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

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Primary Care Blueprint

Production Version – For Approval

September 2023

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

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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

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.

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Our vision for Primary Care

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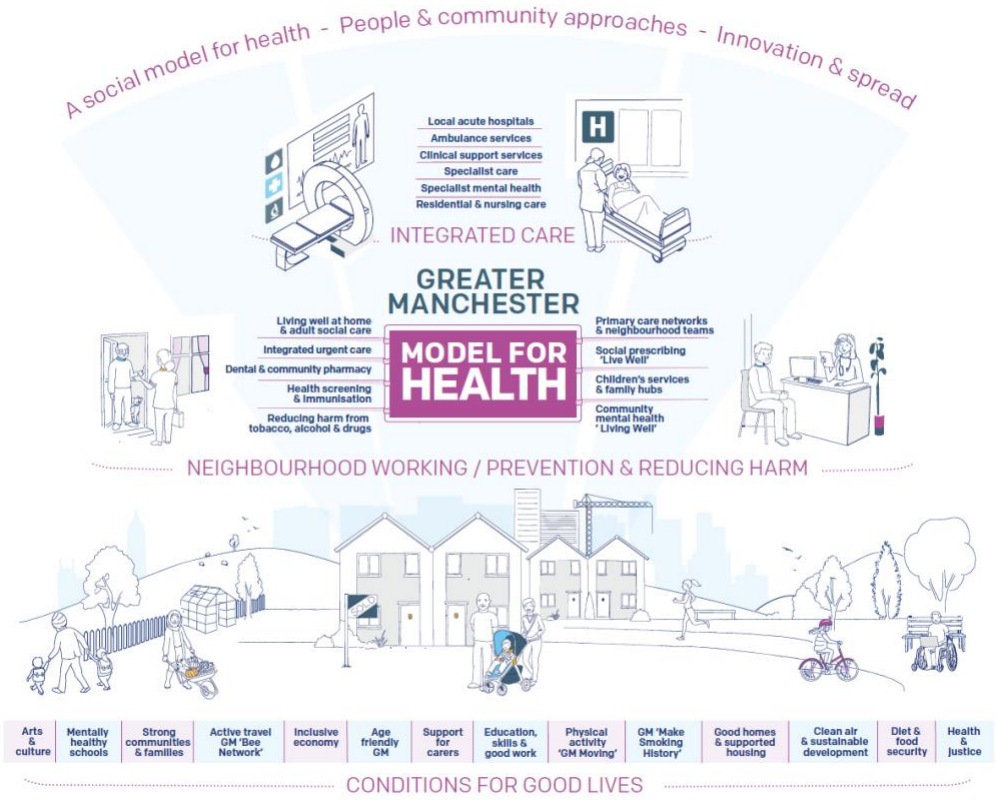
About this Blueprint

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

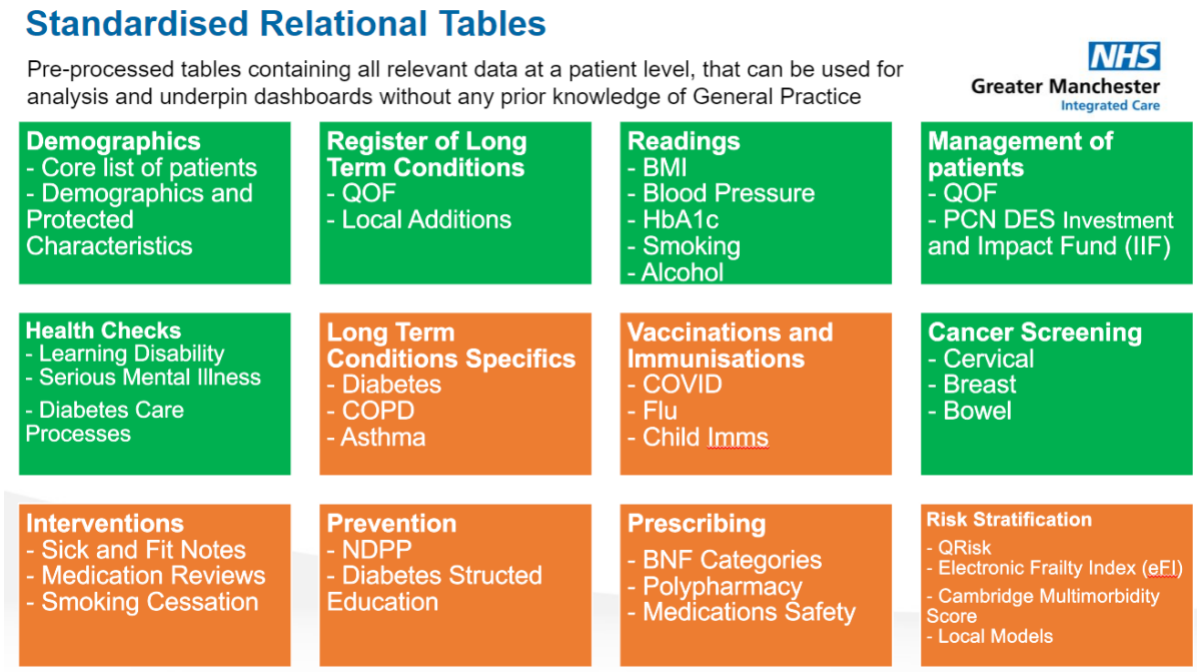
We have identified this as a key area of focus, with Primary Care well placed to benefit from the new technologies and ways of working. The Analytics and Data Science Platform (ADSP) provides the cloud infrastructure suitable to process big data and complex linkages that will enable an approach to analysis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

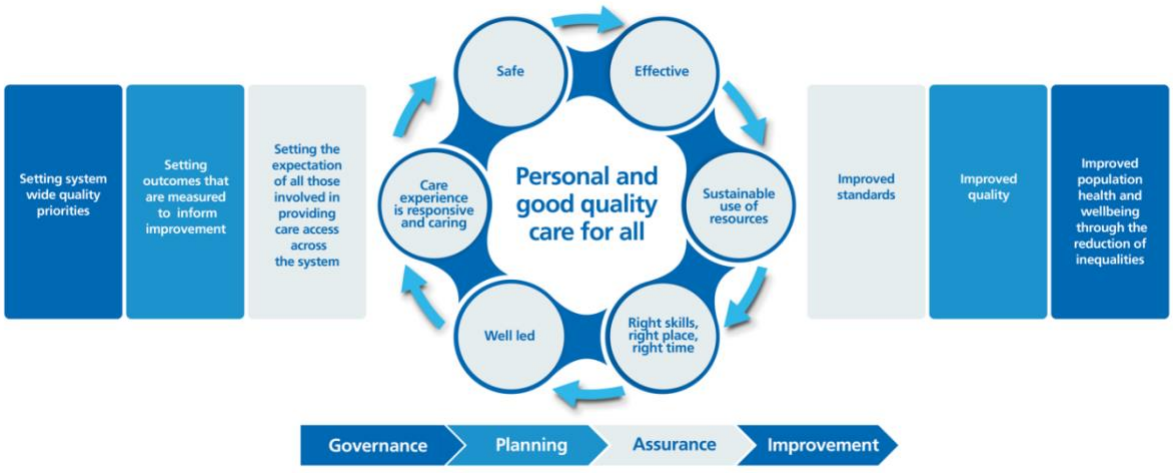
Delivering safe, effective services, with a focus on quality improvement

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:

$$\text{Sustainable value} = \frac{\text{Outcomes for patients and populations}}{\text{Environmental + social+ financial impacts (the 'triple bottom line')}}$$

- 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