the most of digital. We must understand the training needs and support Providers to train all health and care staff to ensure that digital competency requirements for all roles are met. We also must support training of staff wanting to develop their digital, data and technology competencies further.

Digital clinical leadership roles need continued development and growth.

Digital social care leadership roles need appointing and supporting.

Executive ownership of digital is critical for our organisations' ability to own the opportunities presented by digital technology. Understanding the investments in the people and process aspects of transformation as well as the digital technology itself is critical to ensuring delivery of benefits.

Digital, data and technology roles need recruitment and retention strategies, recognising the competition with industry for these posts.

We will set out the responsibilities of the ICB and provider organisations for recruitment and development plans, exploring sharing resources across the ICS, offering career development opportunities.

In order to develop the pipeline of people with the right skills from diverse backgrounds, we will explore partnerships with Further and Higher Education Institutes and Local Authorities.

We want citizens to be able to take part at this pivotal point for digital transformation in the health and care sector, digital, data and technology roles offer the opportunity to impact the lives of hundreds of thousands of people.

Digital inclusion matters

The Greater Manchester Independent Inequalities Commission identified digital access and access to care & support as key drivers of socio-economic inequalities.

While we know that digital tools aren't always the preferred way for citizens to access and navigate health and care services, we are committed to providing digital access channels that are easy to use by all citizens who would want to use them.

When well designed and accessible, digital tools can help improve access to services and address health inequalities. However, it is recognised that in an increasingly digital world, people who are digitally excluded are at risk of worse access to services and poorer health outcomes, deepening inequalities.

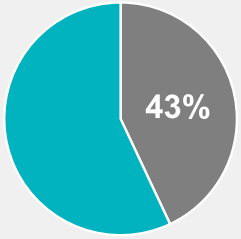
There is a close correlation between digital exclusion and social disadvantages including lower income, lower levels of education, and poor housing.

GM has significantly advanced the use of digital approaches across public services, but there are still significant numbers of people who cannot easily access or benefit from digitally-enabled services and tools.

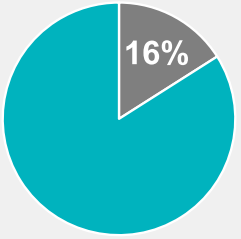
The NHS long term plan makes a commitment to a more concerted and systematic approach to reducing health inequalities and addressing unwarranted variation in care.

We are aligned to the Greater Manchester Strategy which includes a commitment to tackle digital exclusion, with priority being given to Young People, Over 75s and Disabled People.

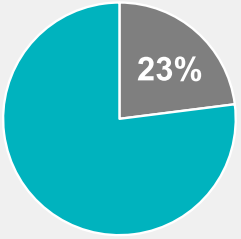
Digital exclusion in our GM population



43% of our population are **excluded in some way** for the opportunity that digital brings.



16% of our population are **'non-users' of the internet** - over half of whom are over 60 years of age.



23% of our population are not using digital services because of a **lack of money**

We need to build inclusion into the digital design, delivery and transformation of health and care services.

Using user experience design approaches and working with partners, we will develop a deep understanding of citizen need, clearly define problems and co-design innovative solutions to improve the patient journey, experience and outcomes.

We have already put this approach to the test in some of our key digital programmes including digital transformation of GP practices, the design and development of virtual wards, and the deployment of remote monitoring technologies. But we now need to take this further through all of our digital transformation work across Greater Manchester in partnership with colleagues from across the public sector, industry and voluntary and community organisations.

The GM ICS Digital Inclusion & User-led Design Plan will be developed in 2023.

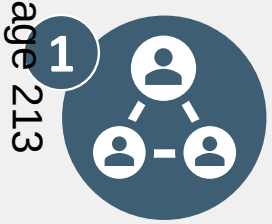
Our Vision

for digitally transformed health and care

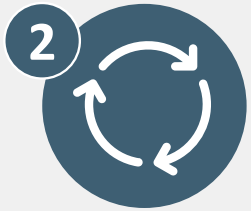
Our 5 ambitions

In Greater Manchester, digital is a key enabler for improving care and outcomes for citizens. We have engaged in conversations and workshops with over 500 individuals - including clinical, care, operational and digital professionals and citizens across GM. We now have a better understanding of the problems they experience, and the opportunities for digital transformation to help solve these problems.

Our 5 inter-related ambitions have been developed through this engagement:



We deliver **integrated**, **coordinated** and **safe** care to citizens.



We enable staff and services to **operate efficiently** and productively.

We **empower citizens** to manage their health and care needs.

We understand **population health** needs and act upon insights.

We accelerate **research and innovation into practice**, as a globally leading centre

We have listened:

As a citizen I want to:

- Feel confident that the people looking after me have access to my medical history
- Feel confident that the people looking after me have access to my preferences and my lifestyle (including cultural) needs
- Feel confident that health and care professionals are making joined up decisions
- Trust that my information is being accessed by health and care professionals to inform my care in a personalised way

Staff want to:

Support transitions of people, information and medicine between care settings – to manage citizens' health and care needs holistically

Use digital technology to solve clinical safety problems

Deliver continuity of care across different members of staff and services, including between care settings

Gain appropriate access to the right information at the right time

Ambition 1:

1

We deliver **integrated**, **coordinated** and **safe** care to citizens.

What this really means for your care:

Receiving joined-up care from different services and professionals, especially for the growing number of patients with multiple long term conditions

We have listened:

As a citizen I want to:

- Order repeat prescriptions easily
- Obtain referrals on the spot so I don't have to remember to schedule another appointment
- Have my medications available for pick up from my local pharmacy
- Tell my health and care story and needs once, not every time I speak to a new professional

Staff want to:

Use digital and data to address workforce constraints and release capacity

Attract and retain staff, including by maximising time available to deliver care and supporting professional development

Ensure patient safety and reduce adverse events

Equip and empower staff to use digital and data tools to improve the care they can deliver

Ambition 2:

2

We enable staff and services to **operate efficiently** and productively.

What this really means for your care:

Services that work well, with health and care professionals who enjoy focusing on delivering the best possible care, supported by the power of digital technology

We have listened:

As a citizen I want to:

- Find information and advice that I trust about my condition easily
- Understand the services available to me and how I can access them
- Understand the information I receive digitally
- Communicate with health and care professionals, even if they don't speak my language
- Know what is going to happen next
- Know who to contact when something goes wrong

- Receive care in my home if appropriate
- Maintain my independence
- If I'm at risk for particular conditions, be supported to manage this
- Feel involved in my care
- Feel empowered by accessing information I trust to manage my own conditions and wellbeing
- Feel confident to use technology that supports my care, if I choose to

- Access care from my GP or hospital when I need it
- Exercise choice over how I contact my GP
- Book appointments for times that suit me, quickly and easily
- Access my own health and care record, in one place
- Log into health and care digital systems and apps with one account/password

Staff want to:

Make navigating a complex system easier for citizens

Support patient involvement in care and their experience

Use digital to enhance patient-centred care and interactions

Ambition 3:

3

We **empower citizens** to manage their health and care needs.

What this really means for your care:

Enabling individuals and communities to manage their own physical and mental needs, helping people stay well and maintain their independence at home.

We have listened:

As a citizen I want to:

- Know if I'm at risk for a particular condition and receive proactive advice
- Be supported as an individual to improve my health and wellbeing
- Connect with others in my neighbourhood to share what's worked
- Feel that the care and treatment I get is fair and equal, and advances in technology don't exclude me.
- Be assured, as a taxpayer, of minimising waste

Staff want to:

Deliver responsive services that are timely, personalised and appropriate

Collaborate across care providers to promote healthy living and prevention

Systematically identify patients with high levels of need and intervene earlier

Ambition 4:

4

We understand **population health** needs and act upon insights.

What this really means for your care:

Health and care services that are more proactive in helping you to manage your health and wellbeing, providing more personalised care when it's needed – including detecting illness and intervening earlier.

We have listened:

As a citizen I want to:

- Know that services provided via digital channels are safe, confidential and effective
- Benefit from the most advanced and leading-edge care and treatment in the world, including advances in genetic and other personalized medicine, Artificial Intelligence etc
- Know that when my information is being used for research, it is anonymous and benefits the communities where I live
- Be assured that the health and care system is focused on prevention

Staff want to:

Learn from and scale what's worked elsewhere in the locality or in GM

Harness the transformative power of health and care, industry and academia working together to address major challenges and tackle inequalities

Ambition 5:

We accelerate **research and innovation into practice**, as a globally leading centre

What this really means for your care:

Receive leading edge care and treatment personalised to your needs, as well as benefit from digital technologies that support you to have equal access to health and care

Our Method

to understand system needs and agree our priorities

GM digital investment decisions are driven by patient outcomes and focused on increasing digital maturity to meet our ambitions for improved care

Strategic inputs

Our strategy and planning has been based on engagement with GM health and care leaders in each sector, staff and citizens - we've engaged with over 500 people in different care settings, service areas and localities during 2021 – 2022 to understand the problems they face and the solutions they need. In addition, we have taken into account key inputs at local and national levels.

GM inputs

Include:

- GM Health and Care Integrated Care Strategy
- Greater Manchester Strategy
- GM Digital Maturity & Investment Framework
  - 1:1 conversations, digital maturity scores and workshops to agree priorities in each care setting and service area
  - Discovery engagement in our service areas
  - Locality and provider organisation priorities and plans
- Lessons learnt since our last strategy and from our current delivery projects
- GM Green Plan
- GM Combined Authority Digital Blueprint
- GM Data Prospectus

National inputs

Include:

- NHS Long Term Plan
  - including underpinning plans and operational planning guidance
- Integrated Care Systems Guidance
  - building smart digital and data foundations
  - connecting health and care services
  - using digital and data to transform care
  - putting the citizen at the centre of their care
- Hewitt Review: an independent review of integrated care systems
- NHSE Transformation Directorate What Good Looks Like
- NHSE Digital Clinical Safety Strategy
- National service contracts
  - including GP, PCN, Community Pharmacy contractual frameworks

OUR METHOD

- **Strategic inputs**
- Understanding our population and the problems experienced
- Defining our ambitions and how we can achieve them
- Financial baselining
- Balanced portfolio for the ICS

Understanding our citizens

We developed personas representative of our diverse GM population. A thorough understanding of our citizen's circumstances, health needs, challenges and opportunities has fed directly into the digital & data capabilities required to transform the experience and outcomes of our citizens.

~35%

Mostly well, with occasional elective intervention

Broadly healthy individual who rarely seeks healthcare but has suffered a specific incident.

Needs to be diagnosed, complete course of treatment and return to normal life.

Opportunity for preventative intervention (e.g. around smoking)

Patient journey

Diagnosis and successful treatment of one new condition; engagement with preventative care

~25%

Family, with young children and wide ranging needs

Low income household with 2-3 children under 5 and limited social support network.

Range of bio/psycho/social needs – e.g. risks relating to school-readiness and childhood obesity, parent with recurrent mild mental health issues, one child with chronic condition such as asthma and/or eczema.

Patient journey

First 1,000 days of youngest child

~10%

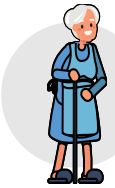
Middle-aged, multiple health needs, lifestyle challenges

45-55 year old with a range of lifestyle risks – including smoking and obesity – and long term multi-morbidity (e.g. some of chronic back pain, depression/anxiety, T2 diabetes and/or CHD risks).

Would like support to return to work following a period of unemployment.

Patient journey

One year in the life following a diagnosis of a long term condition



~8%

Elderly, frail and housebound

65-80 year old who is clinically frail, lives in their own home but is largely housebound.

English is not their first language.

The individual is not digitally engaged and apart from a basic mobile phone does not have many devices at home.

Patient journey

Recent bed stay in hospital following a fall, discharged back to primary care.

~% of GM population

Note: Additional personas were used in each care setting

OUR METHOD

- Strategic inputs
- **Understanding our population and the problems experienced**
- Defining our ambitions and how we can achieve them
- Financial baselining
- Balanced portfolio for the ICS

“These new digital services, such as apps and patient portals, will cause considerable stress to patients if not developed properly.

What we need is a few digital functions that are easy to use and focused on making access to services and their delivery much easier for everyone. Then there is potential to have a big impact, improving the wellbeing and quality of life for many.”

GM citizen

Meeting our ambitions

Having engaged in conversations and workshops with clinical, operational and digital colleagues and citizens across GM, we have better understood the problems they experience and the opportunities for where digital transformation can help to solve these problems. These problems are detailed at the end of this document. Our 5 ambitions are a direct result of this engagement and feedback from citizens and staff.

1. We deliver **integrated**, **coordinated** and **safe** care to citizens.
2. We enable staff and services to **operate efficiently** and productively.
3. We **empower citizens** to manage their health and care needs.
4. We understand **population health** needs and act upon insights.
5. Through each of these, we accelerate **research and innovation into practice**, as a globally leading centre.

Innovate

We will develop and deliver proven innovations, novel technologies and data science approaches to improve health outcomes, address inequalities and design new models of care. This is achieved by fostering collaborative partnerships between health, care, academia and industry.

Integrate

We will deliver person-centred care based on the specific needs of citizens by providing patients, carers and clinicians with access to virtual information where and when they need it. This includes integrating digital tools that join up services, as well as empowering citizens and connecting them with health and care professionals.

Digitise

We will get the basics right for all services and increase efficiency by adopting digital systems, processes and tools, and collecting data to inform better care. This all needs to be delivered to shared standards to support convergence across providers.

OUR METHOD

- Strategic inputs
- Understanding our population and the problems experienced
- Defining our ambitions and how we can achieve them
- Financial baselining
- Balanced portfolio for the ICS

Our 47 Digital & Data Capabilities

We have invested significant time to understand the diverse needs of our citizens and describe a set of digital and data capabilities that are required for us to achieve our ambitions - in a language that we can all use, independent of professional background, care setting, service area or locality. Through our engagement in GM, we have identified 47 digital and data capabilities required to meet our ICS digital transformation ambitions, which are grouped into the three layers of activity - digitise, integrate and innovate.

Innovate

- New models of care
- NHS at Home / Remote Monitoring
- Personalised care apps
- Understand and predict population health need
- Research data
- Decide and design care interventions
- Innovation hub

Integrate

- Integrated shared care record
- Care coordination
- Eventing: sharing actions and alerts
- Integration engine
- Internal / external API
- Healthcare interoperability standards
- Demand led management of capacity & scheduling
- System monitoring and transparency
- Supply chain automation
- Connected Workforce
- Robotic process automation
- Real time staff, patient, equipment tracking
- Multi channel consultations
- Targeted, tailored and personalised comms
- Digital front door and navigation
- AI enabled self help triage
- Health record accessed by citizen
- Booking appointments across settings of care

Our 47 Digital & Data Capabilities

Digitise

Underpinning digital and data capabilities required for integration and innovation

Data security and governance

- Single sign on (SSO)
- Security: network & cyber
- Identity and access mgmt.
- Information governance

Core clinical systems

- Electronic Patient Record
- Specialist systems
- Order comms
- Multi-resource scheduling
- e-referals
- e-prescribing and prescribing
- Patient Administration System
- Imaging
- Laboratory Information Management Systen

Data ecosystem and analytics

- Data warehouse & data Lake
- Analytics and reporting models and tools
- Collecting and managing multisource data

Support services

- System for communication (any type)
- IT service mgmt.
- Asset mgt. & tracking

Digital infrastructure

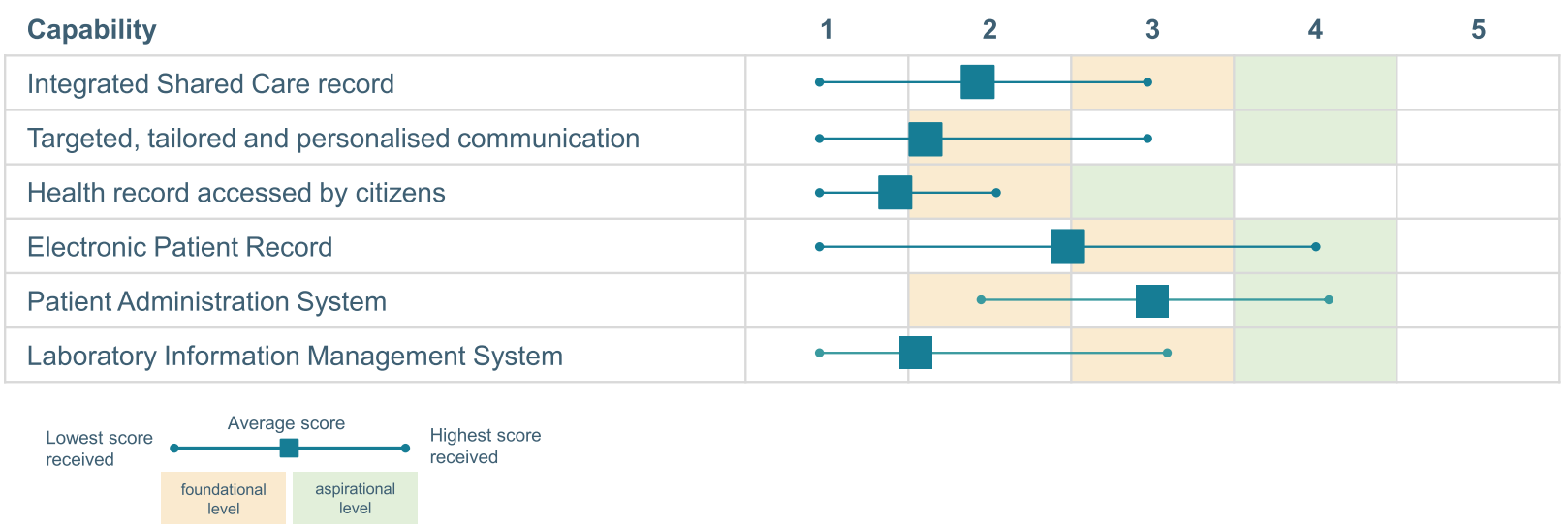
- Unified communications (email, phone, smart device)
- Networking (WAN/LAN/WiFi/Beacons)
- Minimum standards for computers (PC, Laptop, VID)
- Network estates (incl. cloud)

GM's nationally recognised digitally maturity assessment

We proactively developed a digital maturity assessment which gives us deep understanding about the digital maturity of the organisations in the ICS for each of the digital and data capabilities required at organisation and ICS level. We have clear descriptors for each level of digital maturity, with specific examples and tailoring for each care setting to ensure consistent interpretation. Our maturity assessment isn't focused on the technology itself – but on how technology is *being used by staff to deliver better care for citizens*. The assessment, developed in GM, is now being adopted by NHSE across all Providers and ICSs.

We have **over 1700** maturity data points received from **over 40 returns from individual organisations**, including all Provider Trusts and Localities in each care setting. The chart below provides example data from selected capabilities.

Example data



This data is invaluable for understanding where we are as an ICS and individual organisations in a consistent way, and measuring our progress. Organisations and the ICS have defined our priority digital & data capabilities, based on the which capabilities require investment to reach foundational levels, mitigating risk, and which we're ready to invest in to transform care pathways.

OUR METHOD
Strategic inputs
Understanding our population and the problems experienced
Defining our ambitions and how we can achieve them
Financial baselining
Balanced portfolio for the ICS

Digitise

In order to deliver our ambitions, we must digitise.

Digitising is about moving from using paper or manual processes to using information technology (IT) systems.

An example of digitisation is the implementation of an Electronic Patient Record (EPR) within a hospital or a Digital Social Care Record in a care provider.

Our 47 Digital & Data Capabilities

Innovate

Integrate

Digitise

Underpinning digital and data capabilities required for integration and innovation

Data security and governance	Core clinical systems		Data ecosystem and analytics	Support services	Digital infrastructure
Single sign on (SSO)	Electronic Patient Record	Patient Administration System	Data warehouse & data Lake	System for communication (any type)	Unified communications (email, phone, smart device)
Security: network & cyber	Specialist systems	Imaging	Analytics and reporting models and tools	IT service mgmt.	Networking (WAN/LAN/WiFi/Beacons)
Identity and access mgmt.	Order comms	Laboratory Information Management Systen	Collecting and managing multisource data	Asset mgt. & tracking	Minimum standards for computers (PC, Laptop, VID)
Information governance	Multi-resource scheduling				Network estates (incl. cloud)
	e-referals				
	e-prescribing and prescribing				

Integrate

In order to deliver our ambitions, we must integrate, enabled by integrated digital capabilities.

Integration is about surfacing the right information at the right time to the right people in the right place, to deliver care centred around the individual. This includes integrating digital tools that underpin services as well as connecting citizens with health and care professionals.

As an important example, the GM Care Record is our ICS-wide integrated shared care record, with data visible from all care settings to support day-to-day clinical decision making, key innovations and secondary uses. Having understood the reasons for and barriers to usage, we are now investing to realise the potential of this digital asset, deploying access to Community Pharmacy and independent social care providers - with targeted training across the ICS and technical enhancements for staff in each care setting to use the GM Care Record as the single platform for integrated care planning.

Our 47 Digital & Data Capabilities

Innovate

Integrate

Integrated shared care record	Demand led management of capacity & scheduling	Multi channel consultations
Care coordination	System monitoring and transparency	Targeted, tailored and personalised comms
Eventing: sharing actions and alerts	Supply chain automation	Digital front door and navigation
Integration engine	Connected Workforce	AI enabled self help triage
Internal / external API	Robotic process automation	Health record accessed by citizen
Healthcare interoperability standards	Real time staff, patient, equipment tracking	Booking appointments across settings of care

Digitise

Spotlight: Using data to support integration

Integrated Shared Care Record: **GM Care Record**

The GM Care Record joins up data from across GM's health and care organisations and gives frontline staff access to vital patient information to enable more informed care for our citizens.

Since its launch, the GMCR is now being accessed by over 19k frontline workers to support the care of over 190k patients each month. It has become a major digital asset for GM, with the potential to support programmes to tackle health inequalities and to transform care in areas such as dementia, frailty, virtual wards and heart failure.

During the pandemic and thanks to close collaboration between the GM clinical-academic community, health and care partners and citizens, 22 COVID-19 related research studies using de-identified data from the GMCR were approved to understand the impact on the communities of Greater Manchester.

All of this activity to support both direct care and research has been underpinned by engagement and strong governance across GM data controllers, providers, commissioners, and central GM bodies, to ensure patient information is used safely and securely.

Understand & predict population health needs – via the **GM Secure Data Environment**

Pre-pandemic	Today	What's next?
10 localities with >500 data controllers and no coherent approach to data sharing	1 Integrated Care System with all data controllers signed up to a single data protection and impact assessment	
2.2m patient records accessible from 67% of practices	3.1m patient records accessible from 100% of practices and Provider Trusts	Access and training for Community Pharmacy
5k users	19k monthly users, with 190k patients accessed each month	Access and training for Social Care
	Remote Monitoring - Covid oximetry at home	Integrated Care Planning
Zero usage of deindentified GMCR data for research or secondary uses	Population Health - 22 Covid-19 related research studies approved	**Secure Data Environment (SDE)** for Research and Development

What is a Secure Data Environment?

SDEs are highly secure computing environments that provide access to health data to use in health and care research. Greater Manchester's SDE is in development, accelerating the sharing of health data to support research and innovation.

Utilising primary care and secondary care data from the GM Care Record, we are developing the SDE and attracting inward investment from life sciences and tech partners. It is supported by significant information governance arrangements (with 500+ data controllers across the city region) and extensive citizen engagement with the public embedded in decision-making.

GM's SDE will provide the infrastructure and analytical tools for artificial intelligence (AI) development, clinical trials, real world studies, translational research, epidemiological studies and health systems research here in GM for the benefit of our citizens.

GM also led on the successful 'Expression of Interest' for the establishment of a North West SDE with a total population of 7.8m. The North West SDE is the only SDE to align to an entire NHS region.

Innovate

To deliver our ambitions, we must innovate, building on the digitised and integrated capabilities, where care settings and places are ready.

We will develop and deploy proven innovations to improve people's health and wellbeing, building partnerships between health, care, academia and industry. Our approach to digital innovation will scan for and deploy key innovations. We will do this on a thematic basis – for example the use of secure multi-source population level data to enable planning and intervention; personalised care informed by genomics; AI to support new care models; wearable technology to monitor clinical status and response.

Health innovation is one of Greater Manchester's frontier industrial sectors. By working at the leading edge of digital transformation we will test and develop new products and services in collaboration with industry that use data and technology to improve standards of care and empower people to have greater control of their own health and wellbeing.

Our 47 Digital & Data Capabilities

Health Innovation Manchester

Through Health Innovation Manchester's innovation pipeline, we will create a dynamic ecosystem where we harness people's creativity to find new solutions, test and refine new digital products and services to either fail fast or demonstrate value, and then scale up proven solutions at pace across Greater Manchester.

We have a large clinical-academic community and four Universities to conduct research and studies into new medicines, tests, treatments, technology and procedures, which is how the NHS continually evolves to provide the best care possible.

Innovate

- New models of care
- NHS at Home / Remote Monitoring
- Personalised care apps
- Understand and predict population health need
- Decide and design care interventions
- Research data
- Innovation hub

Integrate

Digitise

Spotlight: Innovate

Design and develop virtual wards across Greater Manchester

Virtual wards are a new model of care designed to provide hospital-level care to people in their own homes or place of residence, enabled by technology.

GM providers are now working together to deliver 2,110 virtual beds across the system using technology to monitor patients' conditions at home, so they don't need to be in hospital.

Not only does this model support the NHS to operate more efficiently, it enables the patient to recovery safely in the comfort of their own home with loved ones, supported by health and care staff.

Patients have said recovering at home has mental health benefits too, with reports of feeling less anxious compared to being on a busy hospital ward.

They have the added reassurance that the technology is monitoring their health and providing regular feedback to clinical teams who can spot signs of deterioration and intervene promptly.

Novel cholesterol lowering drug to help prevent stroke or heart attack

900 GM patients took part in a pioneering study to better understand how a new medication should be effectively administered to patients in a 'real world' setting for maximum results.

Inclisiran is a new cholesterol-lowering injection to treat people with persistently high cholesterol despite standard treatment with statins. It can help prevent stroke or heart attack.

20 GP practices took part in the study which uses research to identify the best ways to speed up adoption and spread across the NHS. It aimed to support reducing the time it takes to bring new medicines into practice to benefit patients.

The study was underpinned by utilising digital technologies to find and recruit potential participants, track the patient journey and provide real-time monitoring.

GM is one of only a few places globally where this sort of digitally-first study is feasible due to its advances in tech, data science, integrated care and academia.

Physical health checks for people with severe mental illness

GP practices in Greater Manchester have implemented a novel point of care testing project to improve physical health checks for people with severe mental illness.

This is traditionally an area with low levels of uptake, with only 25% of eligible people having an annual health check.

In collaboration with a technology partner, GP practices have tested new ways of delivering health checks including health promotion days, lead practice models and greater coordination through primary care networks.

Thanks to the introduction of this novel tech-enabled approach, one primary care network in Oldham is now achieving 60% of eligible patients with a severe mental illness have now received an appropriate health check.

This not only improves their overall access and experience of health care, it identifies risk factors to enable earlier treatment.

1	2	3	4	5
We deliver **integrated**, **coordinated** and **safe** care to citizens.	We enable staff and services to **operate efficiently** and productively.	We **empower citizens** to manage their health and care needs.	We understand and plan for **population health** needs.	We accelerate **research and innovation**, as a global exemplar.
Innovate		New models of care	NHS at Home / Remote Monitoring Personalised care apps	Understand and predict population health need Decide and design care interventions	Research data Innovation hub
Integrate	Integrated shared care record Care coordination Eventing: sharing actions and alerts Integration engine Internal / external API Healthcare interoperability standards	Demand led management of capacity & scheduling System monitoring and transparency Supply chain automation Connected Workforce Robotic process automation Real time staff, patient, equipment tracking	Multi channel consultations Targeted, tailored and personalised comms Digital front door and navigation AI enabled self help triage Health record accessed by citizen Booking appointments across settings of care		

Our 47 Digital & Data Capabilities

Digitise

Underpinning digital and data capabilities required for integration and innovation

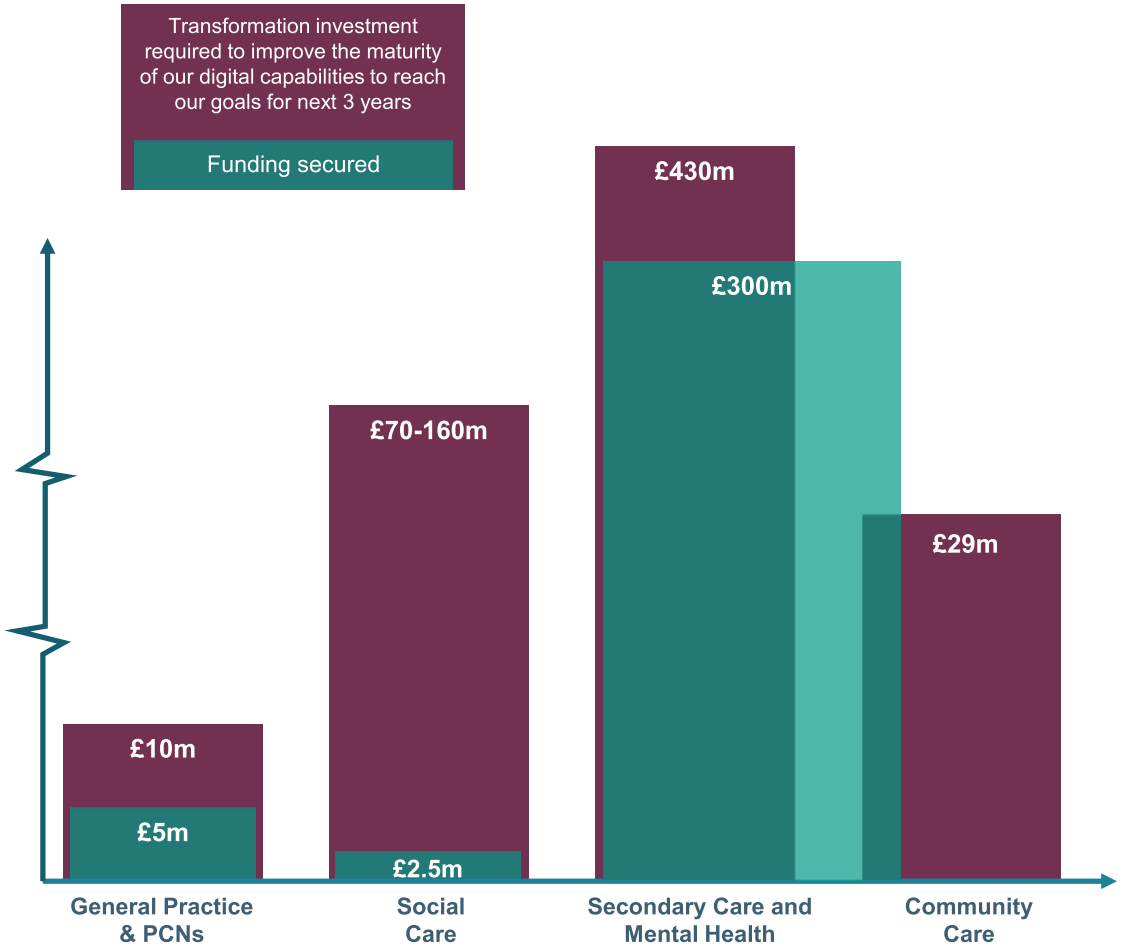
Data security and governance	Core clinical systems		Data ecosystem and analytics	Support services	Digital infrastructure
Single sign on (SSO)	Electronic Patient Record	Patient Administration System	Data warehouse & data Lake	System for communication (any type)	Unified communications (email, phone, smart device)
Security: network & cyber	Specialist systems	Imaging	Analytics and reporting models and tools	IT service mgmt.	Networking (WAN/LAN/WiFi/Beacons)
Identity and access mgmt.	Order comms	Laboratory Information Management Systen	Collecting and managing multisource data	Asset mgt. & tracking	Minimum standards for computers (PC, Laptop, VID)
Information governance	Multi-resource scheduling				Network estates (incl. cloud)
	e-referals				
	e-prescribing and prescribing				

Investment

We understand our digital maturity per capability in individual organisations and care settings, and have identified which capabilities require investment to support providers to improve care. We can now better understand where to invest and how much it will cost – not only to buy the technical systems, but to deliver true transformation taking into account the people, process and cultural changes required that reflects the actual total cost of ownership.

At the GM level, financial baselining helps colleagues in provider organisations to collaborate and agree when funding opportunities arise which organisations are most in need. We can focus upon 'levelling up' organisations and care settings who are less mature, to ensure that we are not exacerbating existing inequalities by investment decisions.

Funding flows and approaches vary in each sector, so we work collaboratively as an ICS to maximise opportunities to secure funding from NHSE and other national and local partners for the places that need it most.



OUR METHOD

- Strategic inputs
- Understanding our population and the problems experienced
- Defining our ambitions and how we can achieve them
- **Financial baselining**
- Balanced portfolio for the ICS

Our Delivery Priorities

Priority capabilities identified…

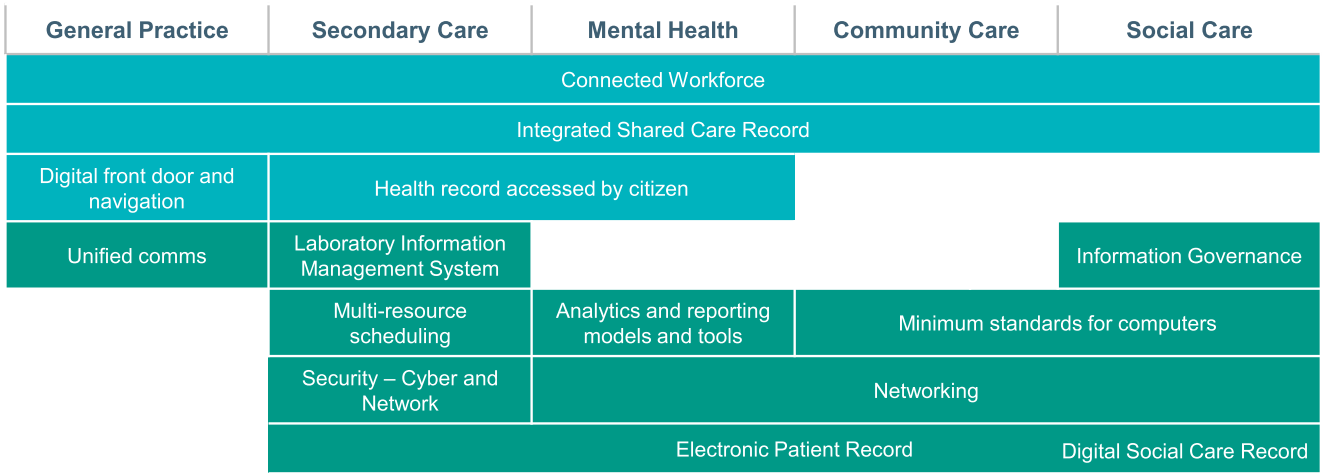
…in all services in our integrated care system

We have engaged in multiple service areas (including maternity, cancer, elderly, elective and urgent and emergency care) to understand the problems experienced by citizens and staff, and explored the opportunities for improvement which digital can help solve. Across all service areas in our ICS, we have identified these priority capabilities for investment.

Understand and predict population health needs	We want to gain insights on our population health need from historical and current data - to drive action at the commissioning, clinical and organisational levels.
Integrated Shared Care Record	We want to provide frontline staff with access to vital patient information from other care settings, supporting daily decision making and transitions of care.
Health record accessed by citizen	We want to support conditions for self-care and trust by providing citizens with access to their health records and care plans.
Proactive alerts and remote monitoring	With up-to-date single records of citizen personal circumstances and preferences, we want to drive translation or adaptation of all communications.
Integrated Care Planning	Sharing information between care professionals - clinical plans, events, actions and alerts. An ability to drive actions at the interventions to drive action at the clinical, organisational and commissioning levels.

…in our care settings

Engagement in each of our care settings have surfaced priority digital and data capabilities, and focused on those capabilities for which we are below foundational requirements of digital maturity. The priorities differ based on where each care setting is on their digital transformation journey.



OUR METHOD

- Strategic inputs
- Understanding our population and the problems experienced
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Our responsibilities across partners

This approach will enable us to identify common methods and develop shared learning, whilst working across differences in digital maturity to give patient benefit

Within individual Providers

There are particular strategies, functions and capabilities that are owned and delivered at a Provider level, aligned to local operational models and to current organisational digital maturity.

Example Provider strategies

- Digitisation
- Digital product procurements

Example functions	Example Digital & Data Capabilities
• Project management • Functionality prioritisation • IT service management	• Electronic Patient Record / Digital Social Care Record/ Specialist System implementations

Our delivery functions, coordinated across partners

*We must coordinate **common functions** across the ICS where appropriate*

- Strategy and portfolio management
- Clinical digital leadership
- Technical architecture
- Information Technology engineering and support
- Data architecture
- Data engineering
- Information Governance
- Cyber Security
- Digital clinical safety
- Data quality
- User design
- Supplier and commercial management
- Programme and project management
- Business analysis and business change
- Benefits analysis and management

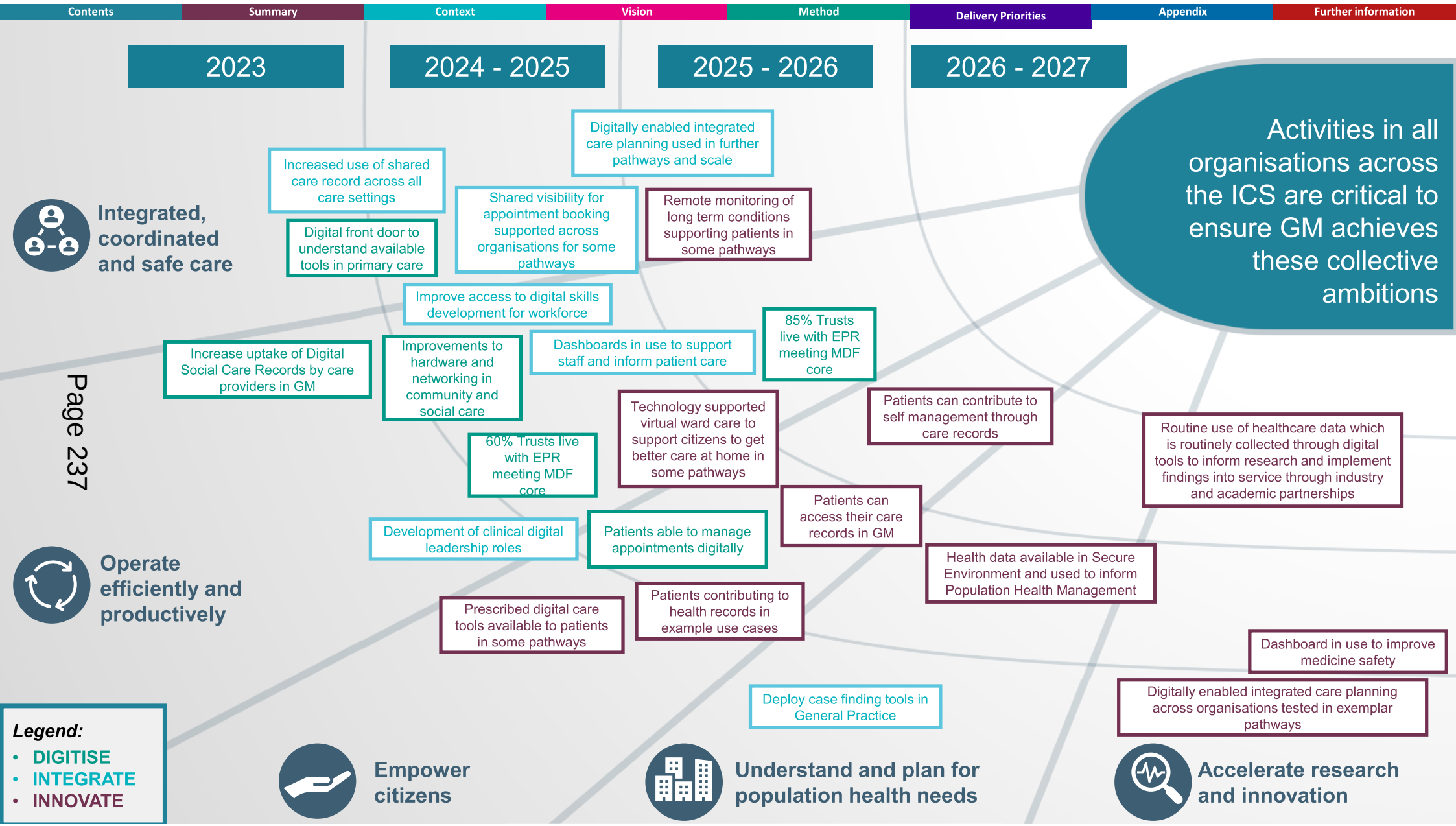
Across the ICS

There are particular strategies, functions and capabilities that we coordinate at the ICS level, in order to maximise the value for standardisation, efficiency/avoidance of duplication and cost savings – to deliver benefits at scale.

Example ICS strategies

- Digital workforce
- Digital inclusion
- Health record accessed by citizen

Example functions	Example Digital & Data Capabilities
• Bid coordination • Innovation pipeline • Sharing learning • Scaling proven technology	• Shared Care Record • Understand and predict population health needs • New models of care

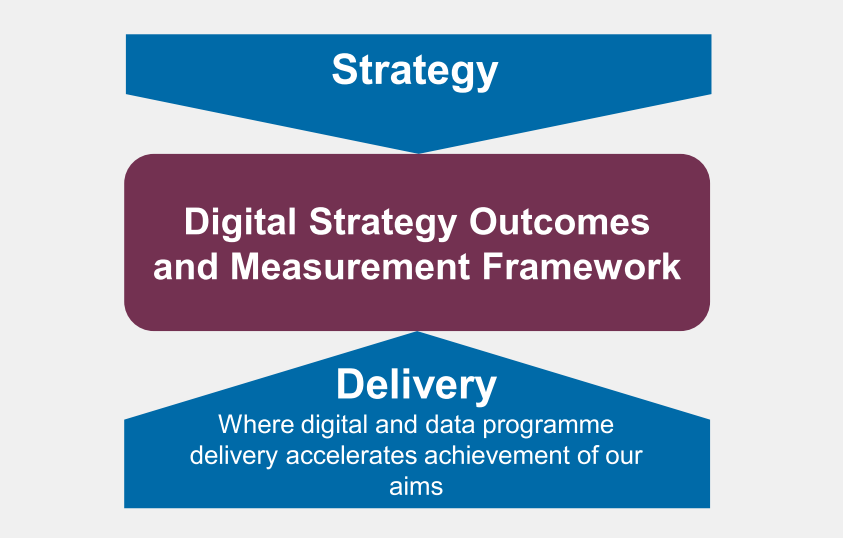

2023
2024 - 2025
2025 - 2026
2026 - 2027
Activities in all organisations across the ICS are critical to ensure GM achieves these collective ambitions
Integrated, coordinated and safe care
Increased use of shared care record across all care settings
Digital front door to understand available tools in primary care
Digitally enabled integrated care planning used in further pathways and scale
Shared visibility for appointment booking supported across organisations for some pathways
Remote monitoring of long term conditions supporting patients in some pathways
Improve access to digital skills development for workforce
Increase uptake of Digital Social Care Records by care providers in GM
Improvements to hardware and networking in community and social care
Dashboards in use to support staff and inform patient care
85% Trusts live with EPR meeting MDF core
Technology supported virtual ward care to support citizens to get better care at home in some pathways
60% Trusts live with EPR meeting MDF core
Patients can contribute to self management through care records
Routine use of healthcare data which is routinely collected through digital tools to inform research and implement findings into service through industry and academic partnerships
Patients can access their care records in GM
Development of clinical digital leadership roles
Patients able to manage appointments digitally
Health data available in Secure Environment and used to inform Population Health Management
Operate efficiently and productively
Prescribed digital care tools available to patients in some pathways
Patients contributing to health records in example use cases
Dashboard in use to improve medicine safety
Digitally enabled integrated care planning across organisations tested in exemplar pathways
Deploy case finding tools in General Practice
Legend:
DIGITISE
INTEGRATE
INNOVATE
Empower citizens
Understand and plan for population health needs
Accelerate research and innovation

Measuring success & benefits management

This strategy will be supported by a co-developed measurement and outcomes framework that will be used to track progress towards achievement of our priorities and demonstrate accountability and collective ownership for the delivery of our ambitions.

The framework will bring together key outcome measures relating to the five priorities across digitise, integrate and innovate and our overall achieving our digital maturity ambition – together with programme level benefits realisation to demonstrate the contribution of digital to improving outcomes across the city-region.

Alongside measuring progress towards our overall aims the measurement framework will also focus on how we are addressing inequalities.



Benefits management is critical for ensuring that public funds are spent on evidence-based, benefits-led activity, ensuring the greatest possible benefit to citizens and staff.

Benefits management begins during programme definition with the identification of target benefits through performance improvements and then continues to deliver the benefits as an integral part of implementing the required business change.

Health Innovation Manchester has nationally-recognised expertise in benefits management, supporting ICSs through the Innovation Collaborative for Digital Health. The responsibility for benefits management usually sits with the organisation accountable for delivery.

Our benefits classifications are as follows:

Fiscal

- **Cash-releasing benefits** – these are benefits that bring revenue to health and social care bodies or reduce their cost. The latter in such a way that there is a budget reduction related to the benefit.
- **Non-cash releasing benefits** - these are benefits that realise an improved input to output ratio, but do not realise money from budgets, such as doing more with the same funding and a reallocation of existing resources.

Economic

- **Public Benefits** – these are benefits realized outside government to individuals, communities and the national economy and which can be monetised, including economic growth.

Social

- **Quality Benefits** – benefits that have value that can be quantified but not monetized, such as improved outcomes, safety, access, satisfaction or quality of life
- **Qualitative Benefits** – benefits which cannot be quantified or monetized and are often recorded through narrative or case studies

GM Health and Care Digital Governance

GM Integrated Care Joint Planning and Delivery Committee

The Digital Transformation Board is purposed to harness the power of digital technology to improve health outcomes for citizens and transform care, and to strengthen GM's position as a world leader in digital health and innovation.

GM Health and Care Digital Transformation Board

Other strategic ICB and ICS-wide fora, including GMCA

Locality Boards

The Digital Delivery Executive brings together digital representatives as the 'engine room' for the work overseen by the DTB.

GM Health and Care Digital Delivery Executive

- Digital Transformation Office
- NHS GM data, analytics and intelligence
- NHS GM Digital and IT
- Provider Digital

Groups in each professional discipline in each care setting
- Clinical and clinical safety
- Finance
- Technical architecture
- Information governance

These professional discipline groups advise on strategy and are consulted to shape and guide delivery programmes.

Delivery programmes & care setting governance, including public representation

Programmes leveraging digital transformation monies are accountable, through defined and representative governance structures, to the DTB as required.

Appendix:
Priorities in each care setting

Primary Care: General Practice (GP)

Background

Practices and Primary Care Networks have been on accelerated journey of deployment of digital tools from the start of the COVID-19 pandemic.

Digitisation in General Practice broadly meets foundational requirements. However, there remain outstanding challenges to optimise the use of the digital technology in practice to meet the above outcomes. This involves a focus on workforce and connecting existing systems to truly integrate care across care settings.

Practices and PCNs are facing more aggregate demand and an increase in non-patient-facing workload. Some have not adapted their ways of working to meet this increased demand, with some reverting to old processes.

Significant business change is required in order to manage demand and capacity efficiently with digital tools, delivering an effective digital 'front door' for patients, alongside traditional routes, into the practice – all to support the best possible experience and outcomes for patients.

Problems for health and care professionals and citizens – providing opportunities for improvement

- Patients understand the benefits that digital can bring, but there is a lack of trust and confidence in digital GP services. Some patients feel forced to use the digital tools and anxious if unable to speak to someone
- There is poor awareness of online services and how to use them.
- There is confusion between GP websites, 3rd party tools and NHS App. Patients struggle due to complicated instructions on websites and 3rd party tools (and for those without English as a first language, online translations can be poor)
- Practice and PCN staff are not always confident or comfortable in using the digital tools.

Priority capabilities

Robotic Process Automation	By automating processes that require reduced human intervention, we capture and interpret data, processing low risk and repetitive transactions in larger volumes more quickly, following defined instructions and criteria. RPA can also support decision making performed by clinicians.
Workforce	Developing the primary care workforce in their digital skills and confidence is critical to transforming patient and staff experiences as well as patient care. We are recruiting and training digital facilitators and digital champions in practices and PCNs.
Integrated Shared Care Record	Realising the potential of the GM Care Record in General Practice is key for providing integrated care. We are providing training for GP staff and deploying access to Community Pharmacy, supporting adoption of the GMCR as the single platform for multi-agency integrated care planning, enabling staff in each care setting to make informed decisions and tailor care appropriately.
Digital front door and navigation	Supporting practices and PCNs to manage their demand by providing consistent and easy-to-navigate access for patients, underpinned by usability and accessibility standards.
Unified Comms	Cloud-based telephony functionality for practices will help them offer a more pragmatic service and facilitating PCN hub delivery both in hours and out of hours.

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Secondary Care: Acute and Specialist Services

Background

There are six acute providers across Greater Manchester, with one specialist and two mental health providers. This page is focused on hospital services.

Each Provider has identified its own priority capabilities for investment – which vary by organisation, partly due to differences in digital maturity. The priority capabilities are those for which at least half of our provider organisations are below foundational or are being invested in across most providers.

Hospitals are under significant financial deficits and operational pressures, whilst in recovery from the COVID pandemic.

The complexity and scale of scope for change programmes is huge, impacting hundreds of thousands of staff - requiring senior ownership of problems, solutions and change programmes. Spending and investment is fragmented and often reactive to national calls, rather than well prioritised to maximise the value of spend across the system. There is significant deficit and risk in the system.

Problems for health and care professionals and citizens - providing opportunities for improvement

- Multiple staff members have to collect patient history – the documentation burden is significant with multiple unintegrated systems and patients have to repeat themselves
- Some patients do not need to be seen by A&E and could be directed to specialists sooner
- Patients might not be informed of results
- There is limited coordination of appointment scheduling and patient support
- Information on patient access to out of hours services are not always available
- There can be confusion about what to do when something goes wrong due to speaking with so many professionals
- Staying in hospital after patients could be discharged reduces patient satisfaction and risks infection and deterioration.

Priority capabilities

NHS at Home / Remote Monitoring	Virtual wards are a new model of care designed to provide hospital-level care to people in their own homes or place of residence, enabled by technology.
Integrated Shared Care Record	The GM Care Record (GMCR) provides frontline staff with access to vital patient information from other care settings. GM's approach to optimise clinical delivery across EPR boundaries is through interoperability via the GMCR. Organistions are committed to providing data into the analytics platform through standard APIs.
Health Record Accessed by Citizen	Support conditions for self-care and trust by providing patients with access to their health records, appointments, correspondance and care plans.
Electronic Patient Record (EPR)	In accordance with NHSE requirements, GM Provider Trusts are working towards meeting the Minimum Digital Foundations by the end of 2025, across all their hospital sites.Convergence of EPRs in GM follows convergence of clinical operating models.
Laboratory Information Management System	GM Imaging and Pathology Network overseeing progress in this area to enhance and standardise as far as possible LIMS provision across GM Provider Trusts.
Cyber Security	Trusts are progressing their own Cyber capabilities and forming inter-Provider groups focusing on Cyber

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Secondary Care: Mental Health Services

Background

Mental Health services, for children, young people, adults and the elderly, are delivered across multiple care settings and organisational boundaries. In GM there are 2 Mental Health Provider Trusts; Pennine Care and Greater Manchester Mental Health, which provide Acute and Community Services and the majority of MH services are delivered in Primary care Care delivered in a shared way across care setting and organisational boundaries, with VCSE sector and social care being key partners in delivery of MH services.

Providers have varied levels of core digitisation – both FTs are working towards core minimum digital foundation requirements for EPR and networking infrastructure to support this is a key enabler.

GM have made progress in provision of digital tools to support MH patients deployed within GM. Fundamental risk factors for mental health patients are related to social challenges, and physical health is evidenced to be worse for patients with SMI.

Problems for health and care professionals and citizens - providing opportunities for improvement

- Data flows between care settings and providers is limited, particularly important for services being delivered across ICS boundaries
- Mixed levels of digital literacy
- Sharing of data across organisations and care settings
- Digital maturity impacts what can be delivered
- Transparent pathways for digital innovations, focus on solution rather than problem
- Variable access to care
- Low ability to self manage care
- Citizens want to feel confident that physical and mental health professionals are making joined up decisions about my care and have access to my information
- Availability of skilled workforce is an ongoing challenge as in other care setting

Priority capabilities

Reporting and Analytics Tools	The ability to share information and data across care settings and organisations to support reporting and analytics as well as care
Integrated Shared Care Record	Sharing of information across organisations is a key digital priority, through integrated tools including shared care records. The GM Care Record (GMCR) provides frontline staff with access to vital patient information from other care settings.
Health Record Accessed by Citizen	Support conditions for self-care and trust by providing patients with access to their health records, appointments, correspondance and care plans.
Networking	Improvement of network infrastructure (e.g. WAN/LAN/WIFI) to ensure staff can access live digital systems
Electronic Patient Record	In accordance with NHSE requirements, GM Provider Trusts are working towards meeting the Minimum Digital Foundations by the end of 2025, across all their hospital sites. Data must be structured and accessible.
E-prescribing and dispensing	Electronic management of medications processes, interoperability across care settings

Community Care

Background

Community services are key part of integrated system, encompassing adult and children's services, community nursing, specialist teams, rapid response and therapies. Integrated care that's centred around the individual relies on community provision and the interactions between community and all other settings are crucial for decision making.

Deliver continuity of care across different members of staff and services, including between care settings, is critical for improving the impact and experiences of community care.

Limited historic Provider-led investment and Community-specific national digital funding has resulted in lower digital maturity in community care, even compared to other parts of the same Provider.

Provider organisations are responsible for ensuring that foundational requirements are met, and the priority capabilities highlight key areas for improvement for targeting the core outcomes above across GM. The costs, technical complexity and extent of operational transformation required to deliver these solutions is significant.

Problems for health and care professionals and citizens - providing opportunities for improvement

- Low digital maturity for underlying digital capabilities
- Existing digital tools that are not tailored for use in Community services
- Existing connectivity issues result in staff's lack of visibility to up-to-date records (both within Community and in other care settings)
- Lack of awareness for staff and citizens for referral processes
- Citizens' lack of felt involvement in care
- Citizens and staff being 'stuck' when the technology doesn't work for them – or confused by the possibilities
- Staff's lower levels of digital literacy

Priority capabilities

Integrated Shared Care Record	The GM Care Record (GMCR) provides frontline staff with access to vital patient information from other care settings. GM's approach to optimise clinical delivery across geographical and care setting boundaries is through use of the GMCR.
Workforce	Building digital confidence in this part of our workforce is critical who are constantly mobile and moving around locations.
Computers that meet minimum standards	Reliable and portable devices suitable for staff in line with recognised minimum standards
Networking	Improvement of network infrastructure (e.g. WAN/LAN/WIFI) to ensure staff can access live digital systems
Electronic Patient Records (EPR)	EPRs that are aligned to community requirements (rather than hospital- or primary care-based requirements) including with features which are tailored to needs of community staff, including offline mode, process tailoring, real-time updates or just-in-time lookups

Social Care

Background

80% of adult social care provision is provided by ~700 independent providers. Provision comprises a variety of residential based care and support such as care homes, supported living, extra care, nursing homes etc. and care at home. Size, budgets, demographics, infrastructure and ambitions of all these providers will vary.

The market composition amongst the providers (a mix of larger chains and smaller providers) is a challenge to adoption of any change programme. There are also numerous voluntary organisations who play a crucial role within the sector, providing a number of invaluable services and often developing insight and knowledge of individuals far beyond what may be recorded by a provider or Local Authority. Unpaid carers also play a hugely significant role in the provision of care and support across the sector. These individuals are often missed or invisible in care statistics, but without their contribution the social care system would be unmanageably stretched.

Digital maturity of the sector is lower than others, and is dominated by the independent investment decisions made by independent care providers. The sector is under-equipped for capacity and demand management.

Problems for care workers (paid and unpaid) & citizens - providing opportunities for improvement

- Lack of change management capacity and capability in provider organisations
- Lack of system wide view of the individual in the care system, systems and partners operate in silos
- Relationships between individuals are far too often the main determiner of the quality of information shared
- Data flows from health to social care are sporadic in quality
- Lack of trust in digital solutions and information systems prevents effective sharing of information. Consequently, this results in poorly coordinated patterns of care

Priority capabilities

Integrated Shared Care Record	The GM Care Record (GMCR) provides frontline staff with access to vital patient information from other care settings. We must provide access to independent care providers, and particular use cases and approaches are being explored.
Technology enabled care	Digital technology which provides guidance or tracks individuals' symptoms to facilitate self management or inform clinical decision making.
Networking	Investment would lead to updated hardware to provide reliable and portable devices suitable for staff in line with recognised minimum standards, to ensure foundational level of maturity is met
Information Governance	All care providers must have sufficient Information Governance, assured by completion of the national Data Security and Protection Toolkit.
Computers that meet minimum standards	Investment would lead to updated hardware to provide reliable and portable devices suitable for staff in line with recognised minimum standards
Digital Social Care Record	All care providers should be using a digital social care record, rather than paper-based processes.

Pharmacy, across care settings

Background

Pharmacy in GM is made up of three major elements:

- PCN Pharmacy – including Clinical Pharmacists based within practices or across PCNs, delivering core and enhanced services
- Hospital Pharmacy – covering both inpatient and outpatient prescribing, providing pharmaceutical care for patients across both planned and unplanned care
- Community Pharmacy – often situated in high street locations, in neighbourhood centres or supermarkets, providing not only dispensing activity but an increasing range of additional healthy living and public health services

Leaders in the above settings have highlighted the role of digital transformation for optimising efficiency and value from medicine and improving medicines safety and reducing adverse events – in addition to the core ambitions.

The costs, technical complexity and extent of operational transformation required to deliver some of the solutions is significant. Some of the solutions depend on national capabilities, programmes and roadmaps – particularly in relation to medicines data and interoperability standards.

Problems for health and care professionals and citizens - providing opportunities for improvement

- Staff have limited visibility to data for direct care and commissioning purposes, and what is available has to be found in multiple systems
- Staff have to manually re-key in data relating to prescriptions from discharge summaries into EPRs
- Sharing of shared care protocol information is inconsistent and can lead to confusion.
- Copying and administration errors are possible
- Citizens receive disjointed dispensing instructions
- Citizens can't collect medications after discharge from chosen Community Pharmacy

Priority capabilities

Healthcare interoperability standards	Application of emerging national healthcare interoperability standards
Integrated Shared Care Record	Providing access to and training for the GM Care Record in community pharmacy, hospital pharmacy and hospital-based pharmacy.
Care Coordination	Enabling sharing of the shared care protocol document from Secondary Care to Primary Care.
e-prescribing and dispensing	Electronic Prescribing and Medicines Administration with closed loop, drug cupboards and barcoding.

Further **information**

Further information

Topic	Contact point
• NHS GM Integrated Care digital delivery portfolio	gmhscp.digitalandit@nhs.net
• General queries, including for the GM digital delivery executive • Health Innovation Manchester digital delivery portfolio • GM Digital Maturity & Investment Framework • ICS Digital Workforce Strategy • ICS Digital Inclusion Strategy	gmdigital@healthinnovationmanchester.com
• GM Combined Authority delivery portfolio	gmcadigital@greatermanchester-ca.gov.uk

Greater Manchester Integrated Care Partnership Board

Date: 29th September 2023

Subject: Optimizing the Role of the NHS in Tackling Poverty

Report of: David Boulger – Assistant Director: Population Health (NHS GM)

SUMMARY OF REPORT:

1. In October 2022, the Integrated Care Partnership Board supported proposals to advance a programme of work aimed at optimizing the role of NHS GM in tackling poverty.

2. This report provides an update on that programme of work and covers:

   a) A summary of activity that has taken place at a pan-GM level.

   b) Examples of good practice from across localities and providers.

   c) A summary of the key findings of population-level survey activity and health and care staff survey activity undertaken by GM Poverty Action on behalf of NHS GM.

   d) A summary of the key findings from an independent review of the NHS GM approach to tackling poverty undertaken by GMPA.

   e) Proposals for the areas of focus for the remainder of 2023/24 and across 2024/25 and 2025/26.

RECOMMENDATIONS:

The Greater Integrated Care Partnership Board is asked to:

- Note the content of this report and breadth of activity taking place within the GMN health and care system to tackle poverty and mitigate the impact the poverty has on health outcomes and the utilisation of health and care services.

- Note the findings of the Independent Review and the surveys undertaken by GM Poverty Action.

CONTACT OFFICERS:

David Boulger – Assistant Director: Population Health (NHS GM)
Dr Claire Lake – Deputy Chief Medical Officer (NHS GM)
Paul Lynch – Director of Strategy and Innovation (NHS GM)

1. INTRODUCTION

1.1 Poverty is the single biggest driver of health outcomes and inequalities.

1.2 At the first meeting of the GM Integrated Care Partnership Board in October 2022, a paper was brought by the GM Population Health Board setting out proposals to optimize the role of NHS GM in tackling poverty a cause of poor health. The paper was strongly supported and serve as a catalyst for action over the past 12 months.

1.3 This update report provides:

- A summary of activity that has taken place at a pan-GM level.
- Examples of good practice from across localities and providers.
- A summary of the key findings of population-level survey activity undertaken by GM Poverty Action on behalf of NHS GM.
- A summary of the key findings from an independent review of the NHS GM approach to tackling poverty undertaken by GMPA.
- Proposals for the areas of focus for the remainder of 2023/24 and across 2024/25 and 2025/26.

2. PAN GM ACTIVITY UPDATE

2.1 Over the past 12 months, a considerable amount of activity has taken place under the joint leadership of the Population Health and Medical directorates within NHS GM, with the support and participation of a wide range of system partners, and underpinned by a new strategic relationship with **Greater Manchester Poverty Action (GMPA)**.

2.2 Some key activities that have taken place are as follows:

System Leadership

- NHS GM plays an active role in the GM Cost of Living Response Group, ensuring a whole system response to tackling financial hardship in GM.

- NHS GM has incorporated a priority action into the Joint Forward Plan to capture this activity within the core business of NHS GM.

Advice and Guidance

- NHS GM contributed to the development of the Helping Hand website hosted by the GMCA to ensure it provided advice and guidance to people in poor health, and advice and guidance that was aimed at preventing poverty becoming a source of poor health.

Raising Awareness / Training and Development

- NHS GM commissioned GM Poverty Action to develop and deliver '*Poverty Awareness*' training to a broad cross-section of NHS staff in GM. The first tranche of training was attended by 150 people between May and August and was well received.

- A further tranche of training has been commissioned which is aimed at reaching 400 people between October 2023 and March 2024.

- GMPA convened the first ever GM Socio-Economic Duty Summit in July 2023 with 3 expert speakers and over 50 attendees from across GM.

Independent Review

- NHS GM commissioned GM Poverty Action to undertake an independent review of the current NHS GM approach to tackling poverty and to make recommendations on where the approach could be strengthened. This included a literature review, a review of existing system documentation and engagement with key stakeholders.

- An interim report is included as **Appendix 1**, with the final report due in October 2023.

- An overview of the summary findings from the interim report are included in Section 4 of this report.

Population Survey

- NHS GM commissioned GM Poverty Action to undertake a survey of the GM Population which received 1000 responses from a diverse cross-section of the population.

- The findings from this survey are included as **Appendix 2** of this report.

- An overview of the findings from this survey are included in Section 5 of this report.

Staff Survey

- NHS GM commissioned GM Poverty Action to undertake a survey of the health and care workforce in GM which received 38 responses.

- The findings from this are included within the interim report, which is included as **Appendix 1**, but some key summary findings were as follows:

- The majority of health care professionals felt that tackling poverty was a highly important part of their role.

- The way in which they contribute to tackling poverty is wide-ranging, although some staff expressed a lack of awareness of what support was available for them to offer to patients.

- Almost 90% of staff felt that "*making sure services are accessible to people on low incomes*" was a highly important part of the NHS role in tackling poverty.

GM Residents Survey

- NHS GM have worked with the GMCA to include questions in the GM Residents Survey around experiences of poverty and the impact of poverty on health which will further strengthen our level of insight.

Focus Groups with People with Lived Experience

- GMPA, on behalf of NHS GM have carried out focus groups to gain insight into how NHS staff can better provide support to people experiencing socio-economic disadvantage.

- People with lived experience of poverty were recruited via community-based partners across GM.

- The focus groups involved 10 participants, spilt into two groups. Each group participated in two sessions – the first session explored "cost implications of accessing GM NHS health and social-care systems/services" and "financial support currently provided by GM NHS." The second session covered "NHS's role as an anchor institution – role of NHS staff/healthcare professionals in tackling poverty" and "physical and mental health impacts of financial crises/poverty."

- The findings from these are included within the interim report include as **Appendix 1**.

Poverty-Proofing Health and Care

- NHS GM commissioned GM Poverty Action and Children Northeast to run a 'poverty proofing' testbed aimed at testing a methodology for assessing the extent to which our approach to provided health and care services to a cohort of the population mitigated or exacerbated poverty.

- The first test bed has commenced and is reviewing the experiences of "*pregnant women and their newly born child (the maternity journey and the first 12 weeks post-partum) who live in the most deprived 20% of Greater Manchester as identified through the Indices of Multiple Deprivation.*"

- The focus of the second test bed has not yet been confirmed.

- Both test beds will be completed during 2023/24.

- The learning from this activity will allow the formation of an NHS GM methodology / toolkit for reviewing services through a poverty *lens* which will be hosted on the Fairer Health for All Academy website and will be accessible to all health and care staff in GM.

High Energy Consumption Medical Devices in Domestic Settings

- NHS GM has engaged with GMCA and energy providers to ensure that individuals whose health needs require them to have high energy consuming medical devices in their homes, are not disproportionately affected by high energy costs.

- This has primarily involved working with a range of stakeholders to ensure that '*at risk*' individuals are able to access the financial and practical support that is available to them.

3. EXAMPLES OF GOOD PRACTICE IN LOCALITY AND PROVIDER SETTINGS

3.1 Whilst we are proud of the way in which NHS GM has led the way nationally in showing the role that the NHS can play in tackling poverty, it is important to recognise the wealth of good practice examples that exist within localities and providers, and which have often existed well in advance of this current piece of Pan-GM activity.

3.2 Some examples, which are by no means exhaustive, include:

- **Manchester Foundation Trust (MFT):**

  - MFT has been working with Citizens Advice on the trauma unit at MRI for a number of years, supporting patients with benefit, debt and other advice linked to their condition. This offer is now being expanded to include North Manchester General Hospital and will be available for all patients and staff. Funding applications are underway to develop this at other sites too, offering patients financial, housing, and other advice and support at the point of care. The impact will be evaluated. Previous work has shown significant benefits to patients in terms of claiming the correct benefits and helping manage debts. Feedback from

other Hospital Trusts suggests having advice workers on site may benefit patient flow and support discharge too.

- **Trafford Locality**:

  - Since January 2023, the Sale Central Primary Care Network (PCN) has worked with local voluntary, community, and social enterprise (VCSE) organisations to run regular drop-in sessions with a community health advisor aimed at people who face specific barriers when accessing traditional services, including those experiencing severe financial hardship. Working in partnership helps people get the advice needed to improve their health and wellbeing and to be linked to services that can support further including cost-of-living advice.

- **Stockport Locality**:

  - Stockport's Resident Advice and Support Team's (RAS) Cost of Living Helpline, which uses a "tell us once" approach to accessing advice, benefit checks, help with applications for benefits and warm referrals to relevant support services, is routinely used by NHS staff. A team of experts offering specialist casework to assist the most vulnerable residents with income maximisation, complex debt and benefit problems is also available. RAS Benefit Advisers also deliver outreach approach to support patients from their hospital ward, or their local community mental health outreach centre to ensure they get the best advice, quickly. This enables patients to leave hospital after long stays with the correct benefits in place.

  - The Council and NHS have jointly delivered a benefit uptake campaign building on successful Pension Credit uptake campaign, and the council is working on a pilot with the Heaton's GP Practice to promote Attendance Allowance to a target cohort of patients i.e., those with long-term limiting health conditions will be encouraged to contact the Cost-of-Living Advice Line for access to a full benefit assessments and support to apply.

- Benefit advisers are supporting patients with mental health needs from their hospital ward, or their local community mental health outreach centre to ensure they get the best advice, quickly and helping patients to leave hospital after long stays with the correct benefits in place.

- **Bury Locality**:

  - 3 anti-poverty summits have been delivered locally with all partners including Health, social care, housing, DWP, food banks, vol sector orgs and people with lived experience, across which we have collectively agreed our anti-poverty strategy and the use of our HSF (along with listening to lived experience).

  - Bury have implemented the Money Advice Referral tool in collaboration with GM Poverty Action and local VCSE partners.

  - Targeted support enabling provision of £306,600 of HSF beyond those receiving direct payments or direct provision from voluntary/community groups.

  - 36 voluntary groups applications supported through Cost-of-Living resilience payments with a total allocation of £80,414.

  - Increased the uptake of healthy start vouchers in Bury to 66% through working with Bury Market to provide more venues to use the vouchers (GM uptake is 61%) (https://www.burymarket.com/bury-market-news/nhs-healthy-start-success)

  - Supported the coordination of over 40 warm spaces in Bury.

  - Invested in a new software (ascendant) which helps to identify cohorts who are financially vulnerable.

- **Bolton Locality:**

  - Bolton has at least one Social Prescribing Link Workers (SPLW) based in each of its nine Primary Care Networks working with people from financially disadvantaged backgrounds – linking with them to services such as financial and debt advice, housing services and skills training.

- **Wigan Locality**:

  - TABA PCN (Tyldesley, Astley, Boothstown and Atherton) which has eleven practices in its network has implemented several initiatives to tackle health inequalities, one of which involved working with the charity Mind to increase the uptake of Severe Mental Illness (SMI) health checks through a more holistic approach to tackle then underlying problems affecting a patient, including any money worries.

4. GM POVERTY ACTION INDEPENDENT REVIEW

4.1 NHS GM commissioned GM Poverty Action to undertake an independent review of the current NHS GM approach to tackling poverty and to make recommendations on where the approach could be strengthened.

4.2 The commission included a broad initial exploration of the GM health system's approach to poverty, reflecting on existing policy and good practice and reviewing this approach against recommendations made by the King's Fund in their publication – 'The NHS's Role in Tackling Poverty'.

4.3 An interim report is included as **Appendix 1**, with the final report due in early October 2023.

4.4 Some key summary reflections from the interim report are as follows:

- NHS GM has undertaken a range of actions that are aimed at tackling the impact of poverty on health outcomes and healthcare experiences, and these mirror some of

the Kings Fund recommendations and are acknowledged as position practice.

- However, NHS GM needs to maintain and intensify its efforts and adopt a strategic approach that builds on current successes and adds robustness to its anti-poverty initiatives.

- The focus on the role of NHS GM as a 'good employer' is positive, but the context for adopting good employer practices (including the real living wage) remains unclear.

- There is a need to ensure that people with lived experience of poverty have a much stronger voice in NHS GM decision-making and governance.

- There are tangible areas where NHS GM could go further, and these are set out within the key recommendations.

4.5 The key recommendations are that NHS GM should:

a) Develop a robust anti-poverty strategy, with a focus on:
   - Setting out a clear mission and vision.
   - Co-production with people with lived experience of socio-economic disadvantage.
   - Appropriate allocation of resources.
   - Cross-system collaboration.

b) Adopt the socio-economic duty.

c) Work with GMPA and the Greater Manchester Living Wage Campaign to realise good employment goals.

d) Prioritise ongoing poverty awareness training for senior and middle management, as well as widespread mandatory poverty awareness training for all NHS professionals, focussing on the NHS's role as a health service provider and employer.

5. POPULATION SURVEY FINDINGS

5.1 NHS GM commissioned GM Poverty Action to undertake a survey of the GM Population which received over 1000 responses.

5.2 The full survey findings are included as **Appendix 2**.

5.3 The key findings from the survey are as follows:

- Almost a third of respondents stated that concerns and/or difficulties with household finances 'always' or 'often' impacted their physical and/or mental health.

- For a significant proportion of the population, household income impacts upon their ability to access health and social care services with over 40% not having accessed an NHS service due to the cost implications.

- Most respondents felt that cost implications are not considered by the NHS, even though more than half felt that the NHS has a responsibility to assist patients who are experiencing financial hardship.

- The majority of respondents could not identify any NHS schemes or assistance that may enable them to get support with health and social care costs.

- Almost two thirds of respondents stated that they would not share concerns about their household financial situation with health and social care professionals, and 89% confirmed that they had never raised concerns about their household's financial situation with an NHS health and social care professional.

- There is significant variation in responses by age, gender, and ethnicity.

6. NEXT STEPS

6.1 The activity that has taken place over the past 18 months has provided a great deal

of learning and insight and has enabled the development of a future plan which builds upon the progress to date.

6.2 The proposed areas of focus for the next 3 years have been captured in the Joint Forward Plan Delivery Framework and are as follows:

a) **Strengthening the use of Data, Intelligence, and Insight:**

- 2023/24: Undertake comprehensive analysis to generate insight into the impact of poverty on health outcomes and health / care service activity in GM.

- 2024/25 and 2025/26: Harness the opportunities of the NHS GM data systems and the academic expertise in GM to develop increasingly innovative and experimental insight and evidence to support activity and strategy.

b) Optimizing the NHS GM strategic approach to Tackling Poverty:

- 2023/24: Complete the independent review of the NHS GM approach to tackling poverty and respond to findings as appropriate; Establish an NHS GM Tackling Poverty Task and Finish Group reporting into the NHS GM Population Health Committee.

- 2025/26: Undertake a review of the Tackling Poverty programme and develop a 3-year plan for 2026/7 to 2028/29.

c) Poverty Proofing Health and Care:

- 2023/24: Complete the two initial 'Poverty Proofing Health & Care' testbeds commissioned through GMPA by 31/3/23.

- 2024/25: Develop and implement an NHS GM Poverty Proofing Health and Care Toolkit within the FHFA Academy; Implement a further 6 poverty proofing reviews of key parts of the health and care system.

- 2025/26: Implement a further 6 poverty proofing reviews of key parts of the health and care system.

d) Raising Awareness across our Workforce:

- 2023/24: Complete phase 1 of the Poverty Awareness training programme which involves the provision of half day poverty awareness training to 550 members of the GM health and care workforce; Develop plans for a 4-tier approach to Poverty Awareness training and development consisting of online learning, poverty awareness sessions, specialist action learning workshops and communities of practice – hosted as part of the Fairer Health for All Academy.

- 2024/25: Host the first ever GM Poverty and Health Conference; Iteratively implement the 4-tier approach to Poverty Awareness training and development.

- 2025/26: Full delivery of the 4-tier approach to Poverty Awareness training.

e) Supporting People Experiencing Financial Hardship:

- 2023/24: Produce an options appraisal around the provision of Financial Hardship support services in health and care settings and agree a future direction of travel.

- 2024/25: Implement the findings of the Financial Hardship services options appraisal.

7. RECOMMENDATIONS

7.1 The Integrated Care Partnership Board are asked to:

7.1.1 Note the content of this report and breadth of activity taking place within the GMN health and care system to tackle poverty and mitigate the impact the poverty has on health outcomes and the utilisation of health and care services.

7.1.2 Note the findings of the Independent Review and the surveys undertaken by GM Poverty Action.

Appendix 1 – GM Poverty Action independent review of the NHS GM approach to tackling poverty and financial hardship: Interim Report

GMPA Interim Report:

Exploring the role of Greater Manchester NHS in tackling poverty,

September 2023

Overview

Greater Manchester Poverty Action (GMPA) has been commissioned by Greater Manchester (GM) NHS to undertake a project looking at the role of the health and care system in tackling poverty over a six month period.

The commission includes a broad initial exploration of the GM health system's approach to poverty, reflecting on existing policy and good practice and reviewing this approach against recommendations made by the King's Fund in their publication – 'The NHS's Role in Tackling Poverty'. It involves assessing the feasibility, value and desirability of GM NHS developing an anti-poverty strategy and adopting and implementing the socio-economic duty, a tool by which public bodies can ensure decisions they make take into account the needs of people experiencing poverty.
This work will develop into producing a single shared narrative around the impact of poverty and health in GM, incorporating a clear articulation of the potential role the health system can play in tackling the issue. This will be facilitated through advice and guidance to NHS GM in relation to poverty and the cost-of-living crisis, and how it is incorporated into the GM Health and Care Strategy, the GM Build Back Fairer framework, and other GM Population Health Board responsibilities.

A key element of this commission is Poverty Awareness training, delivered to an initial cohort of managers and policy and strategy leads within the health system, with a view to evaluating and developing this training to a wider group of health and care professionals, tailored to certain specialisms, in the future.

A final, ongoing part of this commission is looking at how 'poverty proofing' could be applied to the health system in GM. Poverty proofing as a concept is about identifying the barriers people experiencing poverty may face in accessing services. A 'poverty proofing'

pilot will be carried out by Children North-East, a partner organisation of GMPA who are experts in providing tailored guidance on what actions can support settings to minimise the impact of poverty on healthcare provision. A final report for the poverty proofing element of the commission will be provided separately and will identify learning and outputs, with next steps and recommendations based on this work to be developed by GMPA and the GM Population Health team. These activities will create space for exploring how the concept can be developed in a way that meets the needs of GM NHS and complements the recommendations made by GMPA in respect of the health system's role in tackling poverty.

Introduction

This paper presents a selection of key findings and recommendations from the literature review and primary research. Although it does not encompass the entirety of the research, this overview offers a preliminary insight into the broader dimensions of the work, with a final report set for delivery in October.

The literature review findings highlight a range of policies, initiatives, and actions being taken across NHS GM to address poverty. However, our research stresses the importance of making NHS GM more poverty-focused in its approach and operations. Addressing poverty should be a top priority, with an ambitious vision for substantial poverty reduction within the partnership.

NHS GM needs to maintain and further intensify its efforts, especially in light of the pressing challenges presented by the cost-of-living crisis. Moving forward, NHS GM must adopt a strategic approach that builds on current successes and adds robustness to its anti-poverty initiatives. Central to this progression should be formulating an anti-poverty strategy, with an action plan outlining short-, medium- and long-term actions.

The strategy should focus on:

- Setting out a clear vision and mission, developed in conjunction with partners and people with lived experience of poverty about the role of NHS GM in addressing poverty and ways of working.
- Enhancing capacity and capabilities throughout the system, ensuring that resources and expertise are appropriately allocated and maximised.
- Sharing good practice and learning among health and care teams.

- Championing cross-system collaboration ensuring that addressing poverty is a prioritised objective.

Primary research

As part of this commission, GMPA undertook several methods of primary research to assess the role of NHS GM in tackling poverty. These included a survey of GM residents, focus groups of people with lived experience of poverty, a survey of NHS professionals and interviews with key stakeholders, as well as observing training. A full methodology will be supplied in the final report.

Below is a thematic summary of the findings of this research and recommendations gleaned.

Household income, cost implications and accessibility of GM NHS health and social care services

Amongst the general public across Greater Manchester (from 1000 survey respondents):

- 39% of all respondents either agree or strongly agree with household income impacting their ability to access NHS health and social care services.
- Most respondents believe that cost implications for patients are not always being taken into consideration by the NHS, with cost implications being taken in account either ‘sometimes’ (29%) or ‘rarely’ (29%).
- 41% of respondents identified as not having accessed an NHS service or amenity due to cost implications, identifying cost implication to be a significant barrier in NHS GM.
- 31% of respondents agree or strongly agree that NHS health and social care services in Greater Manchester have become more accessible to those facing financial hardships over the past two years, whilst the majority (46%) neither agreed nor disagreed with the statement.

Amongst health and care professionals from both the public and VCSE sectors in Greater Manchester (38 respondents in total):

- "Making sure services are accessible to people on low incomes" is the most popular 'highly important' option amongst health and care professional for health services to address poverty, with 89% of respondents ranking it a '5' (i.e. highly important).

The following key points were highlighted from the lived-experience focus group (with 12 participants from across Greater Manchester):

- In accessing healthcare services, all answering participants mentioned transport costs as a key barrier, many referencing the cost-of-living crisis and fear of elongation of treatment through missing appointments. Some participants mentioned digital costs, childcare costs, and costs specific to individuals that are undocumented and/or are seeking asylum.
- All answering participants highlighted the lack of adequate and/or effective communication by NHS staff with patients being a significant barrier to accessing NHS systems/services, specifically on the lack of regard for specific healthcare needs/circumstance (particularly mental health) and a work culture than is more reactive than pro-active and is not based on empathy/compassion as it should be. Other participants identified accessibility of information, digital exclusion, lack of consistency of care between boroughs, and a lack of adequate/effective communication within/between NHS and/or Health and Care staff as other key barriers.
- All answering participants believe that cost implications of accessing health and social care systems/services should be considered by the NHS.

Awareness of GM NHS assistance/schemes

Amongst the general public across Greater Manchester:

- Two-thirds of all respondents could not identify any NHS schemes or assistance (such as with prescription costs, funded transport, vouchers etc.) that Greater Manchester residents may be able to access to get support with health and social care costs.

Amongst health and care professionals from both the public and VCSE sectors in Greater Manchester:

- Directly assisting and/or supporting patients facing poverty via various tools, programmes and schemes (e.g., vouchers, social prescribing, helping with or directing to services helping with benefits/household income etc.) is the most popular option amongst health and care professionals in enabling the NHS to respond to poverty.
- Many respondents stated that they helped tackle poverty in their role through multiple ways. The majority (42%) stated that they directly assist/support individuals via in-house tools, programmes, and/or schemes, such as giving vouchers, offering advice (etc.) whilst 37% of respondents stated to actively put-in or change structures, systems and/or procedures – such as more effective teamwork and exchange of information, reducing barriers/accessibility issues caused by poverty, staff training to awareness/knowledge on poverty (etc.) – to better accommodate those facing poverty.
- Similarly, 39% of respondents stated that their organisation directly assists/supports individuals in-house, and 37% of respondents stated that their organisation actively seeks to put-in or change structures, systems and/or procedures to better accommodate those facing poverty. However, 21% of respondents – namely some from the NHS – were unaware of what their organisation does overall in responding to poverty outside their role/area, highlighting a need for an overall anti-poverty strategy (particularly by larger and more complex organisations such as the NHS).

The following key points were highlighted from the lived-experience focus group:

- Majority of answering participants had no knowledge or know-how of any scheme or support provided by the NHS to help overcome barriers caused by poverty. A few participants knew of some travel cost reimbursement schemes, social prescribers, and prescription certificate schemes. All highlighted that awareness of these things was a result of ‘word of mouth’ rather than direct information from health and care professionals.

Assistance and responsibilities of NHS health and care professionals regarding financial hardships

Amongst the general public across Greater Manchester:

- 54% agree or strongly agree that NHS health and social care professionals have a responsibility to assist patients with financial hardship.
- Almost two-thirds of all respondents (64%) stated that they would not raise concerns about their household's financial situation with NHS health and social care professionals.
- Of those who feel comfortable in sharing concerns about their household's financial situation with an NHS professional, the majority (76%) were happy to share such concerns with their GP.
- A vast majority (89%) stated that they have never raised concerns about their household's financial situation with an NHS health and social care professional.

Amongst health and care professionals from both the public and VCSE sectors in Greater Manchester:

- More than half (58%) identified tackling poverty to be 'highly important' to their role, whilst only 3% identified it as 'not important'.
- The need to tackle poverty to effectively meet the primary aims/objectives of the health and care professionals' job role (e.g. providing effective healthcare, ensuring accessibility to services/systems etc.) was the most popular reasoning (34% stating as such) as to how poverty was relevant to the respondents' job roles.
- 71% of respondents stated that there are opportunities for them/their organisations to respond to poverty that aren't being currently realised. 18% of respondents do not know whether there are such opportunities present, whilst 8% state that there are no such opportunities at all.
- 79% of all respondents view a "lack of adequate funding for services" as a highly significant barrier to health and care services aiming to tackle poverty. In the following open-ended question, 21% of respondents identified the lack of appropriate/adequate focus, awareness, or understanding of poverty and how to tackle it, being a barrier for health and care services in seeking to tackle poverty.

The following key points were highlighted from the lived-experience focus group (with 12 participants from across Greater Manchester):

- All answering participants believe that the NHS is not providing adequate financial assistance in this cost-of-living crises, instead highlighting a decrease in free services offered and staff becoming more understaffed and overworked.
- A majority of participants stated that they would not raise concerns about their household's financial situation with NHS health and social care professionals, with only a couple stating that they would only be comfortable with their GP/family doctor. However, a majority of participants were also agreeable to having NHS approach them regarding their financial situation (to initiate a process of getting help/support), but only under particular conditions around anonymity/semi-discreteness and the staff having soft-skills and emotional intelligence. Some stated they would not want to be approached, or were unsure about being approached or not, because of stigma and how well the NHS can deliver on it with its current resource/capacity issues.

Effect of financial hardship on mental/physical health

Amongst the general public across Greater Manchester:

- 31% of all individuals state that concerns and/or difficulties with household finances ‘always’ or ‘often’ impacts their physical and/or mental health.

The following key points were highlighted from the lived-experience focus group (with 12 participants from across Greater Manchester):

- All answering participants expressed strongly regarding concerns about/difficulties with households finances impacting their physical and/or mental health. The inverse was also found to be true, with participants stating the cyclical nature of dire financial circumstance and physical and mental health.

Recommendations can be found at the end of this interim report.

Analysis of NHS GM against King's Fund recommendations

Please note this literature review offers a preliminary insight and does not encompass all the areas explored. The full report will delve deeper, providing additional case studies and detailed analysis.

The King's Fund (2021) report highlights that the NHS can tackle poverty in three specific ways:

1. Action (in relation to actions to mitigate the impact of poverty as well as actions to address the drivers of poverty);
2. Awareness (raising awareness of the impacts of poverty on people's health and access to care);
3. Advocacy (being a strong advocate for tackling poverty).

Below, we outline examples from our research of key findings and recommendations to be considered by NHS GM.

Action

Integrated Care Systems (ICS) are partnerships of organisations that come together to plan and deliver joined up health and care services, and to improve the lives of people who live and work in their area. One of the four core purposes of the ICS is to help the NHS support broader social and economic development. A wide range of system-level actions are taking place in GM to boost the local and regional economy and reduce socio-economic and health inequalities. However, we have identified that the ICS can further support and build a more systematic approach to social and economic development to make the GM population better and better off.

A report by Goodwin (2023) highlights recommendations on how ICS can develop their potential as networks of anchor institutions. Summarising the recommendations and

adapting to the NHS GM context, we outline the following key takeaways and insights that should be considered to move to a more connected anchor system:

- Be purposeful about social and economic development: going forward, there needs to be a more robust narrative that underlies the ICS commitment to social and economic development. One of the key GM Integrated Care Partnership (ICP) strategy missions is ‘helping people get into, and stay in, good work’, and the Joint Forward Plan highlights a key area of focus is ‘increasing the contribution of the NHS to the economy’ with an action of developing the NHS as an anchor system with the development of a GM NHS anchors network. We are aware NHS GM Integrated Care Board (ICB) is seeking a provider to give leadership to the NHS GM anchors network and programme, with one of the key priorities being to develop and implement vision, strategy, and targets for anchors’ work within GM. There must be a coherent anchor vision that pledges to use anchor practice to tackle poverty.

- Enable local enterprises to play a more significant role: we are pleased to see a pivotal priority to the GM anchors network developing and implementing local supply chain opportunities. To grow and develop this, the ICB must integrate procurement data into economic development practice.

Goodwin (2023) suggests that to integrate procurement data into economic development practice, the ICB should:

- Examine procurement data to pinpoint areas of spend that can be influenced and collaborate with local authorities to identify alternate suppliers, which involves local development officers liaising with local small businesses and social enterprises. A key area of focus could be exploring the feasibility of a local manufacturing offer for consumable items, which could be incorporated into supply chains (as the Covid-19 pandemic demonstrated that many SMEs could quickly adapt to provide the NHS with the necessary consumables). Moreover, this is a further opportunity to engage organisations and build a shared commitment to tackling poverty by promoting the real Living Wage.

- Explore commissioning community development workers to support more inclusive economic development, working at a neighbourhood level to identify the community's needs.
- Unify approaches to securing social value: it is encouraging to see plans to adopt the GM social value framework. Reed et al. (2019) recommend that the NHS should apply social value principles across areas where the NHS has greater flexibility, such as hotels and catering, as social value tends to be primarily part of competitive tender processes. Social value should be a priority, but care should be taken. Some suppliers might give a positive appearance but try to work around the system, over-promising the social value they will deliver.
- Give the local NHS greater control of land: housing and planning policy plays a vital role in reducing the risk of poverty and health inequalities. While we understand the pressure to sell assets for profit, ICB partners should consider whether any extra land and property could be used for affordable commercial or residential development. This extra space could support local businesses and community use, helping to expand and grow the local economy. For example, Reed et al. (2019) outline examples of some NHS organisations explicitly prioritising social value as part of decisions to sell land. For example, NHS Property Services sold the former St George's Hospital site in Hornchurch for £40m (the most considerable reinvestment in the NHS through the sale of surplus land); 15% was allocated for social housing, and 1.6 hectares of land retained to host a new community health centre. Furthermore, they describe how some NHS sites have an existing green that they have open to the local community and others are working to develop green space on unused land. For example, at a primary care centre near Sunderland, staff worked with NHS Property Services and a local charity, Groundwork, to convert derelict space into a community garden and allotment. The space is now used to run a gardening course as part of a community mental health recovery programme.

Maximising the role of the NHS as an employer / good employment

It is positive that NHS GM has a strong focus on maximising its role as an employer, with two of the missions in the ICP strategy explicitly focusing on employment, ‘helping people get into, and stay in, good work’ and ‘supporting our workforce and our carers’ with a dedicated GM People and Culture Strategy, which sets out the vision for the health and care workforce, with critical commitments on good employment, attraction and retention of the health and social care workforce closely aligning with the Greater Manchester Strategy. Additionally, these efforts are in the process of alignment and evaluation based on the benchmarks of the national Long-Term Workforce Plan.

We are pleased to see that there is a commitment to increase membership of the Greater Manchester Good Employment Charter by organisations within NHS GM and it is positive to understand some boroughs have witnessed the ‘domino effect’ of membership by several primary care providers. It is also indicative of the value that NHS GM places on ‘good’ employment that there are representatives from NHS GM's People and Culture team on both the GM Good Employment Charter Board and the Living Wage Board.

However, the context to which good employment practices have been adopted remains unclear. According to the Living Wage Foundation, only one NHS service provider from GM, the Greater Manchester Mental Health NHS Foundation Trust is an accredited Living Wage employer and very few NHS organisations are members of the GM Good Employment Charter. Our primary research suggests poverty awareness training for middle management is crucial in making clear the link between low pay, poverty and ill health which may then impact a person’s ability to work.

Through our research, we have identified gaps that need to be built on to reduce poverty. There is an increasing amount of evidence that paying the ‘real’ Living Wage (rate set annually by the Living Wage Foundation, based on the true cost of living, unlike the government’s National Living Wage; the statutory minimum rate of pay dependent on age, based on fluctuations in average earnings) has benefits to employers as well as its employees. The Living Wage has lifted hundreds of thousands of people and families onto a wage that covers their every day needs and can be credited with improvements to an employee’s mental health and wellbeing. In current NHS pay scales, an employee earning

below Band 2, spine point 3 is “paid a wage that does not support an employee’s needs – a difference of more than £1,000 a year between the Living Wage and what a low-paid employee earns each year” (Lewis, 2022). When considering NHS GM’s role in tackling poverty, it is important to look at the impact paying the Living Wage would have on staff, given the scale of employment across the city region and how many households are provided their income by the NHS.

GMPA is realistic and understands the complexity of the ICS and the challenges in achieving widespread GM Good Employment Charter membership and Living Wage Foundation accreditation. At GMPA we run the Greater Manchester Living Wage Campaign which has unique links with the Living Wage Foundation, GMCA, Citizens UK as well as trade unions and other key stakeholders working in promoting good employment, unlike in other regions of the UK. As such, we believe we can offer more support and co-ordination in promoting these areas of employment that would make a significant difference to poverty across GM. With funding allocated to establish a Community of Practice for health and care employers to improve employment standards[1], we would be pleased to contribute by sharing our expertise on quality work practices and their role in addressing poverty.

Enhancing the scale of work and health programmes

It is welcome that working with the Greater Manchester Combined Authority (GMCA), NHS GM will continue to evolve the ‘working well system’, with a number of new services being put into place. However, it is vital that employment support is not done to, but rather in collaboration with, those who have lived experience of socio-economic disadvantage and health inequalities. This is what is missing in national employment support. NHS GM and the GMCA should take an approach that involves people from the outset, committing to processes of engagement (rather than single events), and creating a lived experience advisory group (described elsewhere in the document).

Growing and developing the workforce

It is positive that there is an active focus on developing GM’s career approach to attract and support career development. NHS GM must target skills and opportunities to those

[1] https://democracy.greatermanchester-ca.gov.uk/mgCommitteeDetails.aspx?ID=426

who need them most, reaching out to communities and mapping the employment profile of providers' trusts to identify any deprived postcodes where trusts employ relatively few people. For example, the Birmingham & Solihull ICS, in partnership with the Birmingham Anchor Institution Network, is leading a programme known as 'I Can' across all its employing providers. 'I Can' has engaged with over 3,000 jobseekers and offered more than 420 people a role. Roles include porters, theatre support workers and healthcare assistants. It was recently shortlisted for a national award (University Hospitals Birmingham, 2023).

Awareness

Mission statement

NHS GM needs to set out the ICS commitment to tackling poverty and clearly define the health and social system's role, working in partnership with internal and external stakeholders and people with lived experience of poverty. This is the cornerstone for action as demonstrated by GMPA's 2023 report 'Local anti-poverty strategies: good practice and effective approaches'. It is vital to ensure a shared understanding to serve as a reference for efficient and effective solutions and to signal across the system that poverty is everybody's business.

Recommendation

Clear vision and mission that acknowledges the role of the health and social care system in addressing poverty as a critical determinant of health.

Enhancing engagement with people with lived experience of poverty

People with lived experience of poverty must have a voice in NHS GM decision-making processes and governance. To counter the inverse care law, whereby those who need services the most are the least likely to receive them and least likely to feel safe to participate.

There has been considerable work across the system to involve people and communities, with different parts of the ICS having their own participation legal duties and

responsibilities, and we are aware there are plans to develop a longer-term partnership approach to engagement. These legal duties, strong relationships within the system, and existing communications and engagement practices provide a platform to be built on to improve engagement with people with lived experiences of poverty at the system level.

Recommendations

Below, we set out the following recommendations to be considered to enhance engagement with people with lived experiences of poverty, building on the national ten principles developed by NHS England (2021):

- Increase the opportunities for experts by experience participation, working with key non-statutory partners. There needs to be a permanent structure such as an 'ICS lived experience advisory group' to ensure that people with lived experience of poverty influence strategy and planning and support service design and transformation. This would require a commitment to sufficient funding, resources, training, and support to do so meaningfully and effectively. This would form one part of effectively implementing the socio-economic duty (discussed elsewhere in this paper). NHS GM to support GMPA to identify how the panel would operate in practice and what mechanisms would be implemented to ensure it influences policy. This would involve the following steps:
    - Establishing a community of practice around the co-production agenda to develop, learn from what works, and build on the assets of all ICS partners to develop a lived experience charter that would form part of the development and implementation of the NHS GM anti-poverty strategy.
    - Toolkit and resources to support the workforce to engage with people with lived experience and deprived communities.
    - Co-production delivery plans across the system.

Adopt the socio-economic duty

The socio-economic duty is a powerful tool available to public authorities to address socio-economic inequality and a central component of a strategic approach to tackling poverty.

The duty, contained in Section 1 of the Equality Act 2010, requires public authorities to actively consider the way in which their decisions increase or decrease inequalities that result from socioeconomic disadvantage. Successive governments have chosen not to enact the duty, and socioeconomic disadvantage is often missing from equality impact assessments that include consideration of other protected characteristics. In the absence of action at a UK government level, equivalent legislation has been introduced in Scotland (known as the “Fairer Scotland Duty”) and Wales.

The duty has not been enacted in England, but there has been voluntary adoption by many local authorities and public bodies. At GMPA, we have been working with local, combined authorities and other public bodies, such as housing associations, to increase the awareness and voluntary adoption of the duty as a means of creating better outcomes for those with lived experiences of poverty.

It is crucial to emphasise that the socio-economic duty complements existing duties, bringing added value to the efforts of the NHS GM in reducing inequalities of outcome related to socio-economic disadvantage. The socio-economic duty is not an isolated duty. Instead, it is one of a series of duties in England which are instrumental in enabling public bodies to work proactively towards advancing equality and combating inequalities.

In this context, the Integrated Care Board should be particularly cognisant of the overlapping yet distinct relationship with the Public Sector Equality Duty.

	Equality Act 2010: **The Socio-Economic Duty**	**Equality Act 2010: Public Sector Equality Duty**
Scope of the duty	Socio-economic disadvantage	Individuals and groups with protected characteristics
Required application of the legal duty	Strategic decisions	Proposed policies and practices
Outcomes in relation to equality	Reduce inequalities of outcome related to socio-economic disadvantage	Eliminate unlawful discrimination Advance equality of opportunity. Foster good relations
Outcomes in relation to health and wellbeing	Reduce inequalities in health and wellbeing outcomes related to socio-economic disadvantage. Remove barriers to access to health services linked to socioeconomic disadvantage	Prevent negative impacts on health arising from discrimination Remove barriers to access to health services and other opportunities that influence health and wellbeing outcomes
The NHS 2022/23 priorities and operational planning guidance outlines that Integrated Care Systems have four strategic purposes, with one key goal being to address inequalities in outcomes, experience, and access. The socio-economic duty will significantly bolster and add value to this objective.		

Figure 1: Mapping the duties and expected health and equality outcomes. Adapted from Public Health Wales.

Case study

We launched our new report in July ‘the socio-economic duty in action: case studies from England and Wales’. Our report, produced with Just Fair, brings case studies from local authorities and public bodies in England who have voluntarily adopted the socio-economic

duty and from the Welsh Government implemented the duty in Wales in 2021. The report finds that, across England and Wales, the duty is being used to tackle inequality in a wide range of areas, including recruitment, addressing the cost-of-living crisis, preventing increases in school meal prices, and responding to the Covid-19 pandemic.

Below, we provide an example of adoption of the socio-economic in Wales in the health and social care context.

Welsh Government

Following the adoption of the duty at national level in 2021, the Welsh Government conducts Integrated Impact Assessments for strategic decisions which now includes considerations of socio-economic disadvantage. The impact of the duty has been particularly visible in centring considerations of socio-economic disadvantage during Covid-19 and in the changing healthcare landscape.

Vaccination Transformation Programme

Consideration of the duty was a central element of the Vaccination Transformation Programme in 2022. The Welsh Government recognised that equitable uptake of vaccination is needed across societies in Wales so that individuals, families, and communities are protected from the harms of vaccine-preventable disease. Reducing the inequities in access to key preventative healthcare was therefore central to the Welsh Government's design of their future strategy for vaccination in a post-Covid-19 context.

The Vaccination Transformation Programme was co-produced with key stakeholders. Task and finish groups supported the design and development phases of the programme – one of which was focused on inclusion and engagement, with a particular focus on vaccine equity. Equity was a design principle of the programme, embedded in all workstreams. The resulting National Immunisation Framework (NIF), published in October 2022, requires all Health Boards in Wales to prepare a Vaccine Equity Strategy. These strategies, which consider socio-economic disadvantage alongside protected characteristics and under-served groups, will be supported by a programme of work to address inequitable vaccine uptake, including by socio-economic status.

The national Vaccination Equity Strategy for Wales also sets out to reduce low uptake among deprived communities by a variety of means, including improving accessibility and affordability by creating local vaccination hubs on well-travelled transport routes. By using the duty and co-production in designing the NIF, the Welsh Government has developed a

framework directly contributing to reducing the inequalities of outcome in health and access to healthcare that result from socio-economic disadvantage.

A Healthier Wales

In 2018, the Welsh Government's A Healthier Wales, aimed to develop a seamless local health and social care model focussed on health and wellbeing, prevention, and accessibility. A transformation programme, comprising twenty six actions centred around four strategic visions, supports A Healthier Wales in developing a new model of care.

Integral to this model of care is the reduction of health inequities, which is included as one of the four strategic visions in the transformation programme. In addition, one of the twenty six actions is given over to tackling inequalities, although this goal has also been embedded across the programme in a whole systems approach. A new NHS Health Inequalities Group has been established to maximise the contribution of the NHS to tackling health inequalities. It will focus on service planning and delivery and be an example for the wider public sector.

Recommendation

NHS GM should commit to voluntarily adopting the duty. GMPA can support effective implementation and provide guidance on what adopting the duty means in policy and practice delivering the work in a staged process. (In the forthcoming full report, we will provide an in-depth outline of this staged process, offering further details about what this means for NHS GM).

Advocacy

NHS GM needs to strengthen its role in advocating for wider social policy change, working with partners to call out the government over the deep-rooted structural issues driving poverty and health inequalities in Greater Manchester. Moreover, NHS GM should work with other ICS across the country to challenge the government's national policies and raise awareness about the consequences of long-term inaction on poverty and the cost-of-living crisis on the health and social care system.

A strong evidence base on the following should support this:

- Complete and consistent data on local poverty rates (using those metrics available at a local level), its drivers, and use population health management and data and intelligence.
- Pressures on current NHS services, resources, and the health and care workforce
- The potential gains associated with poverty alleviation.

Conclusion

As mentioned at the outset, this interim report is provided to give an overview of the primary and secondary research undertaken as well as a selection of the key findings and recommendations thus far.

The key recommendations GMPA has identified for NHS GM in its approach to tackling poverty include:

- Developing a robust anti-poverty strategy, with a focus on:
    - Setting out a clear mission and vision;
    - Co-production with people with lived experience of socio-economic disadvantage;
    - Appropriate allocation of resources;
    - Cross-system collaboration.
- Adopting the socio-economic duty.
- Work with GMPA and the Greater Manchester Living Wage Campaign to realise good employment goals.
- Prioritise ongoing poverty awareness training for senior and middle management, as well as widespread mandatory poverty awareness training for all NHS professionals, focussing on the NHS's role as a health service provider and employer.

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Appendix 2 – GM Poverty Action: Survey of GM residents experiences of poverty and its impact on health outcomes, health service access, and health service experience.

NHS SURVEY RESULTS FINDINGS

Sample Size and Demographics

- **Total sample:** 1000 respondents

- **Gender**: 54% Male (544), 45% Female (454), and <1% Other (1)

- **Age**: 19% 18-24 (191), 23% 25-34 (226), 21% 35-44 (210), 20% 45-54 (198), 11% 55-64 (113), and 6% 65+ (62).

- **Local Authority Area:** 40% Manchester (400), 9% Bolton (93), 7% Bury (71), 5% Oldham (52), 5% Rochdale (54), 4% Salford (41), 9% Stockport (89), 6% Tameside (57), 5% Trafford (45), 10% Wigan (98).

- **Household Income:** 11% 'Less than £15,000' (109), 27% £15,000-£30,000 (271), 28% £30,001-£50,000 (279), 18% £50,001 - £80,000 (181), 6% £80,001-£100,000 (61), 4% '£100,001 or more' (40), and 6% 'I don't know/prefer not to say' (59).

- **SEG (Socio-Economic Grade)** *(system of demographic classification based on occupation):* 39% AB (*higher and intermediate managerial, administrative, professional occupations) (*389), 30% C1 (*supervisory, clerical & junior managerial, administrative, professional occupations*) (296), 13% C2 (*skilled manual occupations*) (129), 19% DE (*semi-skilled & unskilled manual occupations, Unemployed and lowest grade occupations*) (186)

- **Ethnicity:** 77% English/Welsh/Scottish/Northern Irish (765), 1% Irish (7), <1% Gypsy or Irish Traveller (2), 3% Other White Background (25), 1% White and Black Caribbean (14), 1% White and Black African (8), 1% White and Asian (13), 3% Indian (30), 4% Pakistani (41), 1% Bangladeshi (11), 1% Chinese (10), 1% Other Asian Background

(8), 4% African (36), <1% Caribbean (4), <1% Other Black/African/Caribbean Background (4), 1% Arab (7), 1% Any Other Ethnic Group/Mixed/Multiple Ethnic Background (12), <1% Prefer Not to Say (3).

Key Findings Summary

The following key findings are taken across the whole sample of 1000 respondents (bar question 8) – for specific findings pertaining to certain demographics, please view the in-depth analysis of each of the questions.

Household income, cost implications and accessibility of GM NHS health and social care services *(Q1, Q2, Q3, Q5)*

- 39% of all respondents either agree or strongly agree with household income impacting their ability to access NHS health and social care services.
- Majority of the respondents allude to cost implications not often being taken into consideration by the NHS, with individuals stating cost implication being taken either 'sometimes' (29%) or 'rarely' (29%).
- 41% of respondents identified as not having accessed an NHS service or amenity due to cost implications, identifying cost implication to be a significant barrier in NHS GM.
- 31% of respondents agree or strongly agree that NHS health and social care services in Greater Manchester have become more accessible to those facing financial hardships over the past two years, whilst the majority (46%) neither agreed nor disagreed with the statement.

Awareness of GM NHS assistance/schemes *(Q4)*

- Two-thirds of all respondents could not identify any NHS schemes or assistance (such as with prescription costs, funded transport, vouchers etc.) that Greater Manchester residents may be able to access to get support with health and social care costs.

Assistance and responsibilities of NHS health and care professionals regarding financial hardships *(Q6, Q7, Q8, Q9)*

- 54% agree or strongly agree that NHS health and social care professionals have the responsibility to assist patients regarding their financial hardships.

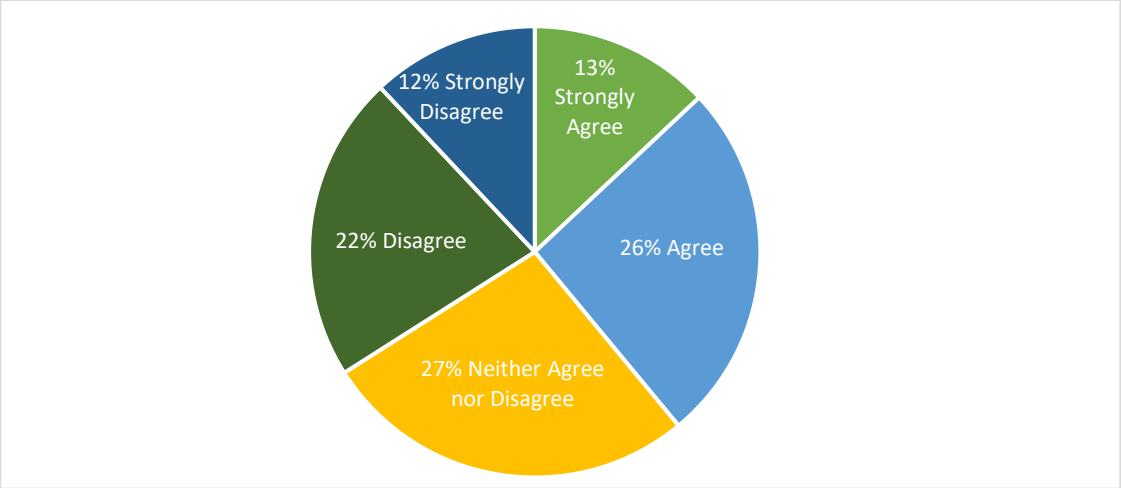
- Almost two-thirds of all respondents (64%) stated that they would not raise concerns about their household's financial situation with NHS health and social care professionals.
- Of those who stated to feel comfortable in sharing concerns about their household's financial situation with an NHS professional, the majority (76%) were happy to share such concerns with their GP.
- A vast majority (89%) stated that they have never raised concerns about their household's financial situation with an NHS health and social care professional.

Effect of financial hardships on mental/physical health *(Q10)*

- 31% of all individuals state that concerns and/or difficulties with household finances 'always' or 'often' impacts their physical and/or mental health.

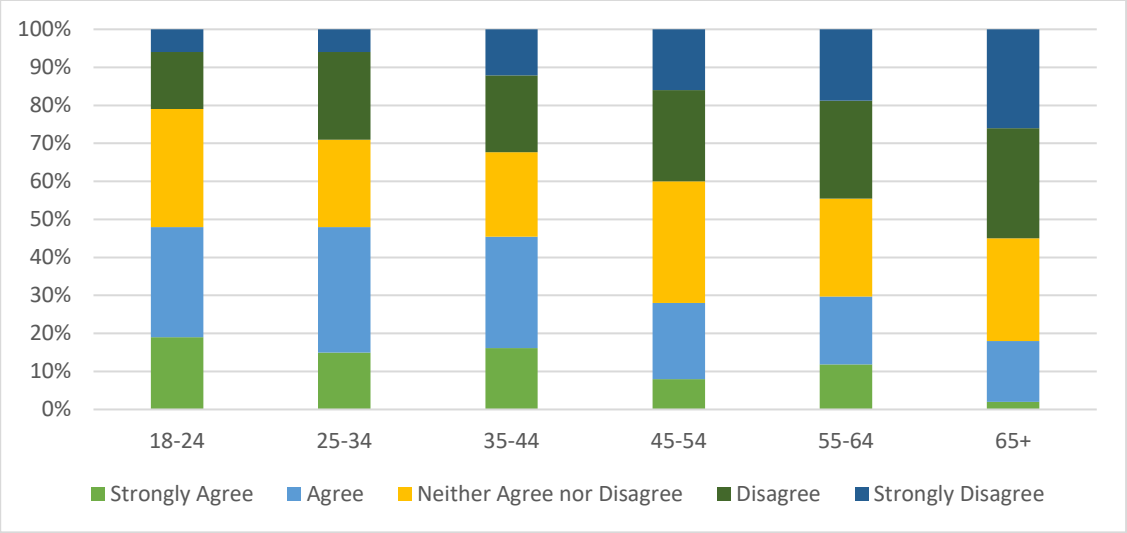
Q1. To what extent do you agree that your household income impacts your ability to access NHS health and social care services?

- **1.1 Total sample:** 13% strongly agree with household income impacting their ability to access NHS health and social care services, 26% agree (thus a majority agreeing in general (39%)), 27% neither agree nor disagree, 22% disagree, and 12% strongly disagree.

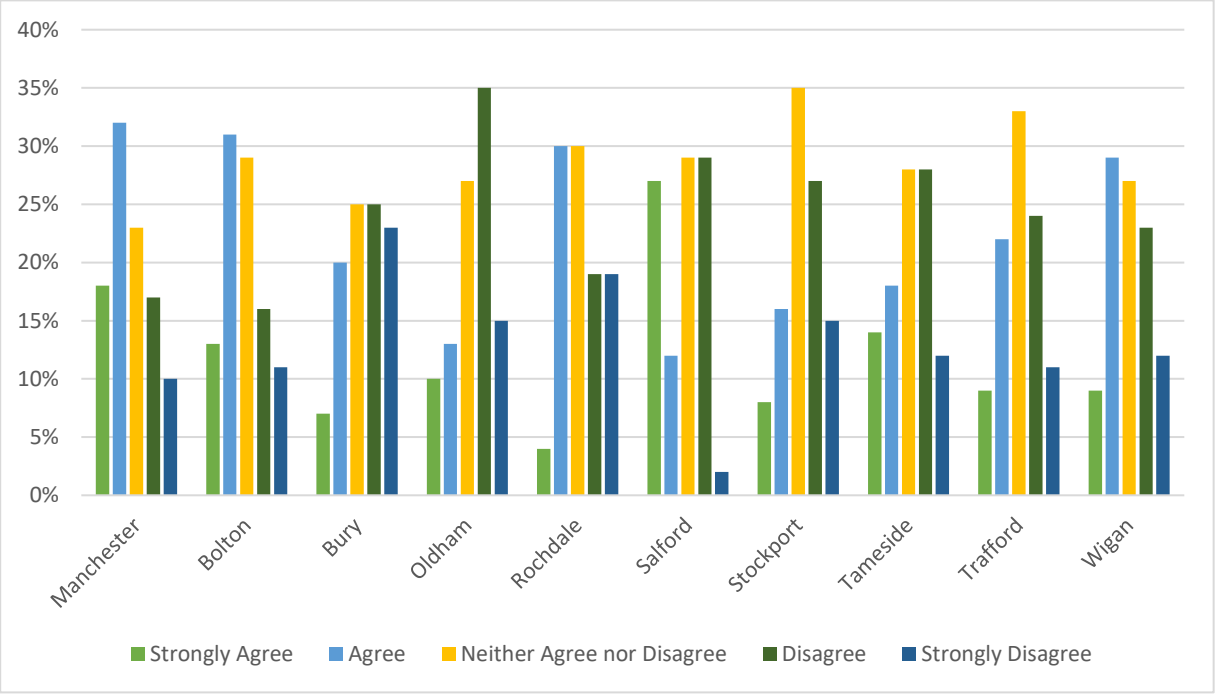


- **1.2 Gender**: Limited difference in results between men and women (max. 2%-point difference), with results almost identical to that of the total sample.

- **1.3 Age**: As age increases, the percentage that disagrees/strongly disagrees that their household income impacts their ability to access NHS health and social care increases, whilst the percentage that agrees/strongly agrees decreases. The highest percentage of those who strongly agree are 18–24-year-olds (19%) whilst those making 65+ category has the lowest percentage (2%). 25-34-year-olds make the highest percentage of those that agree (33%), whilst the 65+ category still makes the lowest percentage to do so (16%). The 65+ category has the greatest percentage of individuals that disagree (29%) and strongly disagree (26%), whilst the 25-34-year-olds make up the lowest percentages in those categories (15% and 65 respectively).

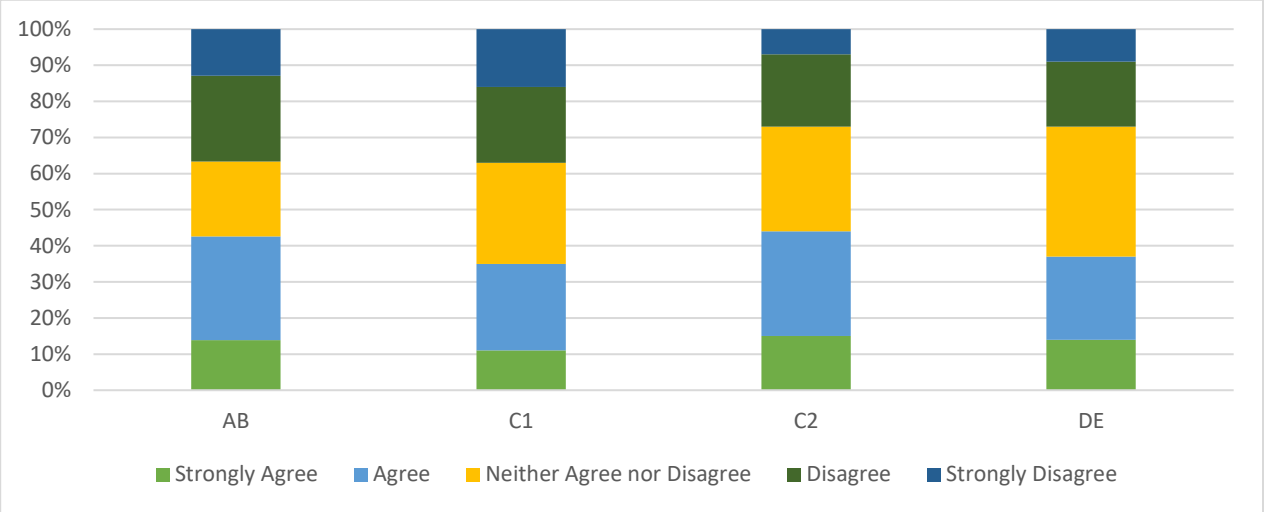


- **1.4 Local Authority Area:** Salford ranked the highest regarding those who strongly agree to their household income impacting their ability to access NHS health and social care services (27%) by a large margin amongst all the local authorities. Manchester ranks the highest in those that agree to the statement (32%) followed closely by Bolton, Rochdale, and Wigan (31%, 30%, and 29% respectively). Amongst those who disagree, Oldham has the highest percentage (35%). Bury has the highest percentage (23%) of individuals who strongly disagree.



- **1.5 SEG (Socio-Economic Grade):** The percentage of those who generally agree (i.e. both strongly agreed and agreed), generally disagree (i.e. both strongly disagreed and disagreed, and neither agree nor disagree are similar across all SEGs – averaging at 13% strongly agreeing,

26% agreeing, 29% neither agreeing nor disagreeing, 21% disagreeing, 11% strongly disagreeing. Greater distinguishment (socio-economically) between can be discerned through the household income categories (see 1.6).



- **1.6 Household Income:** In general, as household income increases, the percentage of those who disagree/strongly disagree that their household income impacted their accessibility to NHS health and social care services increases, whilst the percentage of those that agree/strongly disagree decreases. The income bracket of 'less than £15,000' has the highest percentage of those that strongly agreed to the statement (19%) amongst all income brackets, whilst the income bracket of £50,001-£80,000 has the highest percentage that agrees with the statement (31%), followed closely by the income bracket of £15,000-£30,000 (30%). The income bracket of '£100,001 or more' has the highest percentage of those that disagree (38%) and strongly disagree (23%) amongst the income brackets.

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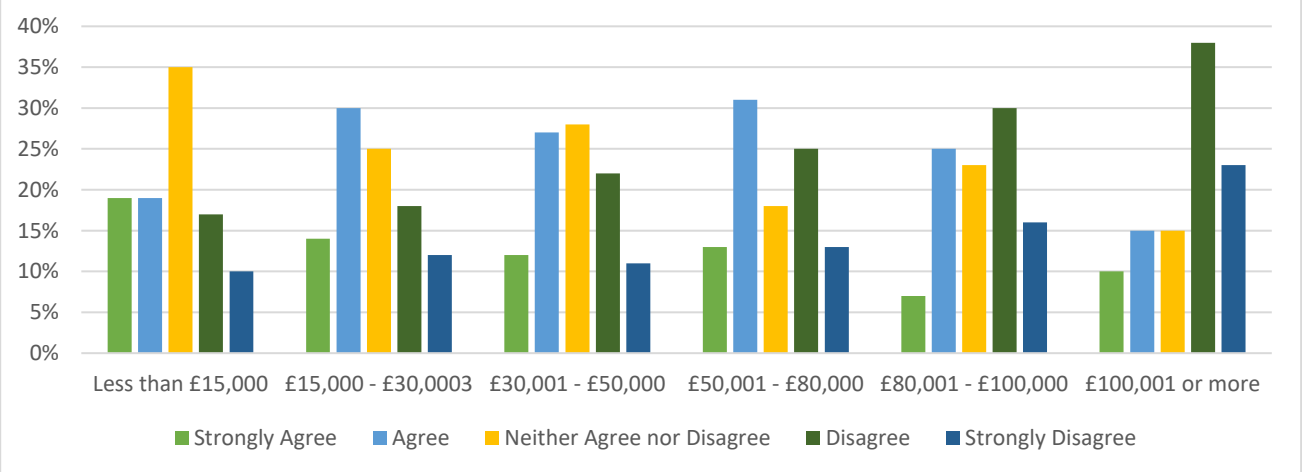
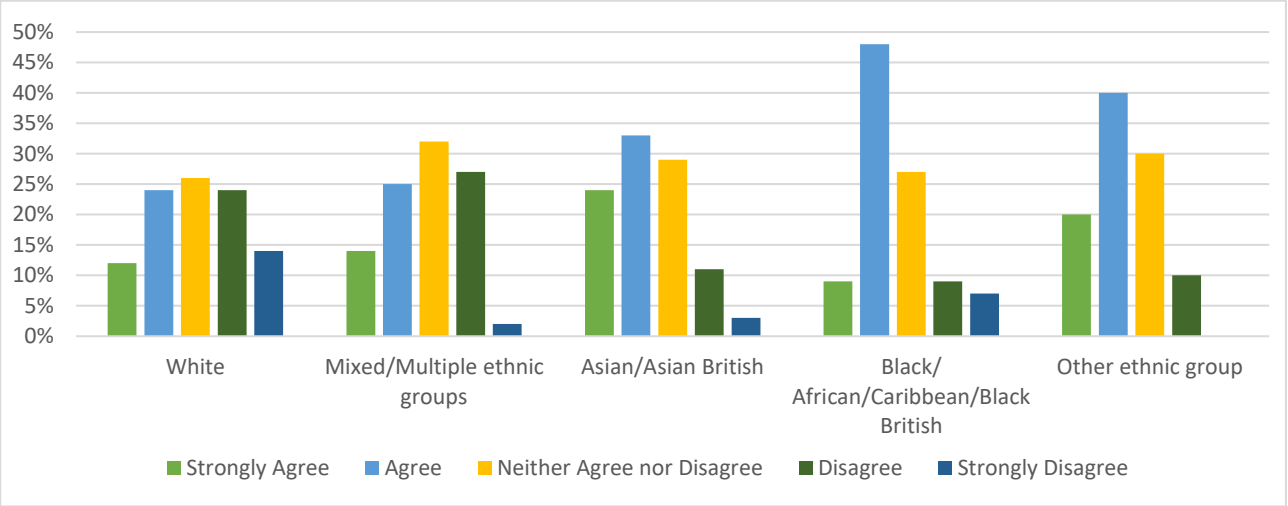
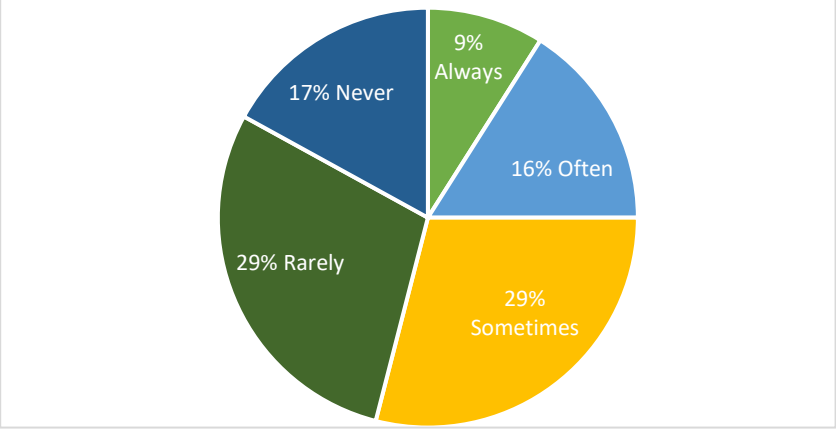


- **1.7 Ethnicity:** In general, individuals from a BAME background have a higher percentage agreeing/strongly agreeing to the fact that their household income their ability to access NHS health and social care services compared to their white counterparts, whilst those identifying as White have a higher percentage disagreeing/strongly disagreeing with the statement. Asian/Asian British make the highest percentage of those that strongly agree to the statement (24%) amongst the ethnicities, whilst Black African/Caribbean/Black British have the highest percentage agreeing (48%). On the other hand, those identifying as White have the second highest percentage amongst all ethnicities that disagree (24%) and the highest that strongly disagree (14%).



Q2. Do you feel that cost implications (such as time away from work, distance from your house, childcare responsibilities, parking etc.) are taken into consideration by NHS health and social care professionals when appointments are scheduled?

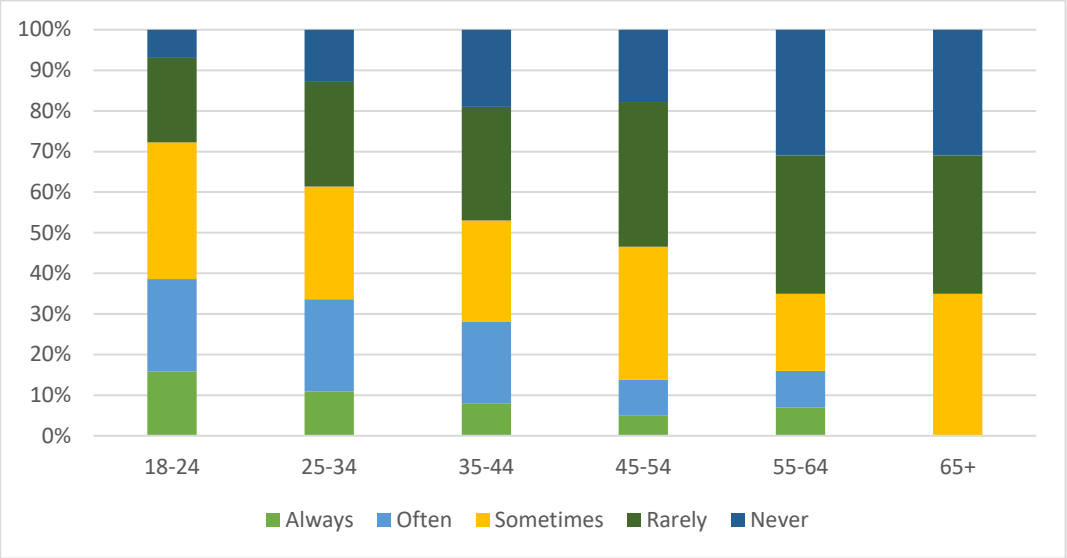
- **2.1 Total sample:** Majority allude to cost implications not often being taken into consideration by the NHS, with the highest percentage of individuals stating cost implication being taken either 'sometimes' (29%) or 'rarely' (29%). Almost half of the respondents answered 'rarely' and 'never' (29% and 17% respectively) and a quarter of respondents responded, 'always' or 'often' (9% and 16% respectively).



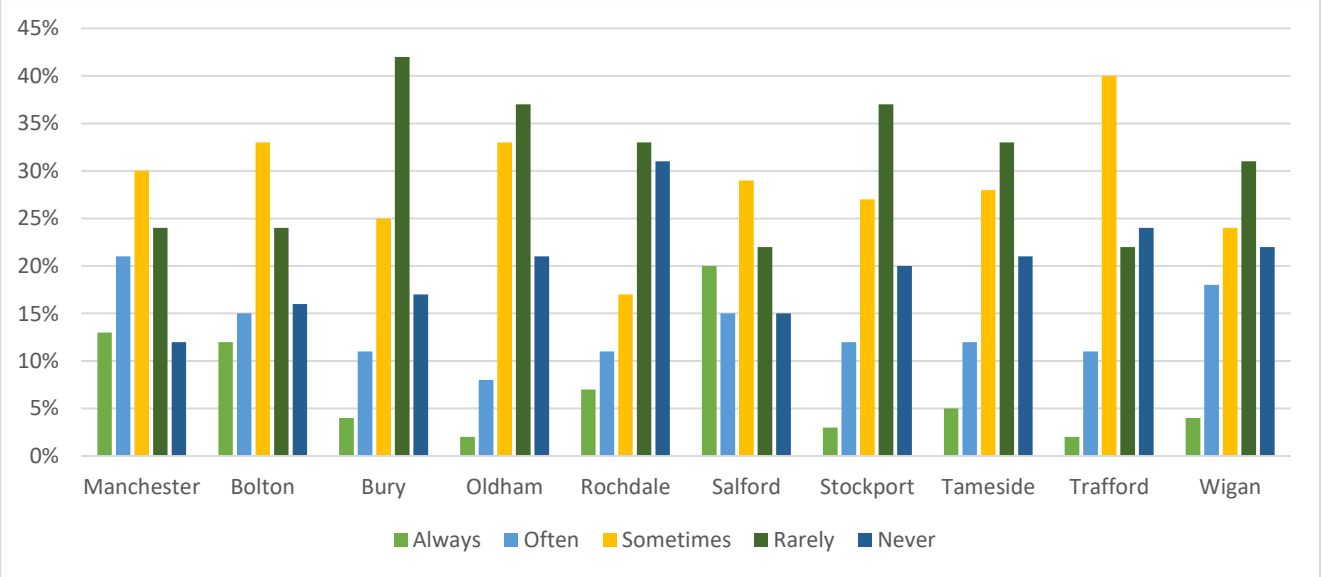
- **2.2 Gender**: Limited difference in results between men and women (max. 2%-point difference), with results almost identical to that of the total sample.

- **2.3 Age**: In general, as age increases, the percentage of individuals that have 'always' or 'often' felt that cost implications are taken into consideration by NHS health and social care professionals (when appointments are scheduled) decreases, whilst the percentage of those that have 'rarely' or 'never' experienced costs being taken into account by NHS professionals increases. The age bracket with the highest percentage of those who believe that cost implications are 'always' taken into consideration by NHS professionals are 18–24-year-olds (16%) and the age brackets with the highest percentage of 'often' experiencing this are 18-24- and 25–34-year-olds (23%), with the inverse being true, with the 18-24 year-old age bracket having the lowest percentage of individuals that felt that cost implications was rarely considered (7%). On the other hand, 0% of individuals 65+ believe that cost implications are 'always' or 'often' taken into consideration by NHS professionals, whilst the group holds the highest percentage

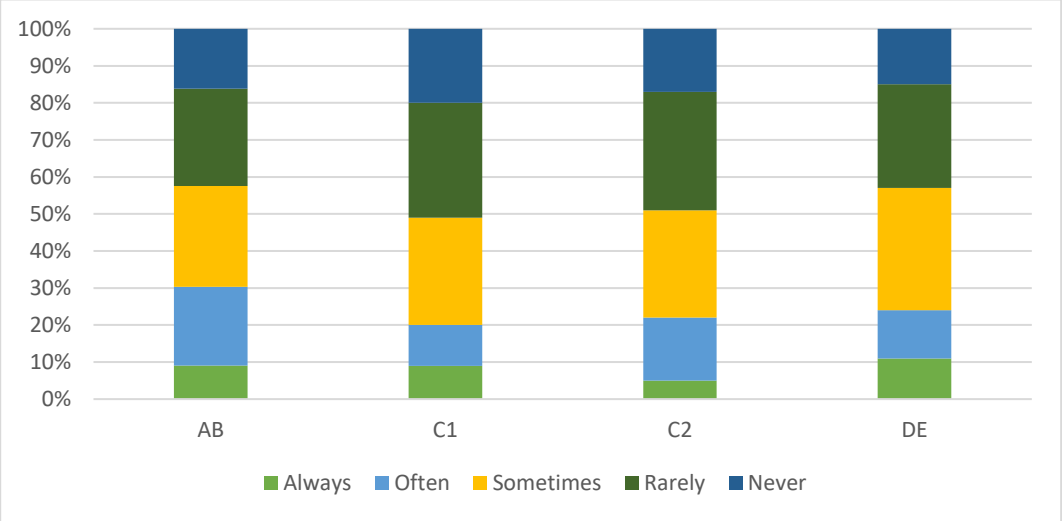
of those that have ‘never’ felt that cost implications are taken in consideration (in conjunction with the 55–64 age group, at 31%).



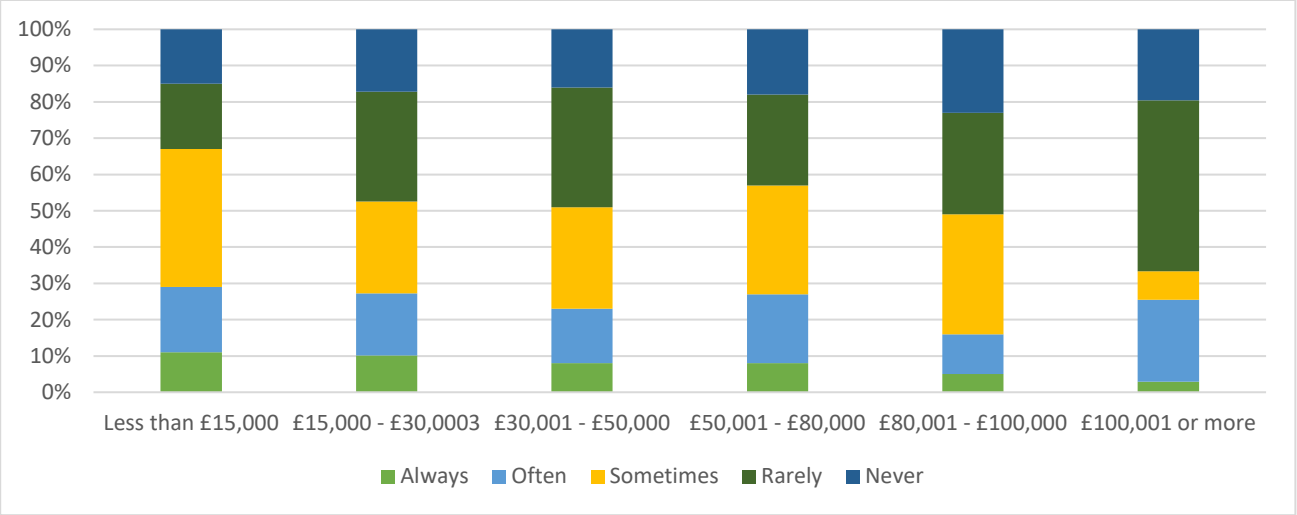
2.4 Local Authority Area: The local authority with the highest percentage of individuals that felt that cost implications are ‘always’ considered by NHS professionals when appointments were scheduled is Salford (20%), whilst the local authority with the highest percentage that felt that they are ‘often’ considered was Manchester (21%). On the other hand, the local authority with the highest percentage of individuals that felt that cost implications are ‘never’ considered or ‘rarely’ considered by NHS professionals were Rochdale (31%) and Bury (42%) respectively.



- **2.5 SEG (Socio-Economic Grade):** The majority of individuals identify cost implications to be either ‘sometimes’ or ‘rarely’ considered by NHS professional across the SEGs (following the general trend seen in the question across the whole sample). The difference in responses due to socio-economic reasons can be seen more clearly via the household income than SEGs (see 2.6).



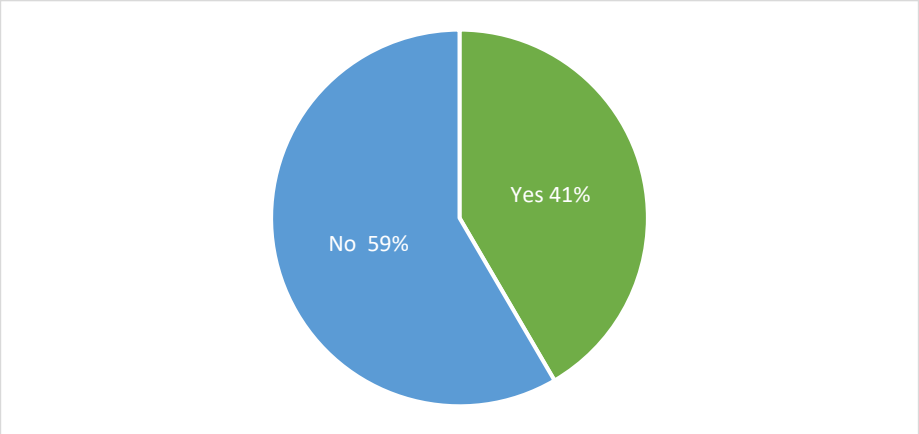
- **2.6 Household Income:** Whilst the key trend across income brackets follow that seen across SEGs – with the responses ‘sometimes’ and ‘rarely’ being dominant – the income brackets help highlight that those having an income of ‘£100,001 or more’ have the highest percentage of those that felt that cost implications were ‘rarely’ considered (48%) across the income brackets, whilst also having the second highest percentage of those that thought cost implications were ‘never’ considered by NHS professionals (20% - second only to the £80,001-£100,000 income bracket at 23%). On the other hand, the ‘£100,001 or more’ income bracket has the lowest percentage of those that believed that cost implications were ‘always’ considered (3%), whilst the income brackets of ‘less than £15,000’ and £15,001-£30,000 have the highest percentage of individuals that believed that cost implications were ‘always’ considered (11% and 10% respectively).



- **2.7 Ethnicity:** Those that identified to be from mixed/multiple ethnic groups or other ethnic groups have the highest percentage of individuals that felt cost implications are 'always' considered by NHS professionals (18% and 20% respectively). Those identifying as Black African/Caribbean/Black British have the highest percentage of individuals that felt that cost implications were 'never' considered (23%) across the ethnic groups, whilst those identifying as White have the highest percentage of individuals that felt that cost implications were 'rarely' considered (32%).

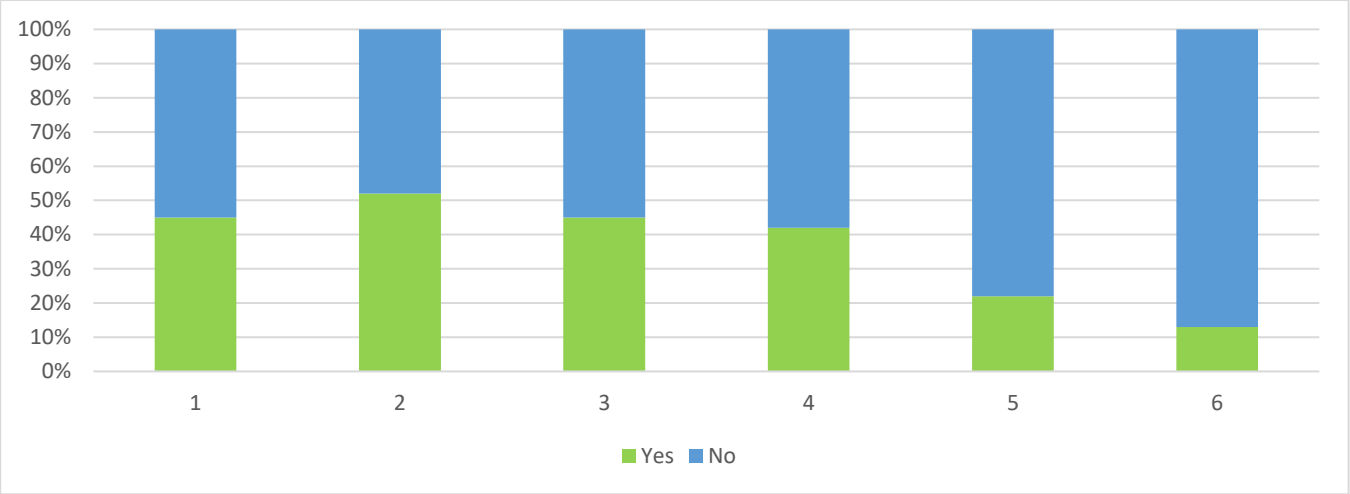
Q3. Have you ever not accessed an NHS health and social care service or amenity due to cost implications (such as time away from work, distance from your house, childcare responsibilities, parking etc.)?

- **3.1 Total sample:** Whilst the majority disagreed with not having accessed an NHS service or amenity due to cost implications, a huge percentage (41%) agreed with the statement, identifying cost implication to be a significant barrier in NHS GM.

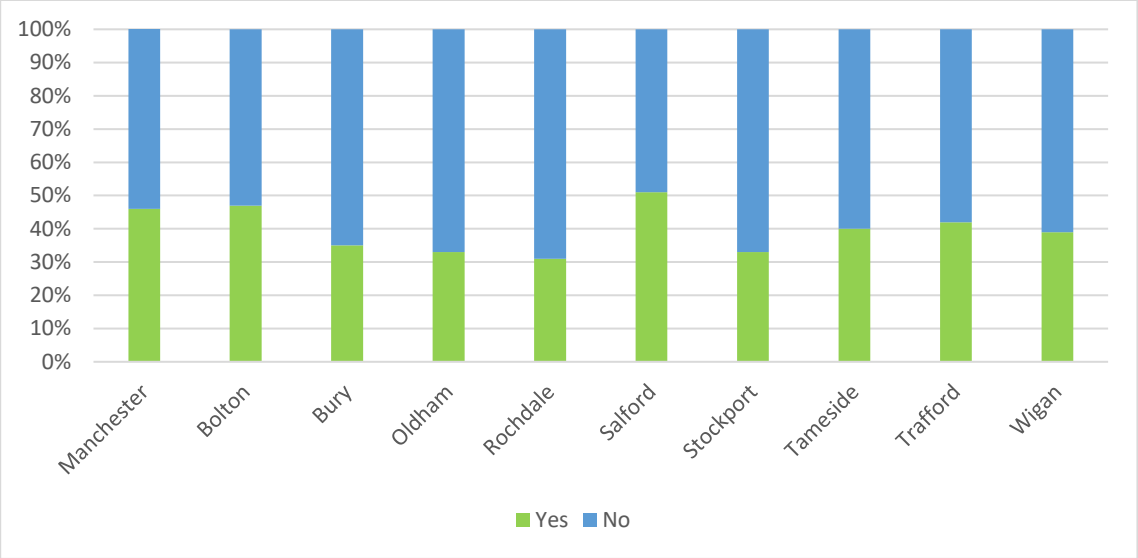


- **3.2 Gender**: Limited difference in results between men and women (max. 1%-point difference), with results almost identical to that of the total sample.

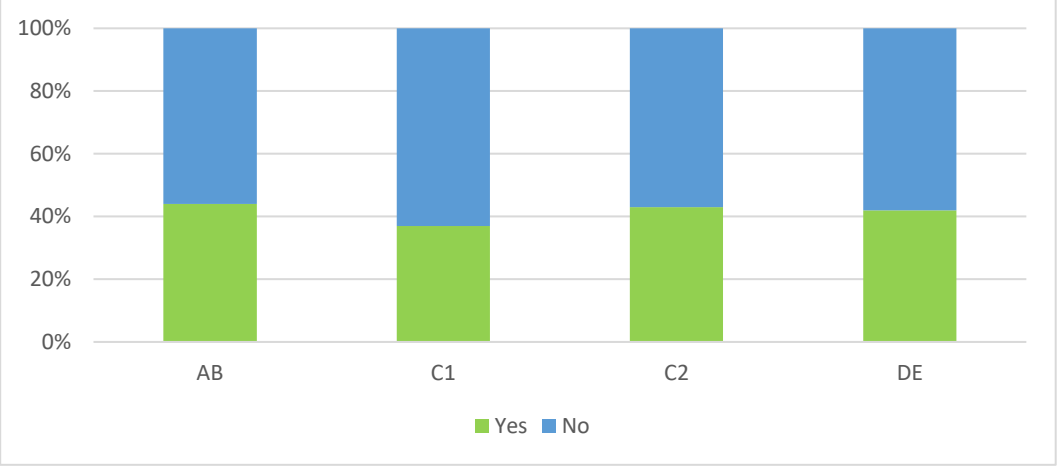
- **3.3 Age**: Overall, as the age increases, the percentage of individuals that have not accessed an NHS service or amenity due to cost implications decreases – the 25-34 age group has the highest percentage of individuals identifying to having not accessed a service/amenity due to cost implications (52%), whilst the 65+ age group has the lowest percentage of individuals facing such circumstance (13%).



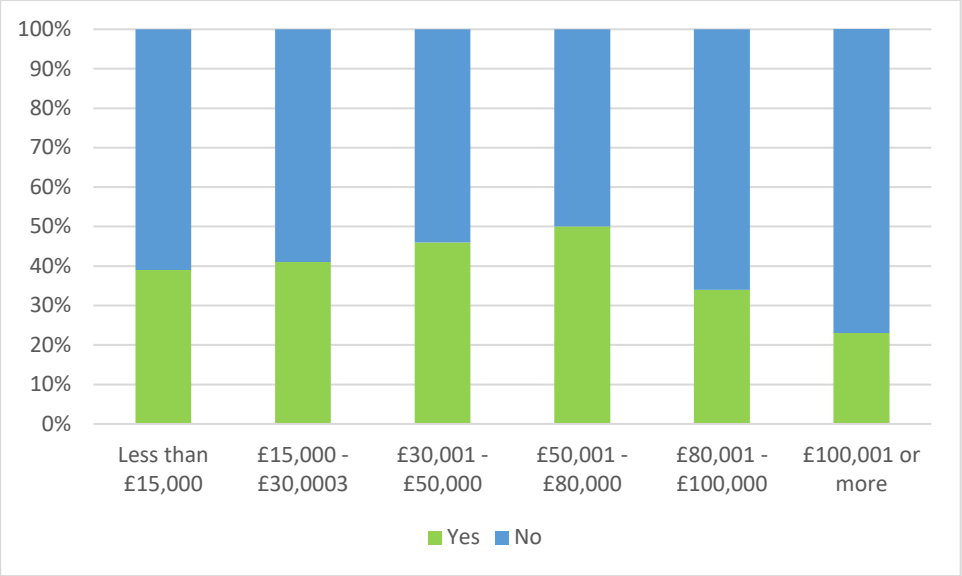
- **3.4 Local Authority Area:** The trend across local authorities follows closely the general trend seen across the whole sample. Salford has the highest percentage of individuals that have not accessed an NHS service or amenity due to cost implications (51%), being the only local authority with the majority having their accessibility impacted by cost implications. Rochdale, on the other hand, has the lowest percentage of individuals having been impacted by such accessibility issues (31%).



- **3.5 SEG (Socio-Economic Grade):** The trend across local authorities follows closely the general trend seen across the whole sample – with only a (maximum) percentage point difference between the values of 3% across the grades for the percentage of individuals having their accessibility to NHS services/amenities being impacted by cost implications. Greater difference can be seen through analysing the household income as a socio-economic indicator instead (see 3.6).



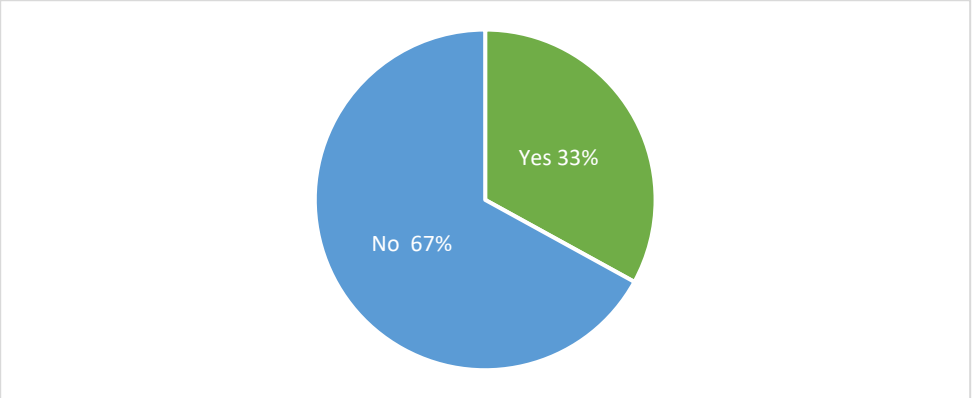
- **3.6 Household Income:** The £50,001-£80,000 household income bracket has the highest percentage of individuals which identified having their accessibility to NHS services/amenities being impacted by cost implications (50%), whilst the '£100,001 or more' income bracket has the lowest percentage facing such circumstance (23%).



- **3.7 Ethnicity:** Fewer individuals who identified as White stated that their accessibility to NHS services/amenities had been impacted by cost implications (39%) compared to those that identified as non-white – with 50% of Mixed/multiple ethnic groups, Black African/Caribbean/Black British, and other Ethnic groups identifying not having accessed an NHS health and social care service or amenity due to cost implications, and 54% of Asian/Asian British also not doing so.

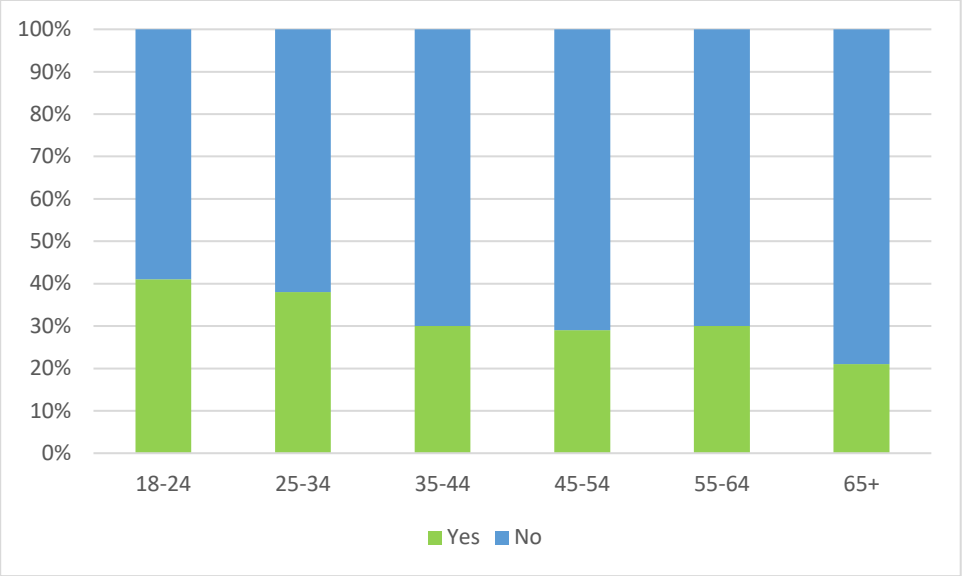
Q4. Are you aware of any NHS schemes or assistance (such as with prescription costs, funded transport, vouchers etc.) that Greater Manchester residents may be able to access to get support with health and social care costs?

- **4.1 Total sample:** Two-thirds of all respondents could not identify any NHS schemes or assistance (such as with prescription costs, funded transport, vouchers etc.) that Greater Manchester residents may be able to access to get support with health and social care costs.

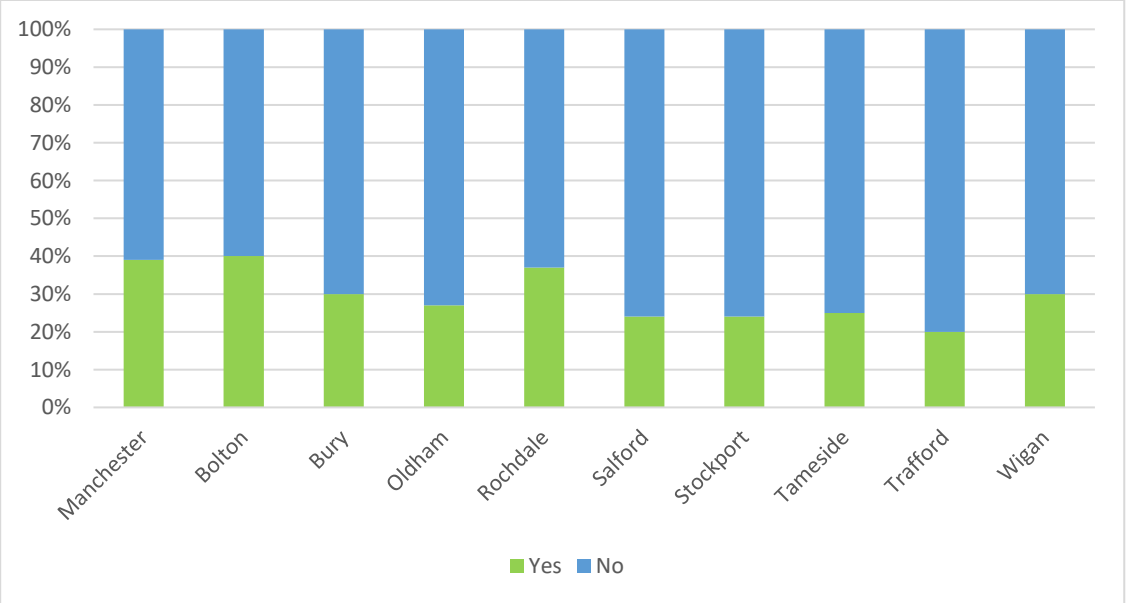


- **4.2 Gender**: Limited difference in results between men and women (max. 2%-point difference), with results almost identical to that of the total sample.

- **4.3 Age**: As age increases, the awareness of NHS schemes or assistance that Greater Manchester residents may be able to access to get support with health and social care costs decreases. The 18-24 year-olds age group has the highest percentage of those who are aware of NHS schemes or assistance that support with health and social care costs (41%), whilst the 65+ age group has the lowest percentage (21%).



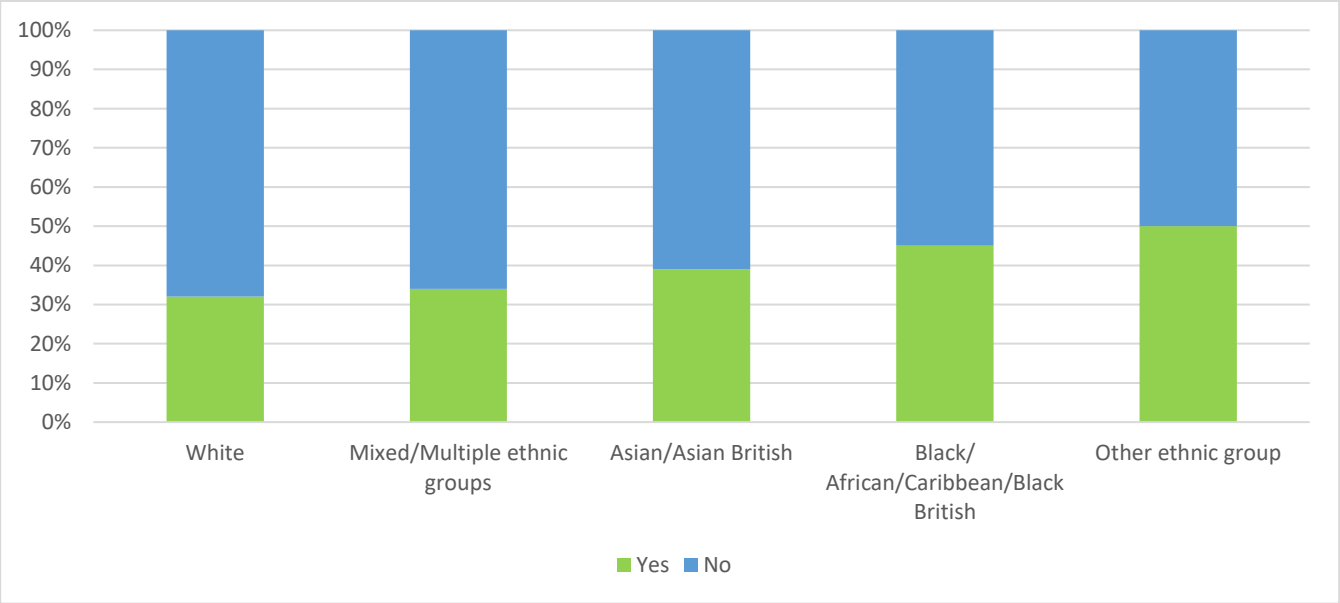
- **4.4 Local Authority Area:** Bolton and Manchester have the highest percentage of individuals that are aware of NHS schemes or assistance that Greater Manchester residents may be able to access to get support with health and social care costs (40% and 39% respectively), whilst Trafford has the lowest percentage of those who are aware (20%).



- **4.5 SEG (Socio-Economic Grade):** The trend across SEGs follows closely the general trend seen across the whole sample – only a (maximum) percentage point difference of 3% across the grades – with an average of 33% of individuals being aware of NHS schemes or assistance that Greater Manchester residents may be able to access to get support with health and social care costs across the SEGs.

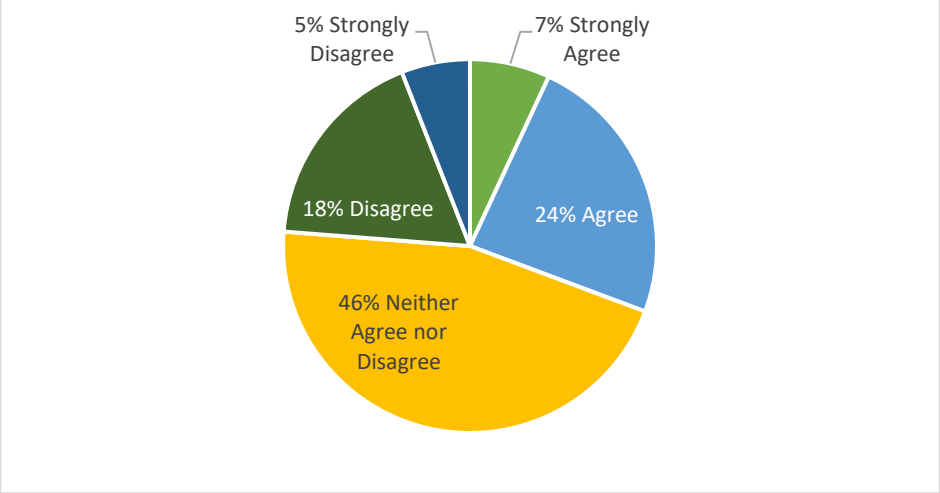
- **4.6 Household Income:** The trend across household incomes follows closely the general trend seen across all the sample, with an average of around a third (34%) of individuals being aware of NHS schemes or assistance across the income brackets.

- **4.7 Ethnicity:** In general, those who identified as White being the least aware of any NHS schemes or assistance (32%) compared to other ethnicities, with those identifying with other ethnic groups category having the greatest awareness (50%), followed by those in Black African/Caribbean/Black British (45%), Asian/Asian British (39%), and then mixed/multiple ethnic groups (34%).

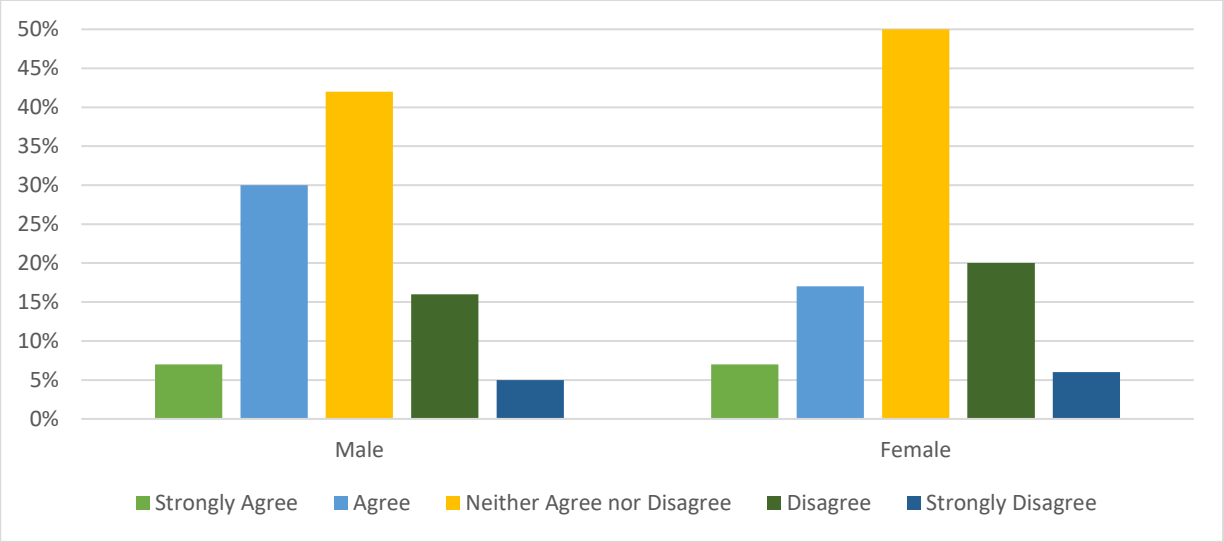


Q5. To what extent do you agree that NHS health and social care services in Greater Manchester have become more accessible to those facing financial hardships over the past two years?

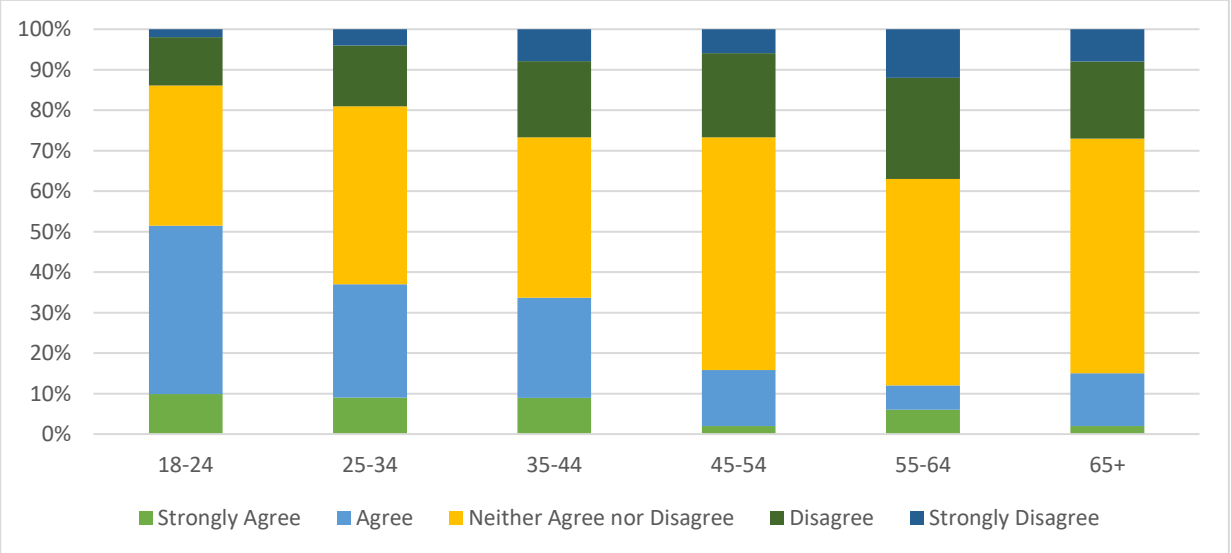
- **5.1 Total sample:** Overall, regarding the statement that NHS health and social care services in Greater Manchester have become more accessible to those facing financial hardships over the past two years, 31% generally agree (i.e. 7% strongly agree and 24% agree), 46% neither agree nor disagree, and 23% generally disagree (i.e. 5% strongly disagree and 18% disagree).



- **5.2 Gender**: A greater percentage of men (30%) agree to NHS health and social care services in Greater Manchester becoming more accessible to those facing financial hardships over the past two years than the percentage of women that agree to the statement (17%). Inversely, a greater percentage of women did not agree with the statement (20%) compared to men (16%). A greater percentage of women neither agreed nor disagreed to the statement (50%) compared to men (42%) – yet this response makes up the majority for both categories.

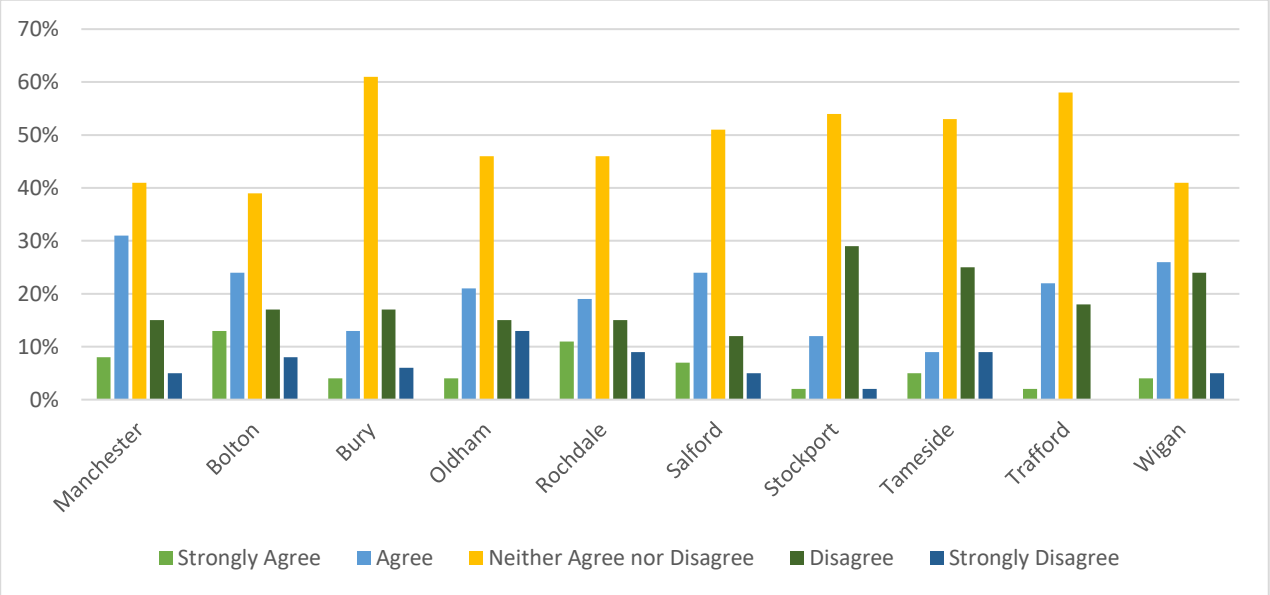


- **5.3 Age**: The 18-24 age group has the highest percentage of individuals that 'strongly agree' and 'agree' that NHS health and social care services in Greater Manchester have become more accessible to those facing financial hardships over the past two years (10% and 42% respectively) amongst the age brackets. On the other hand, the age group of 55-64 has the highest percentage of individuals that both 'disagree' and 'strongly disagree' (25% and 12% respectively) amongst all the age groups. However, the 'neither agree nor disagree' make the majority of all age groups (bar 18–24-year-olds group).

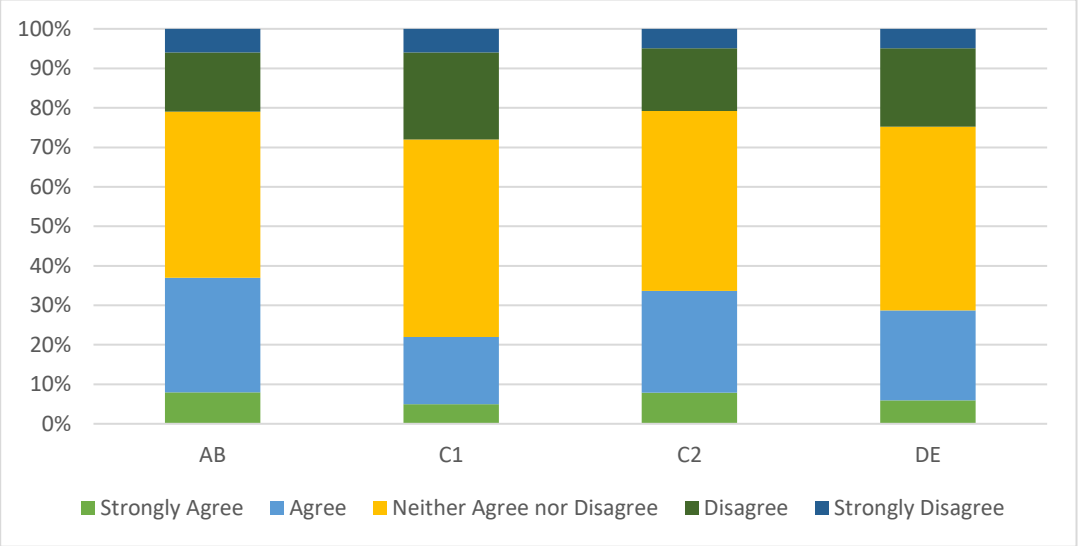


- **5.4 Local Authority Area:** The local authorities with the highest percentage of individuals that strongly agree and agree with the statement are Bolton (13%) and Manchester (31%) respectively. Stockport and Oldham have the highest percentage of those that disagree (29%) and strongly disagree (13%) respectively. However, as is the

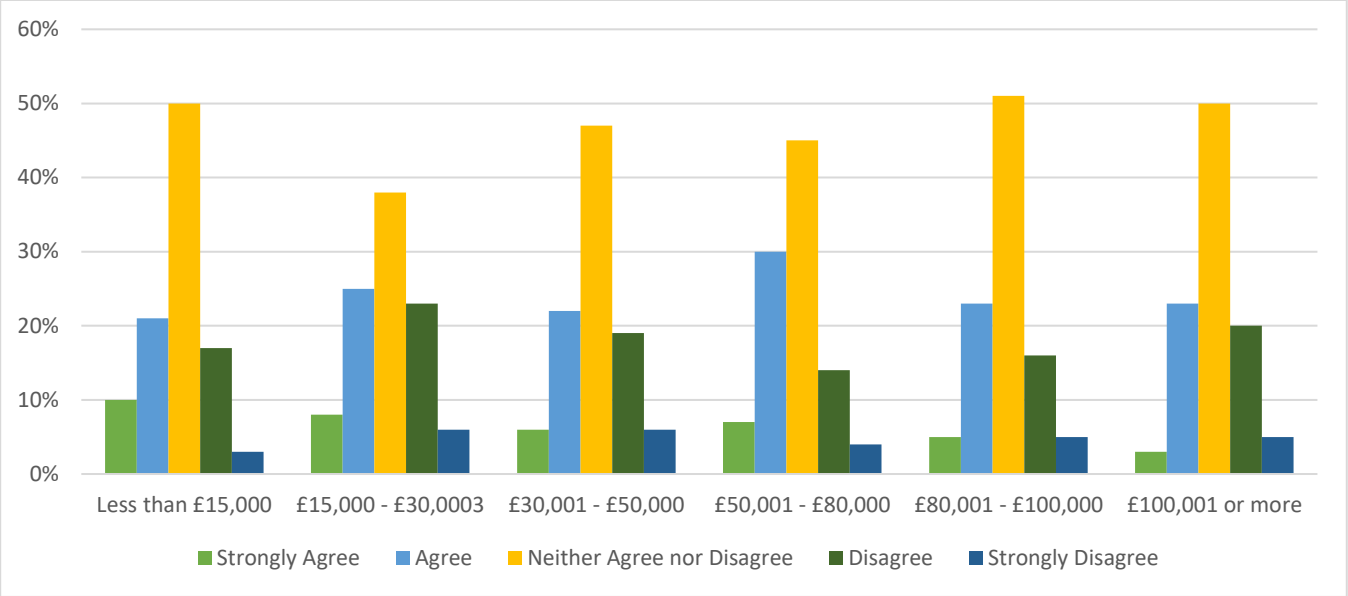
trend in the whole sample, the majority within each local authority stated that they neither agreed nor disagreed that NHS health and social care services in Greater Manchester have become more accessible to those facing financial hardships over the past two years.



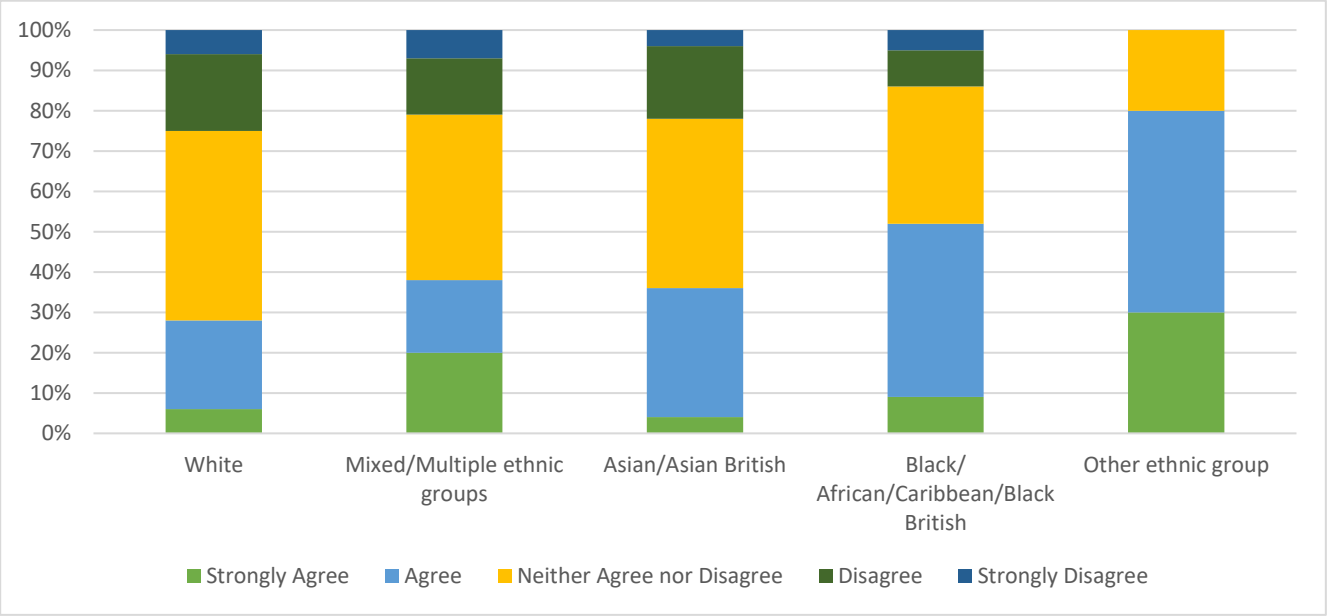
- **5.5 SEG (Socio-Economic Grade):** The trend across SEGs (i.e. average percentages) follows closely the general trend seen across the whole sample (see 5.1).



- **5.6 Household Income:** The trend across income brackets follows closely the general trend (i.e. average percentages) seen across the whole sample (see 5.1).

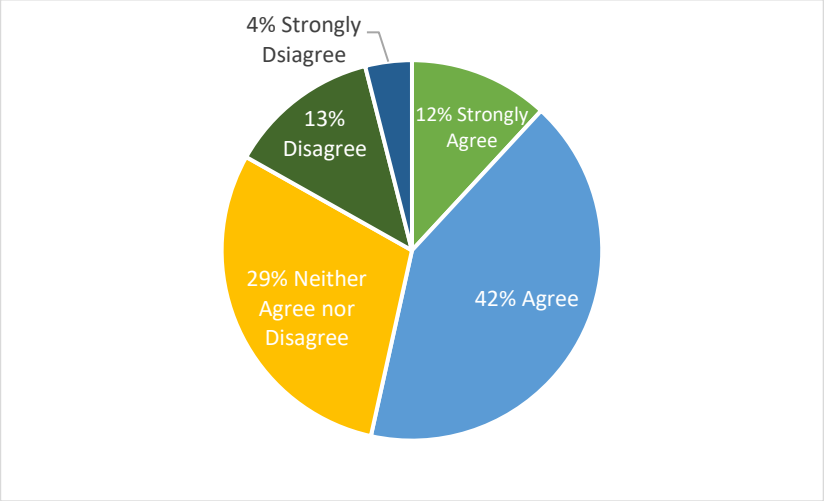


- **5.7 Ethnicity:** In general, those who identified as White are least likely to agree that NHS health and social care services in Greater Manchester have become more accessible to those facing financial hardships over the past two years compared to other ethnicities. 28% of those that identified as White agree to the statement to some extent (i.e. agreed and strongly agreed) compared to those of mixed/multiple ethnic groups (38%), Asian/Asian British (36%), Black African/Caribbean/Black British (52%), and other ethnic groups (80%).



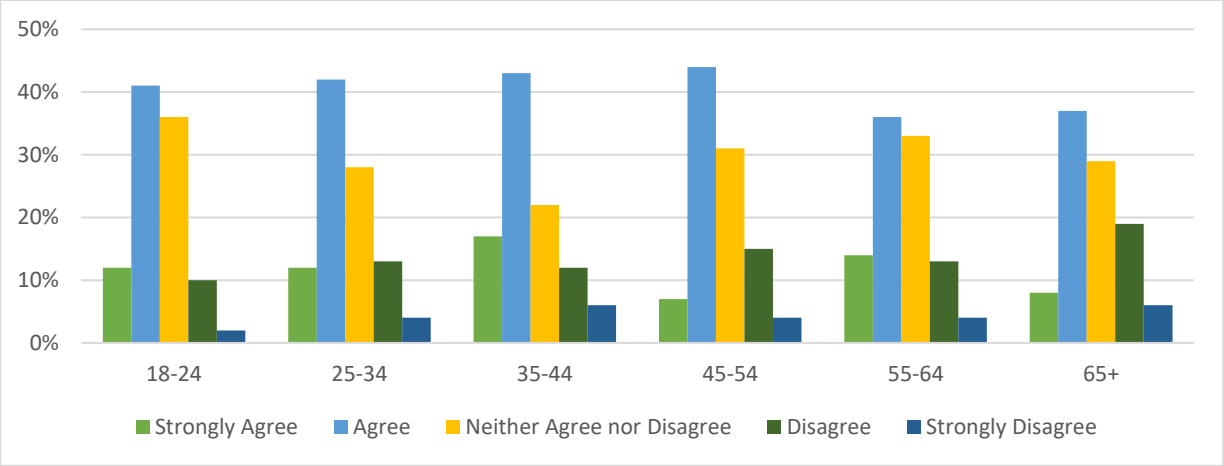
Q6. To what extent do you agree that NHS health and social care professionals have some responsibility to assist patients regarding their financial hardships?

- **6.1 Total sample:** Over half of all respondents (54%) agree to some extent (i.e. either agree or strongly agree) that NHS health and social care professionals have the responsibility to assist patients regarding their financial hardships, whilst only 17% disagree to some extent (i.e. disagree or strongly disagree). Almost a third neither agree nor disagree.

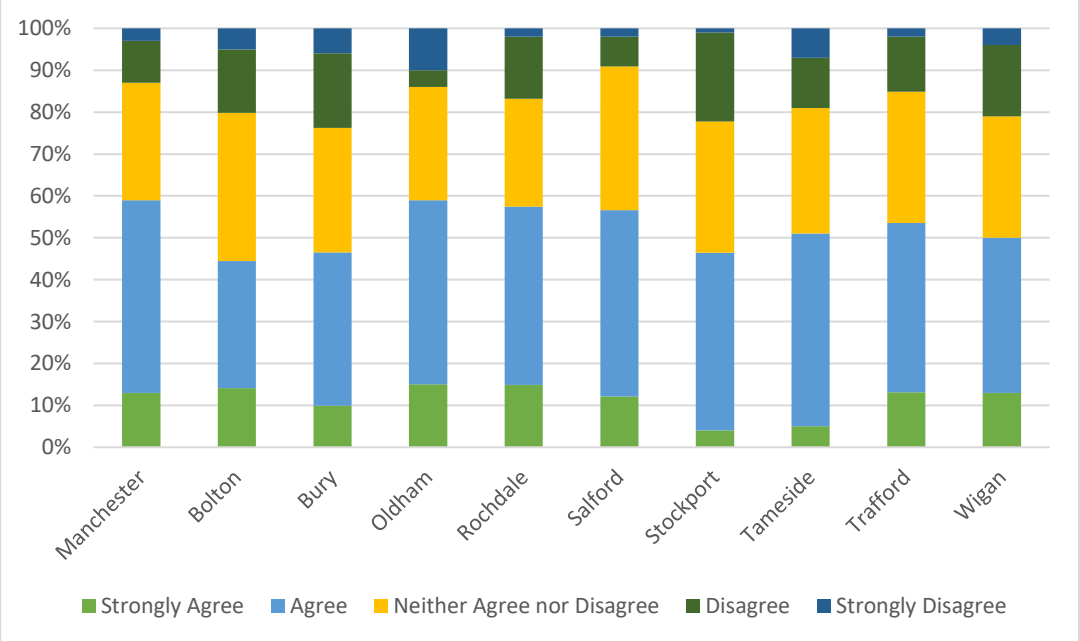


- **6.2 Gender**: Men were more likely to agree to some extent (i.e. strongly agree or agree – at 13% and 43% respectively) that NHS health and social care professionals have the responsibility to assist patients regarding their financial hardships than women (who strongly agree or agree at 11% and 40% respectively). Inversely, the pattern continues, with men being less likely to disagree with the statement (11%) than women (15%).

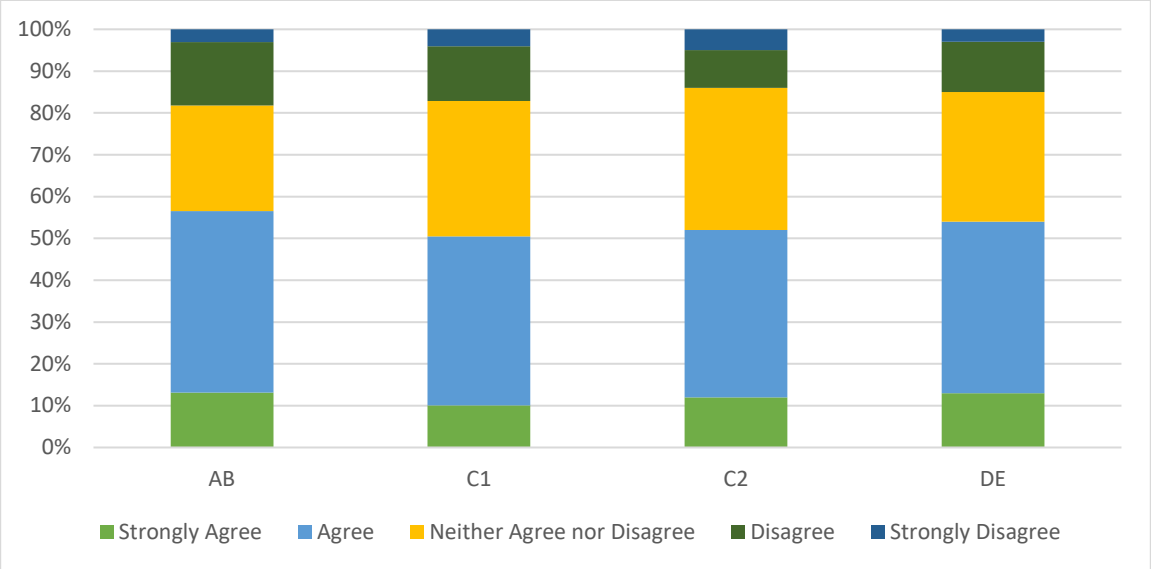
- **6.3 Age**: Overall, the predominant response across all age-groups consisted of agreeing to the sentiment that NHS health and social care professionals have some responsibility to assist patients regarding their financial hardships. The 35–44 age group had the highest percentage of individuals that strongly agree (17%) and agree (43%) to the statement amongst all age categories (second only to the 45–54-year-old age group at 44%). On the other hand, the 65+ age group has the highest percentage of individuals that generally disagree (19% disagreeing and 6% strongly disagreeing) across the age groups.



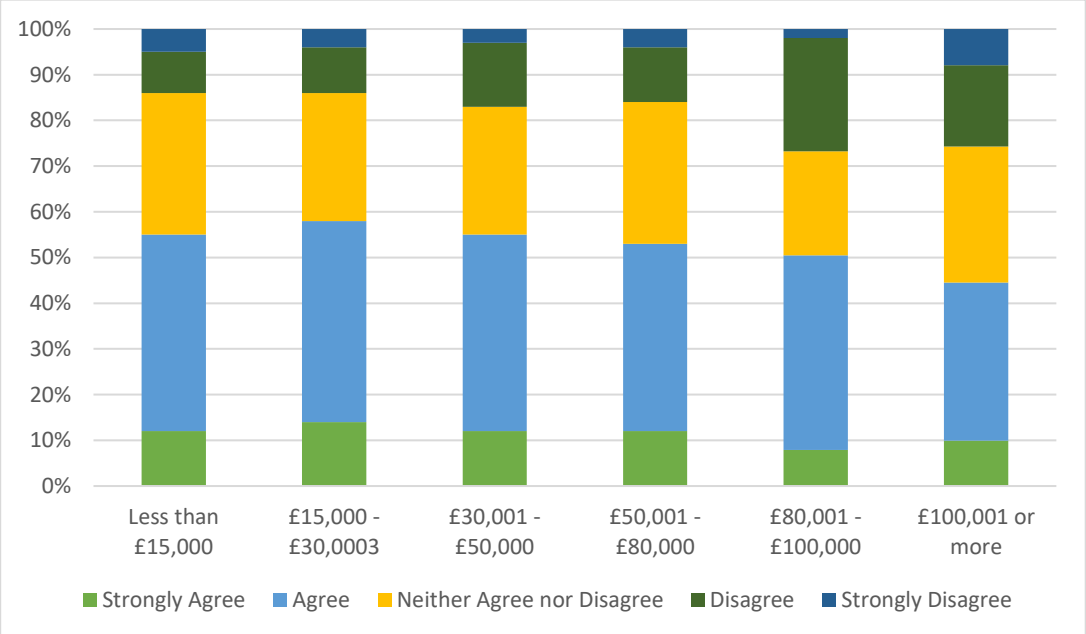
- **6.4 Local Authority Area:** Across all local authorities (bar Bolton), the most popular response, amongst all responses, to the statement is that of 'agree'. Oldham and Rochdale have the highest percentages of individuals agreeing (both strongly agreeing – both 15% - and agreeing – 44% and 43% respectively) to the need of NHS professionals have some responsibility to assist patients regarding their financial hardships. On the other hand, Stockport has the highest percentage of individuals that disagree with the statement (21%).



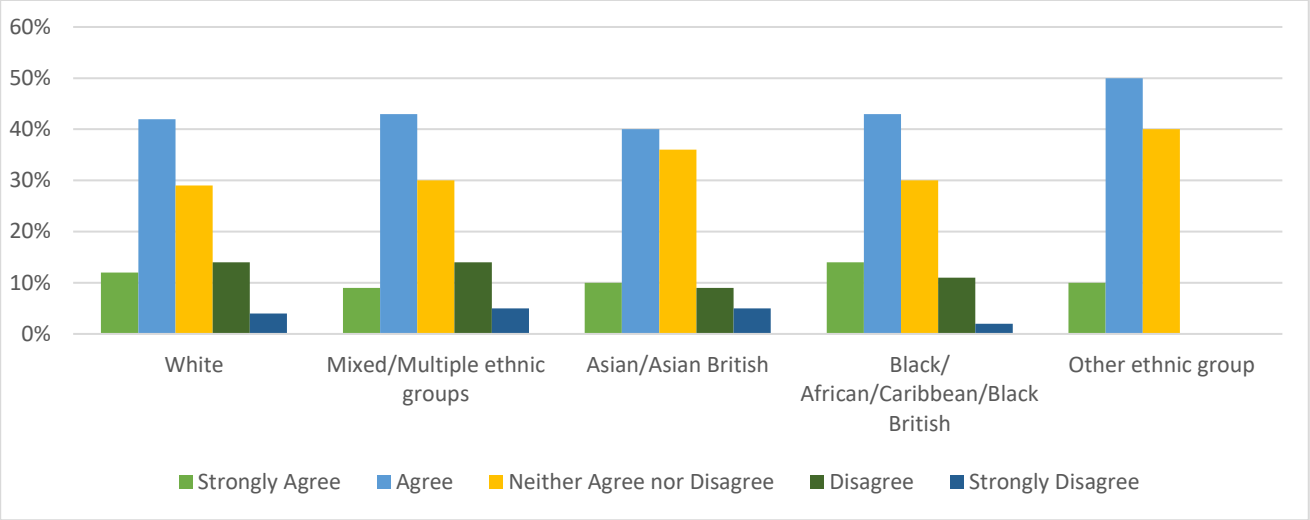
- **6.5 SEG (Socio-Economic Grade):** The trend across SEGs (i.e. average percentages) follows closely the general trend seen across the whole sample (see 6.1).



- **6.6 Household Income:** The trend across income brackets (i.e. average percentages) follows closely the general trend seen across the whole sample (see 6.1).

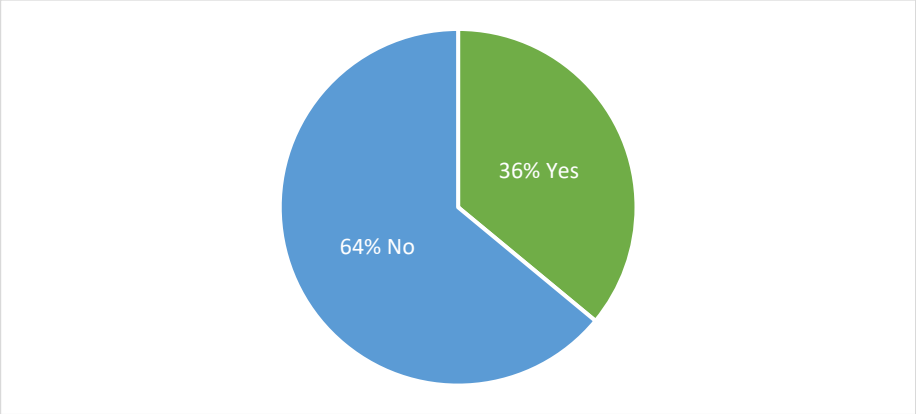


- **6.7 Ethnicity:** Across all ethnicities, the most popular response to the statement is that of 'agree' amongst all responses, with at least 40% of respondents from each ethnicity agreeing with the statement. Those from a White or mixed/multiple ethnic groups have the highest percentage of those who disagree (both 14%), whilst those categorised in other ethnic group have no respondents that identify to disagree with the statement.

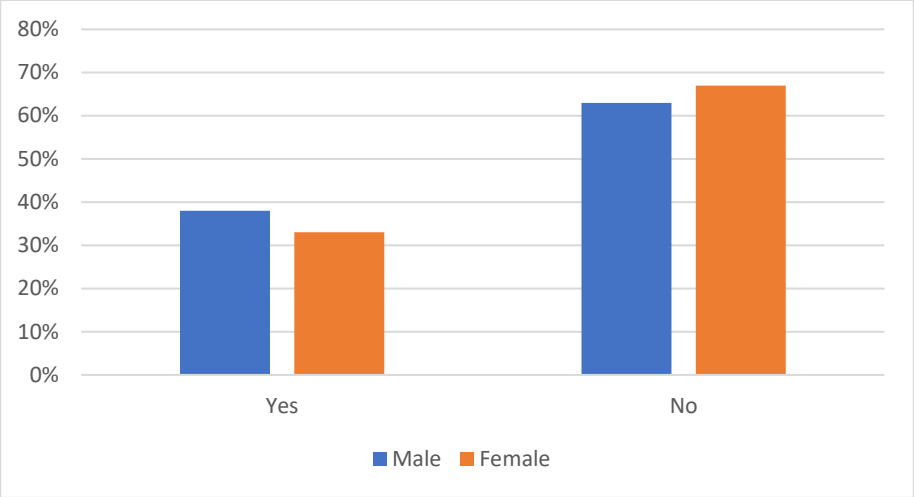


Q7. If you had concerns about your household's financial situation, would you raise these with NHS health and social care professionals?

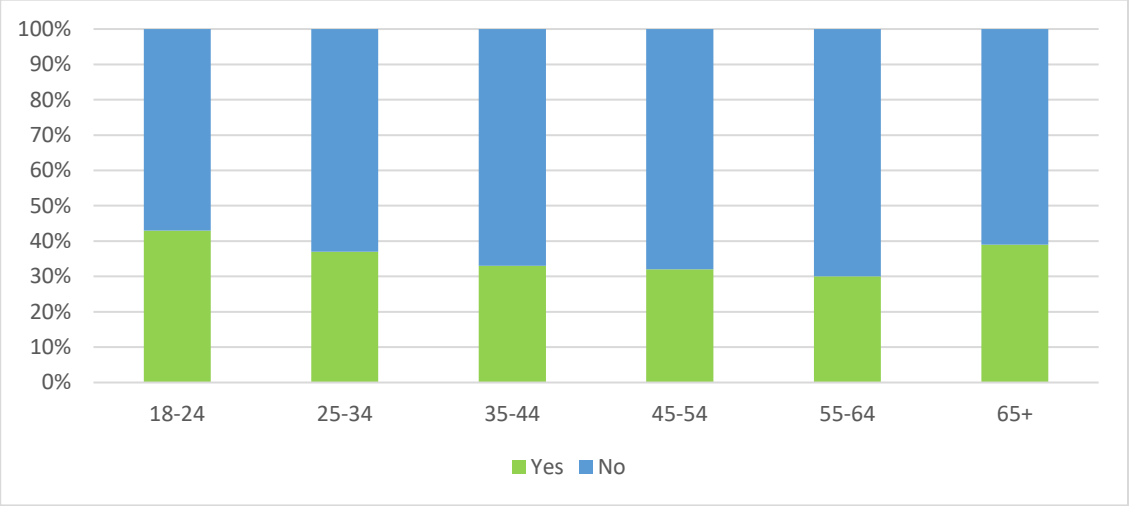
- **7.1 Total sample:** Almost two-thirds of all respondents (64%) stated that they would not raise concerns about their household's financial situation with NHS health and social care professionals.



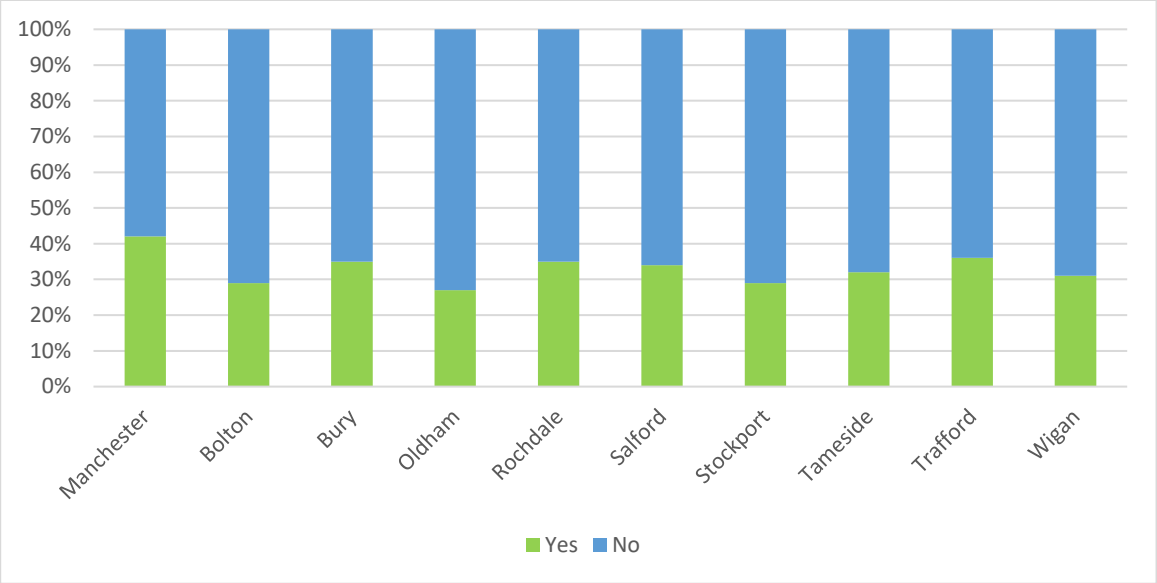
- **7.2 Gender**: The overall trend across the genders followed that of the total sample (as seen in 7.1), however, a greater percentage of men (38%) would share their financial concerns with NHS professionals than women (33%).



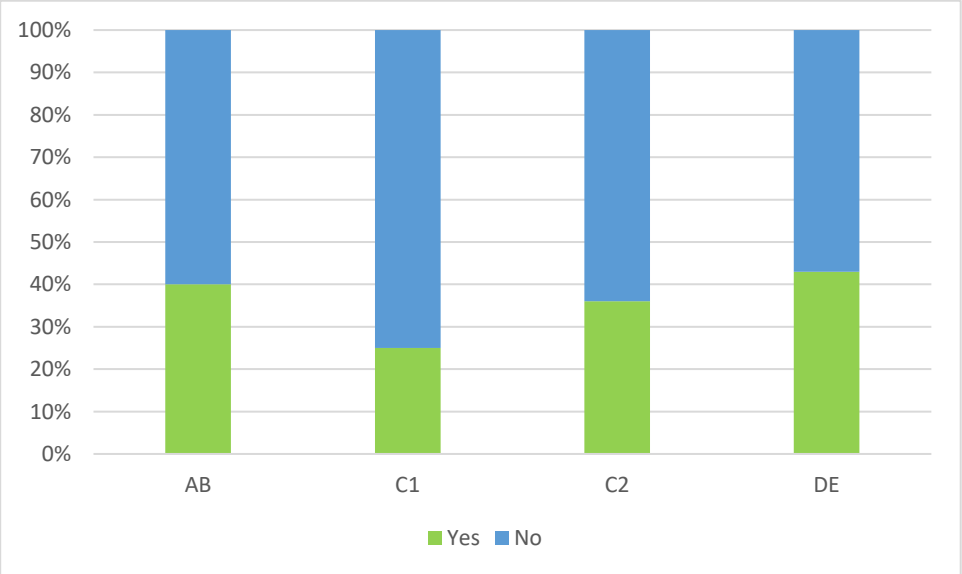
- **7.3 Age**: From the age group of 18-24 till 55-64, as the age increases, the percentage of individuals willing to share concerns about their household's financial situation with an NHS professional decreases; with 43% of individuals in the 18–24-year-old age group willing to share, compared to 30% in the 55-64 year-old age group. However, individuals in the 65+ age group had a higher percentage of individuals (39%) willing to share their financial concerns with NHS professionals than all other age groups, bar 18–24-year-olds.



- **7.4 Local Authority Area:** Across all local authorities, a greater percentage of individuals said 'no' to sharing their financial struggles with NHS professionals (like the trend seen in the whole sample for the question); Oldam having the highest percentage not willing to share (73%) and Manchester having the lowest percentage (58% - yet still maintaining a majority in those that responded 'no' to the statement).

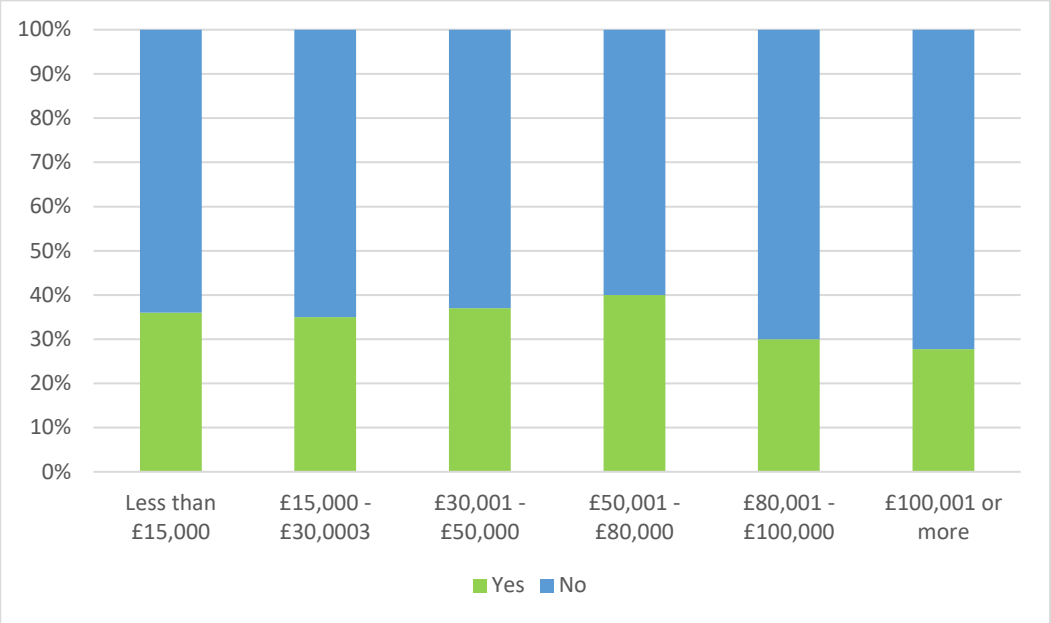


- **7.5 SEG (Socio-Economic Grade):** Across all SEGs, a greater percentage of individuals said ‘no’ to sharing their financial struggles with NHS professionals (like the trend seen in the whole sample for this question). Those in C1 have the highest percentage of individuals unwilling to share their financial struggles with NHS professionals (75%), whilst those in DE having the lowest percentage of individuals unwilling to do so (57% - yet still maintaining a majority in those that responded ‘no’ to the statement).

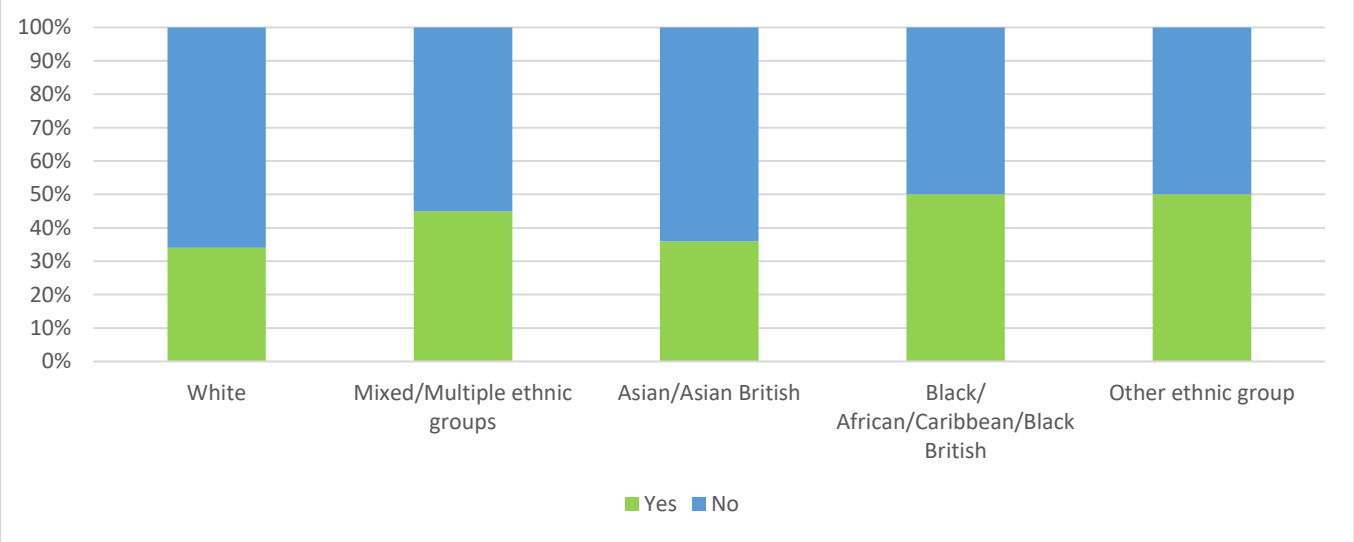


- **7.6 Household Income:** Similar to the trend seen in SEGs (and across the whole sample for this question), a greater percentage of individuals said ‘no’ to sharing their financial struggles with NHS professionals across all income brackets, with at least

60% saying ‘no’ to the statement – in the £50,001-£80,000 income bracket – to up to 73% saying so – in the ‘£100,001 or more’ income bracket.



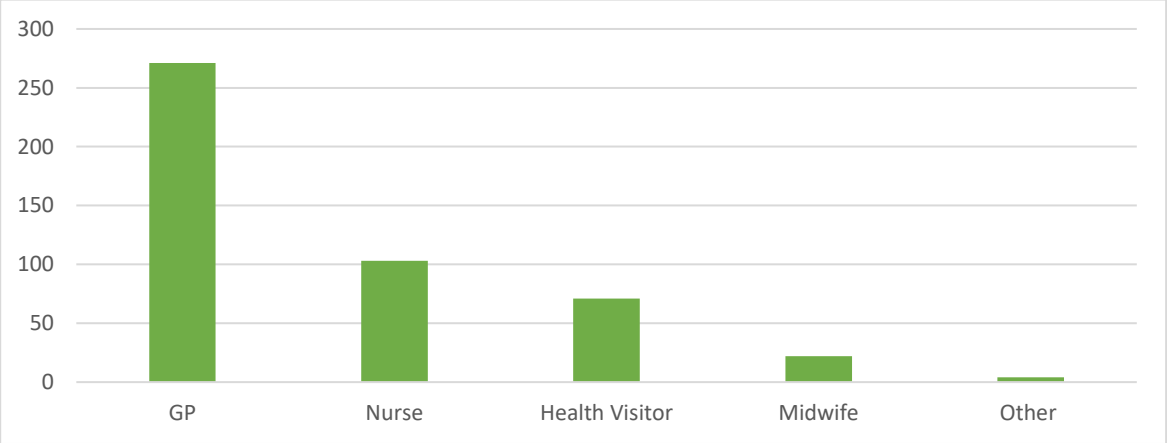
- **7.7 Ethnicity:** The majority of individuals who identified as either White, Mixed/multiple ethnic backgrounds, or Asian/Asian British stated that they would not raise their household financial concerns with NHS professionals – with those identifying White having the highest percentage (66%) amongst the three groups – whilst those that who identified as Black African/Caribbean/Black British and Other ethnic group had an equal percentage of individuals willing to share their financial concerns with NHS professionals to those not willing to share (i.e. 50%).



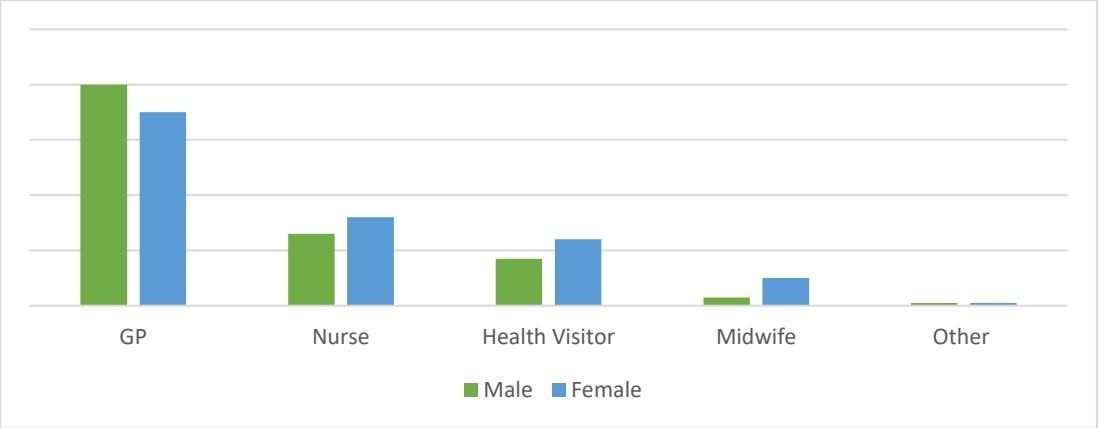
Q8. You said if you had concerns about your household's financial situation, you would raise these with NHS health and social care professionals (based on the previous question). Who would you feel most comfortable discussing your financial concerns with?

Number of respondents (for this question): 357. It should be noted that this question (unlike any other question in this survey) allowed respondents to choose multiple answers.

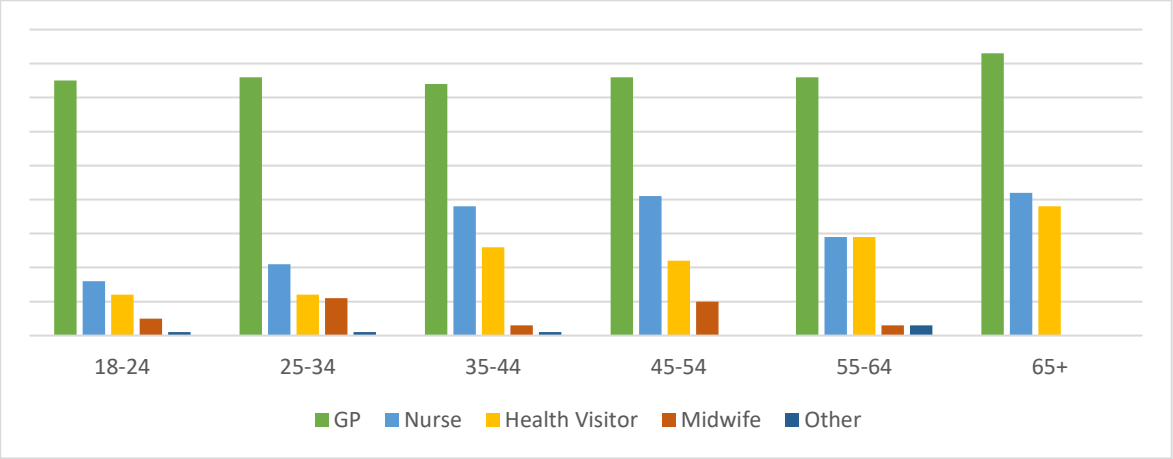
- **8.1 Total sample:** In this question, where respondents could select multiple options, the most popular answer – regarding which health and social care professional they would feel most comfortable with raising their household concerns – was GP, with 271 respondents (76% of the sample), followed by Nurse with 103 respondents (29%), health visitor (71 respondents – 20%), then midwife (22 respondents – 6%).



- **8.2 Gender**: The general trend regarding the preference of the type of NHS healthcare professional that both genders feel comfortable in confiding their financial struggles with matches that of the general population – with GP being in lead, followed by nurse, health visitor, then midwife. However, the level of popularity for each option varies amongst the genders, with GP being the more popular amongst men (with 80% of men choosing the option) compared to women (with 70% of women choosing the option). On the other hand, the choices of nurse, health visitor, and midwife were more popular amongst women in comparison to men (given the respective percentage of individuals that selected the option in their gender).

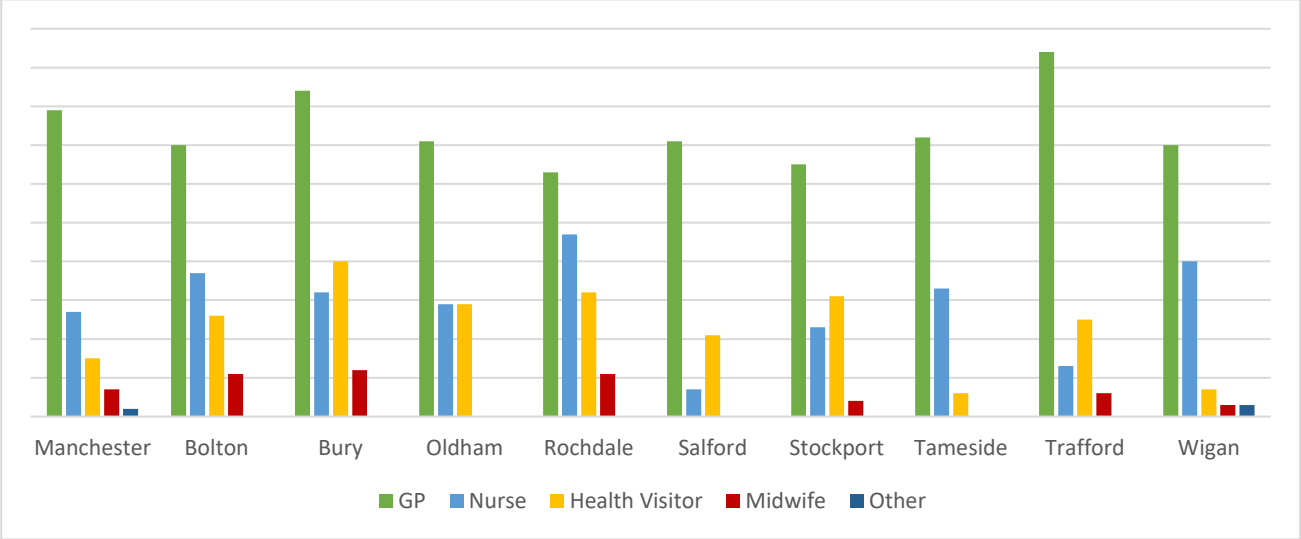


- **8.3 Age**: The general trend regarding the preference of the type of NHS healthcare professional amongst all age groups matches that of the general population – with GP being in lead, followed by nurse, health visitor, then midwife. However, the level of popularity for each option varies amongst the age brackets. An average of 75% of individuals choosing a GP as the healthcare professional they would be most comfortable confiding their financial struggles across each age group bar the 65+ age group (where a higher percentage of 83% choosing a GP as a healthcare professional they would feel comfortable discussing their household financial worries with). The 45–54-year-old age group had the highest percentage of individuals choosing a nurse (41%) amongst all age groups; the 25-34 year-old age group having the highest percentage of individuals choosing a mid-wife (11%); the 65+ age group having the highest percentage choosing a health visitor (38%).

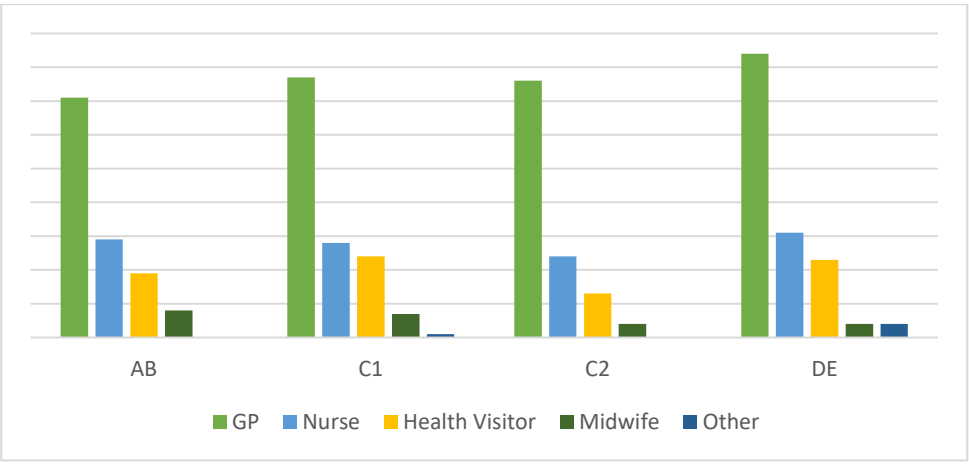


- **8.4 Local Authority Area:** Across all local authorities, the most popular answer was that of a GP, with Trafford having the highest percentage of individuals choosing that option (94%) across the local authorities and Rochdale having the lowest percentage (63%) (whilst still being the most popular answer within the local authority). The local

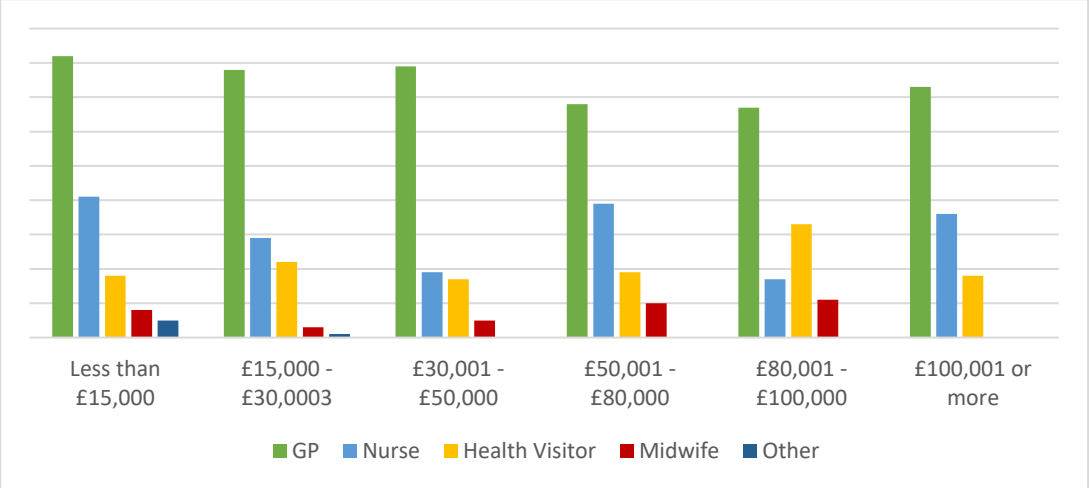
authority with the highest percentage of individuals that chose a nurse as an option was Rochdale (47%), whilst the local authority with the lowest percentage was Salford (7%). For the option of a health visitor, Bury had the highest percentage choosing the option (40%) whilst Tameside had the lowest percentage (6%). Oldham, Salford, and Tameside had no individuals (0%) that chose midwife as an option for comfortably discussing their financial situation with, whilst Bury had the highest percentage of individuals choosing that profession as an option (12%).



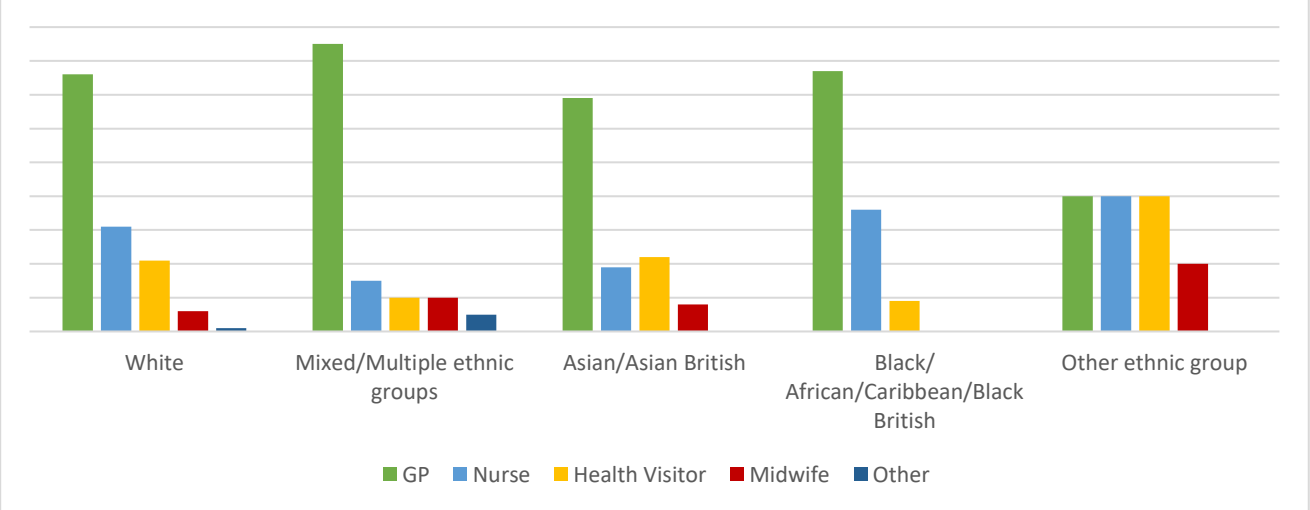
- **8.5 SEG (Socio-Economic Grade):** The general trend regarding the preference of the type of NHS healthcare professional amongst all SEGs matches that of the general population – with GP being in lead, followed by nurse, health visitor, then midwife. However, the level of popularity for each option varies amongst the SEGs. The options for GP and nurse have the highest percentages (amongst the SEGs) in DE (at 84% and 31% respectively), whilst health visitors are most popular in C1 (24%) and midwifes are most popular in AB (8%).



- **8.6 Household Income:** Across all income brackets, the most popular answer was that of a GP, with the 'less than £15,000' income bracket having the highest percentage (at 82%) amongst all income brackets. The second most popular answer amongst all income brackets – bar £80,001-£100,000 – for an NHS professional to share financial concerns with was a nurse, the 'less than £15,000' income bracket having the highest percentage of individuals choosing the option (41%). The options for health visitor and midwife are the most popular in the £80,001-£100,000 income bracket (at 33% and 11% respectively).

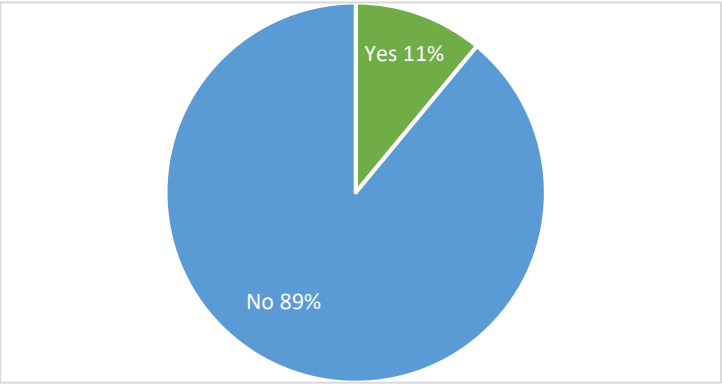


- **8.7 Ethnicity:** Across all ethnicities, the most popular answer is that of a GP, with mixed/multiple ethnic groups having the highest percentage of individuals choosing the option (85%). Other ethnic groups have the highest percentage of those choosing nurse, health visitor, and midwife (40%, 40%, and 20% respectively); on the other hand, the mixed/multiple ethnic groups have the lowest percentage of individuals that chose nurse as an option (15%), Black African/Caribbean/Black British have the lowest percentage of individuals that chose health visitor and midwife as options (9% and 0% respectively).



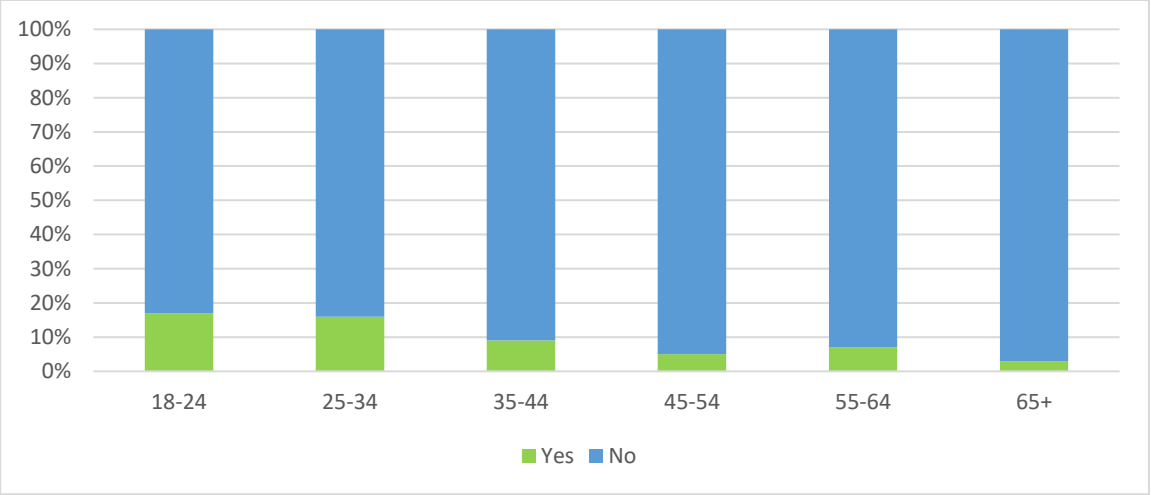
Q9. Have you ever raised concerns about your household's financial situation with an NHS health and social care professional?

- **9.1 Total sample:** A vast majority (89%) state they have never raised concerns about their household's financial situation with an NHS health and social care professional.

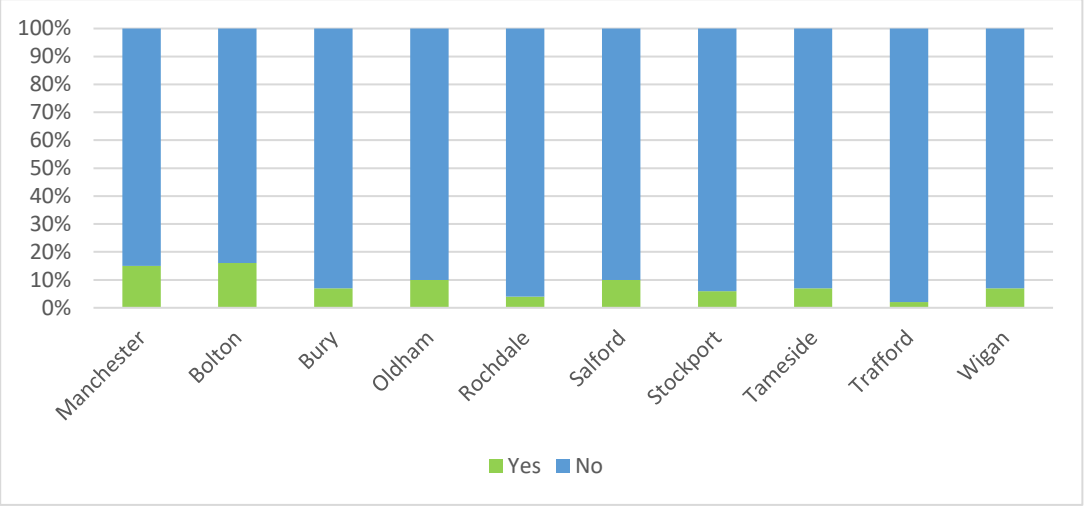


- **9.2 Gender**: The overall trend across the genders followed that of the total sample (as seen in 9.1), however, more men have raised concerns about their household's financial situation with an NHS professional than women have (by 3%).

- **9.3 Age**: Across all age groups, a vast majority of individuals said 'no' to having expressed their financial struggles with NHS professionals, with this percentage incrementally increasing as the age increases. The 18-24 year-old age group has the highest percentage of those who raised concerns about their household's financial situation with an NHS professional (17%) (and inversely having the lowest percentage amongst all age groups regarding voicing their concerns), whilst the 65+ age group has the lowest percentage (3%)of individuals that who raised concerns about their household's financial situation with an NHS professional (with the inverse of having the highest percentage (97%) of not expressing their concerns).



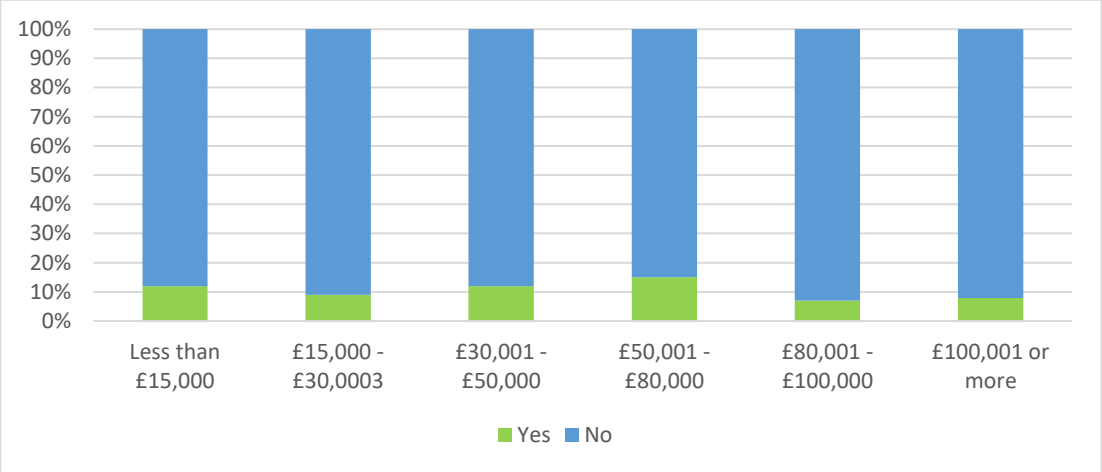
- **9.4 Local Authority Area:** A vast majority of individuals (over 80%) across all local authorities said 'no' to having expressed their financial struggles with NHS professionals. The local authorities with the highest percentage of individuals that expressed their financial concerns to NHS professional are Bolton (16%) and Manchester (15%), whereas the local authority with the lowest percentage of individuals expressing their financial concerns is Trafford (2%).



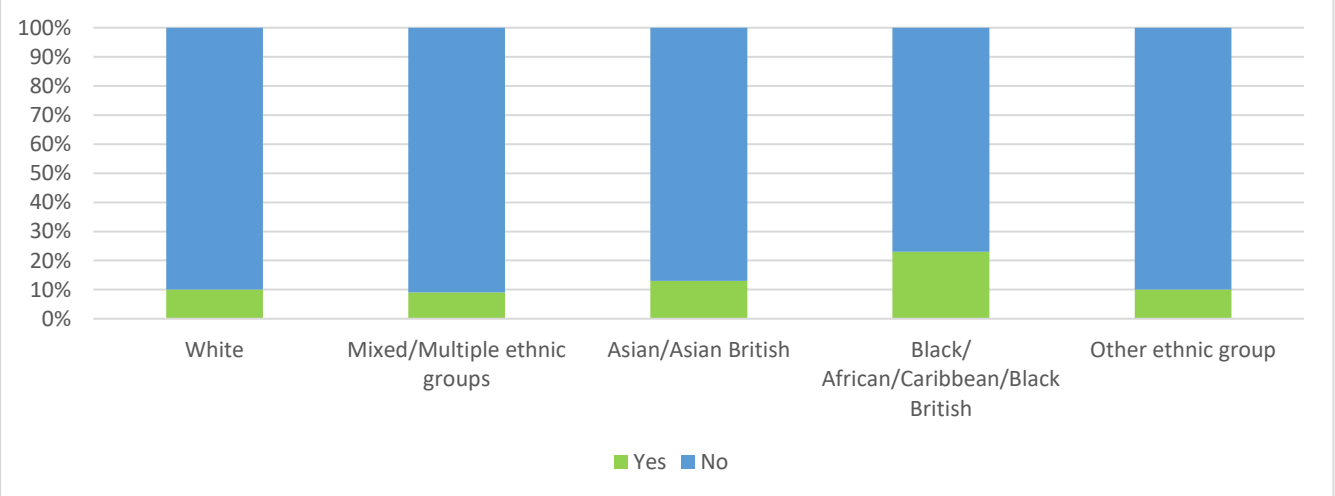
- **9.5 SEG (Socio-Economic Grade):** A vast majority of individuals (over 85%) across all SEGs said 'no' to having expressed their financial struggles with NHS professionals, with the highest percentage of individuals being in C2 (93%) – followed closely by C1 (92%) and DE (10%) – and the lowest percentage in AB (86%).

- **9.6 Household Income:** Similar to the trend seen across SEGs, a vast majority of individuals (over 85%) across all income brackets said 'no' to having expressed their

financial struggles with NHS professionals, with the highest percentage of those that did not raise their concerns being in the £80,001-£100,000 income bracket (93%), whilst the lowest percentage of such individuals being in the £50,001-£80,000 income bracket (85%), followed closely by '£100,001 or more' (8%).

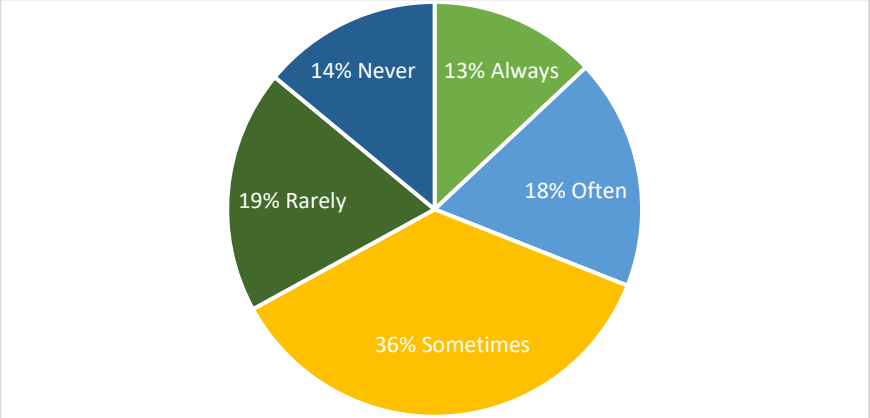


- **9.7 Ethnicity:** Similar to the trend seen across other demographics, the majority of individuals across all ethnicities said 'no' to having expressed their financial struggles with NHS professionals. The ethnic group with highest percentage of individuals that raised their financial struggles with NHS professionals are those that identified as Black African/Caribbean/Black British (23%). The ethnicity that has the lowest percentage of those that shared their financial situation with NHS health and social care professionals are mixed/multiple ethnic groups (9%), followed closely by White (10%) and other ethnic group (10%).



Q10. Do concerns about and/or difficulty with household finances impact your physical and/or mental health?

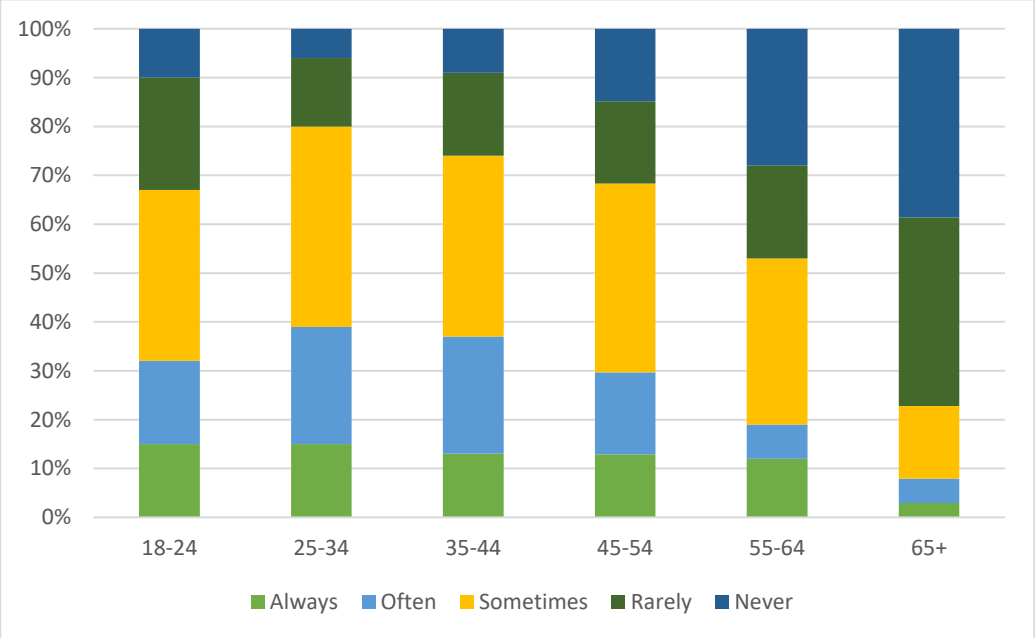
- **10.1 Total sample:** Almost a third (31%) of all individuals state that concerns and/or difficulties with household finances ‘always’ or ‘often’ impacts their physical and/or mental health. Over a third (36%) of individuals state that concerns about and/or difficulties with household finances ‘sometimes’ impacts their physical and/or mental health. A third (33%) state that concerns and/or difficulties with household finances ‘rarely’ or ‘never’ impacts their physical and/or mental health.



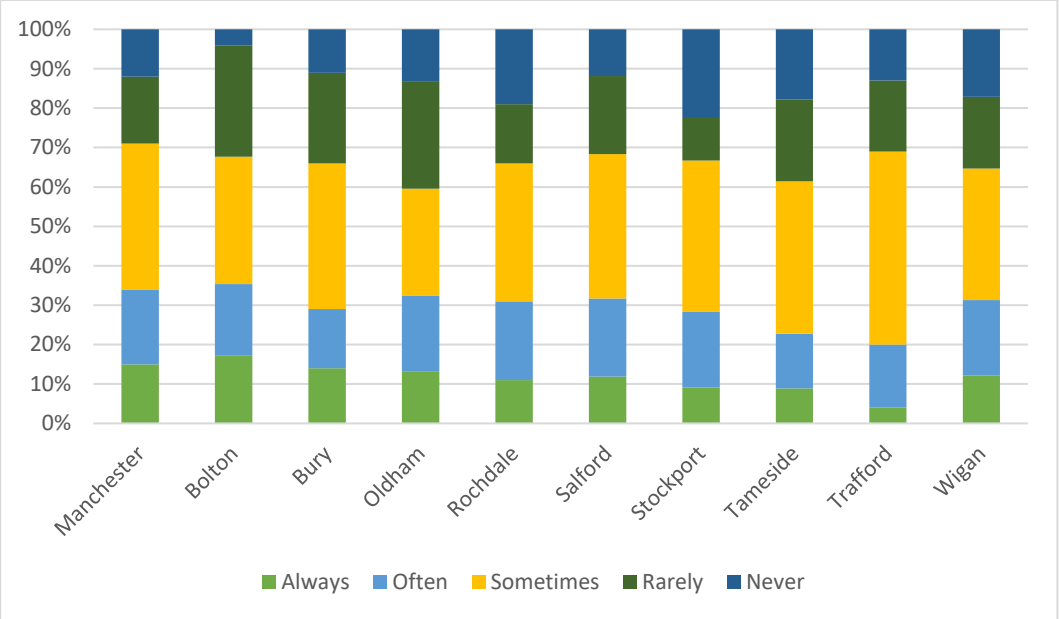
- **10.2 Gender**: The overall trend across the genders follows that of the total sample (as seen in 10.1), however, a greater percentage of women state that concerns and/or difficulties with household finances ‘always’ or ‘sometimes’ impacts their physical and/or mental health (4% and 5% more than men, respectively), whilst a greater percentage of men state that concerns and/or difficulties with household finances ‘often’ or ‘rarely’ impacts their physical and/or mental health (4% and 3% more than women, respectively).

- **10.3 Age**: In general, as the age increases, the percentage of individuals that believe that concerns and/or difficulties with household finances impacts their physical and/or mental health decreases. The age groups 18-24- and 25–34 age groups have the highest percentage of individuals that believe that concerns and/or difficulties with household finances ‘always’ impacts their physical and/or mental health (15%). Similarly, 25–34 age group has the highest percentage that believe that concerns

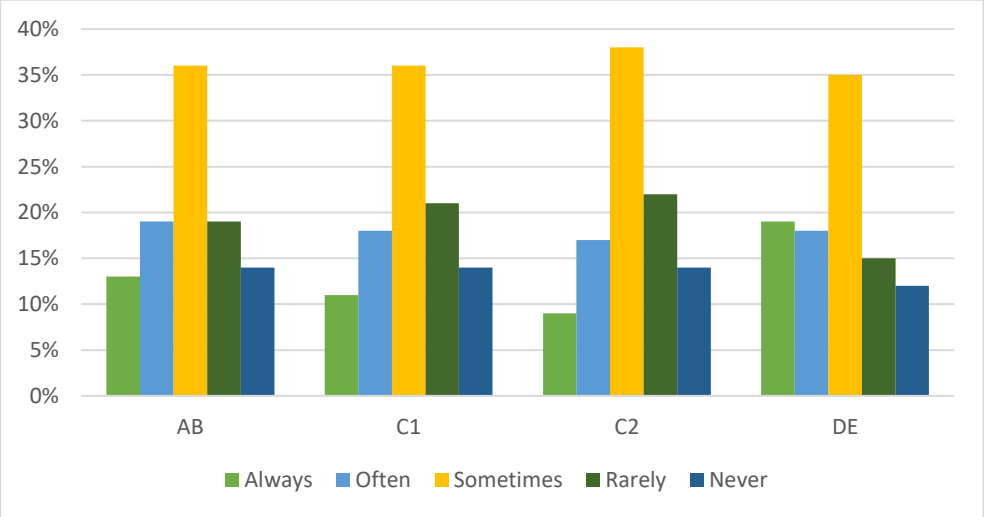
and/or difficulties with household finances ‘often’ or ‘sometimes’ impacts their physical and/or mental health (24% and 41% respectively), whilst having the lowest percentage of individuals that believe such concerns ‘rarely’ or ‘never’ impact their physical and/or mental health (14% and 6% respectively). On the other hand, the 65+ age group has the lowest percentage of individuals that ‘always’, ‘often’, and ‘sometime’ relate with the statement (3%, 5%, and 15% respectively), whilst having the highest percentage that ‘rarely’ or ‘never’ does (39%).



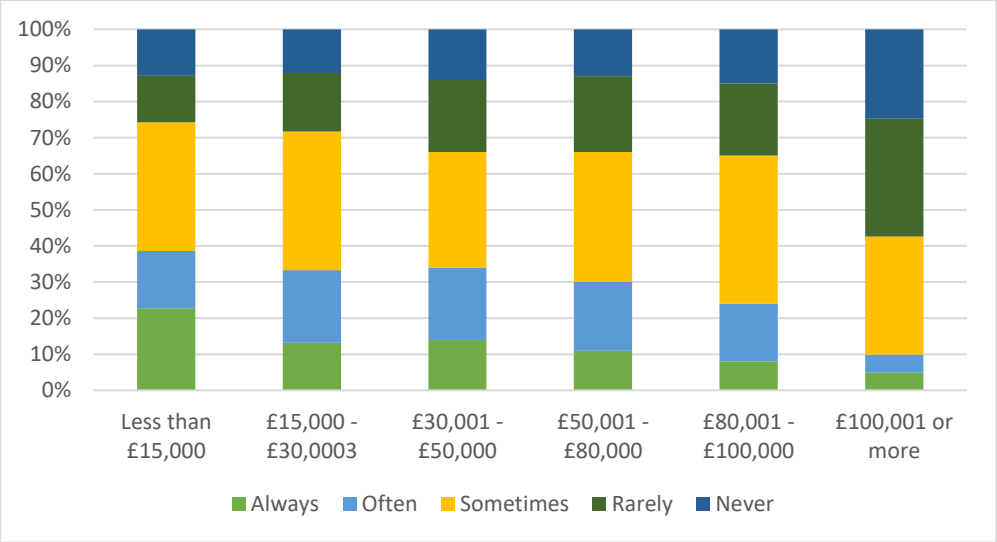
- **10.4 Local Authority Area:** The general trend across the local authorities follows that seen across the total sample (see 10.1), with only a few deviations across some local authorities. Trafford has the lowest – and a significantly lower – percentage of individuals (compared to all local authorities) that ‘always’ relate concerns about and/or difficulties with household finances to impacts on their physical and/or mental health (4%). On the other hand, Bolton has the lowest – and a significantly lower – percentage of individuals that ‘never’ relate with the statement (4%), whilst having the highest percentage that ‘always’ relate concerns about and/or difficulties with household finances to impacts on their physical and/or mental health (17%). Bolton has a much higher than average percentage of individuals that ‘rarely’ related with the statement (28%), where Stockport comparatively has a much lower percentage as such (11%).



- **10.5 SEG (Socio-Economic Grade):** The overall trend across the SEGs follows that of the total sample (as seen in 10.1), with the only deviation being C2 having a significantly lower percentage of individuals that 'always' relate concerns about and/or difficulties with household finances to impacts on their physical and/or mental health (9%), whilst DE having a significantly higher percentage of individuals that 'always' relate to the statement (19%).



- **10.6 Household Income:** Overall, as household income increases, the percentage of those that experience the impacts of concerns about and/or difficulties with household finances on physical and/or mental health decreases. The lowest income bracket of 'less than £15,000' has the highest percentage of individuals that 'always' relate concerns about and/or difficulties with household finances to impacts on their physical and/or mental health (23%), whilst the '£100,001 or more' income bracket has the lowest percentage of such individuals (5%). The income bracket '£100,001 or more' has the highest percentage of individuals that 'rarely' and 'never' relate concerns about and/or difficulties with household finances to impacts on their physical and/or mental health (33% and 25% respectively).



- **10.7 Ethnicity:** Similar to the trend seen across the whole sample (see 10.1), the majority of individuals across all ethnicities – bar 'other ethnic groups' – stated that they 'sometimes' relate concerns about and/or difficulties with household finances to impacts on their physical and/or mental health (an average of 39%). Individuals identifying from mixed/multiple ethnic groups have the highest percentage of individuals that 'always' related to the statement (23%). Black African/Caribbean/Black British individuals have the highest percentage of those who 'often' related to the statement (20%). On the other hand, those identifying as 'other ethnic group' have the highest percentage of those who 'rarely' and 'never' relate concerns about and/or difficulties with household finances to impacts on their physical and/or mental health (50% and 30% respectively).

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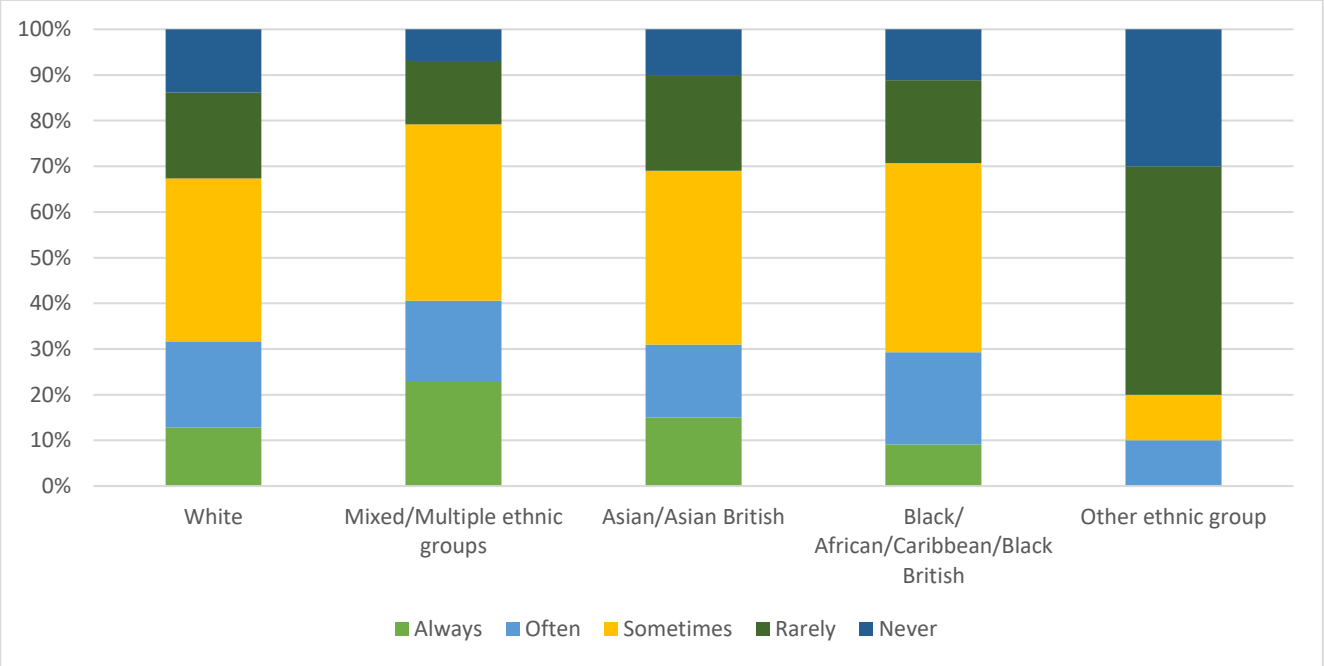
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
White
Mixed/Multiple ethnic groups
Asian/Asian British
Black/ African/Caribbean/Black British
Other ethnic group
Always
Often
Sometimes
Rarely
Never

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