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**GREATER
MANCHESTER**

BeCCoR Prevention, Population Health & Neighbourhoods Toolkit

April 2026 - Version 1.1



Live Well everyday support in
every neighbourhood

NHS

Greater Manchester



Purpose of this toolkit:

This toolkit has been developed to support General Practice delivery of the Prevention, Population Health and Neighbourhood (PPH&N) domain of the Greater Manchester GP Incentivisation Scheme – “BeCCoR” for 2026-27.

The Toolkit will give you practical summaries and resources to help approach the ‘Neighbourhood’ element of the scheme. This aims to reach people who aren’t engaging and better address their needs through working with neighbourhood and community partners.

It has been compiled by the NHS Greater Manchester team who work as part of the Live Well programme.

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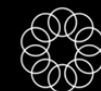
Section	Slide Number
1. Background - ground yourself in why this matters and where its come from <ul style="list-style-type: none">• The BeCCoR Prevention, Population Health and Neighbourhoods Scheme• Live Well – Greater Manchester’s Neighbourhood model	<u>4</u>
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1. Background

- This short section helps anchor you in the requirements of the BeCCoR Prevention, Population Health Management and Neighbourhoods (PPHM&N) scheme.
- It also provides background on Greater Manchester's Neighbourhood model – Live Well.



BeCCoR Prevention, Population Health management and Neighbourhoods scheme overview

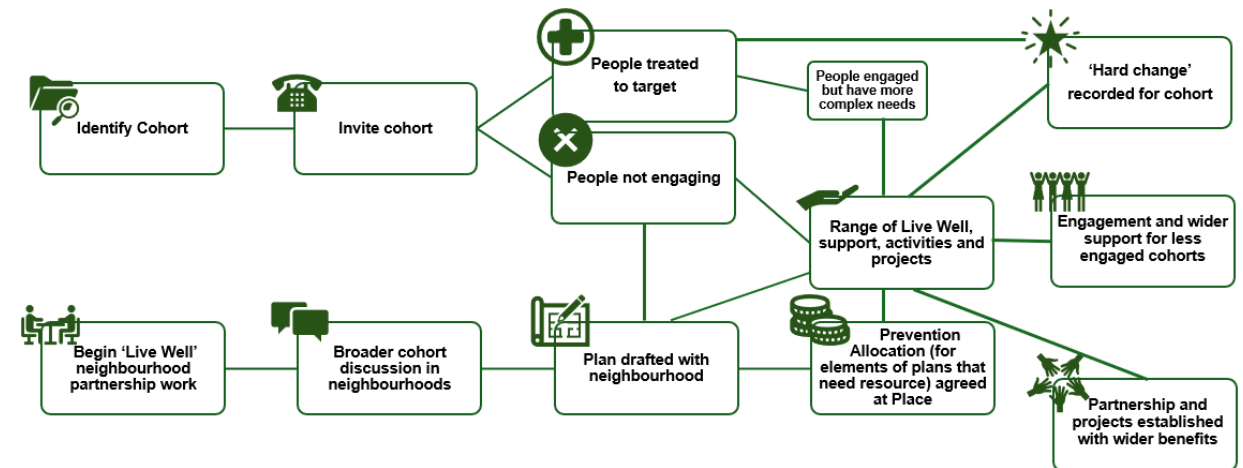
This NHS Greater Manchester incentivisation scheme supports General Practice to implement at scale a combined Population Health Management and Neighbourhood/Live Well model that:

- **Identifies and prioritises people with high unmet clinical need** across selected long-term condition cohorts (CVD, Diabetes, Respiratory – adult and children)
- Supports completion of **high-impact cohort-based reviews** and optimisation actions to prevent worsening ill health and reduce avoidable urgent care use (including avoidable ED attendances)
- Further **strengthens existing neighbourhood partnerships and Live Well pathways** to improve engagement and support for people who are not engaging and/or have additional non-medical needs that impact health outcomes.

For people you are struggling to engage, or who are engaging but have more complex needs affecting their health, the scheme supports, and potentially funds, practices/PCNs to have a good two-way conversation with neighbourhood partners, and to get into action to address these challenges.

These activities are likely to have broader benefit than just the 'BeCCoR' cohort. Examples of the kind of projects possible are included in this toolkit. Plans will be considered for funding at a locality level.

Full BeCCoR (**Beyond Core Contract**) Scheme overview, requirements and supporting guidance and resources can be found [BeCCoR - GP Quality Scheme, GM Areas of Consistency | GM ADSP](#)



What is Live Well?

GM Live Well is Greater Manchester's commitment to ensure everyone can access great everyday support in every neighbourhood.

We're tackling health, social and economic inequalities by changing how we work with people and communities, and in public services.

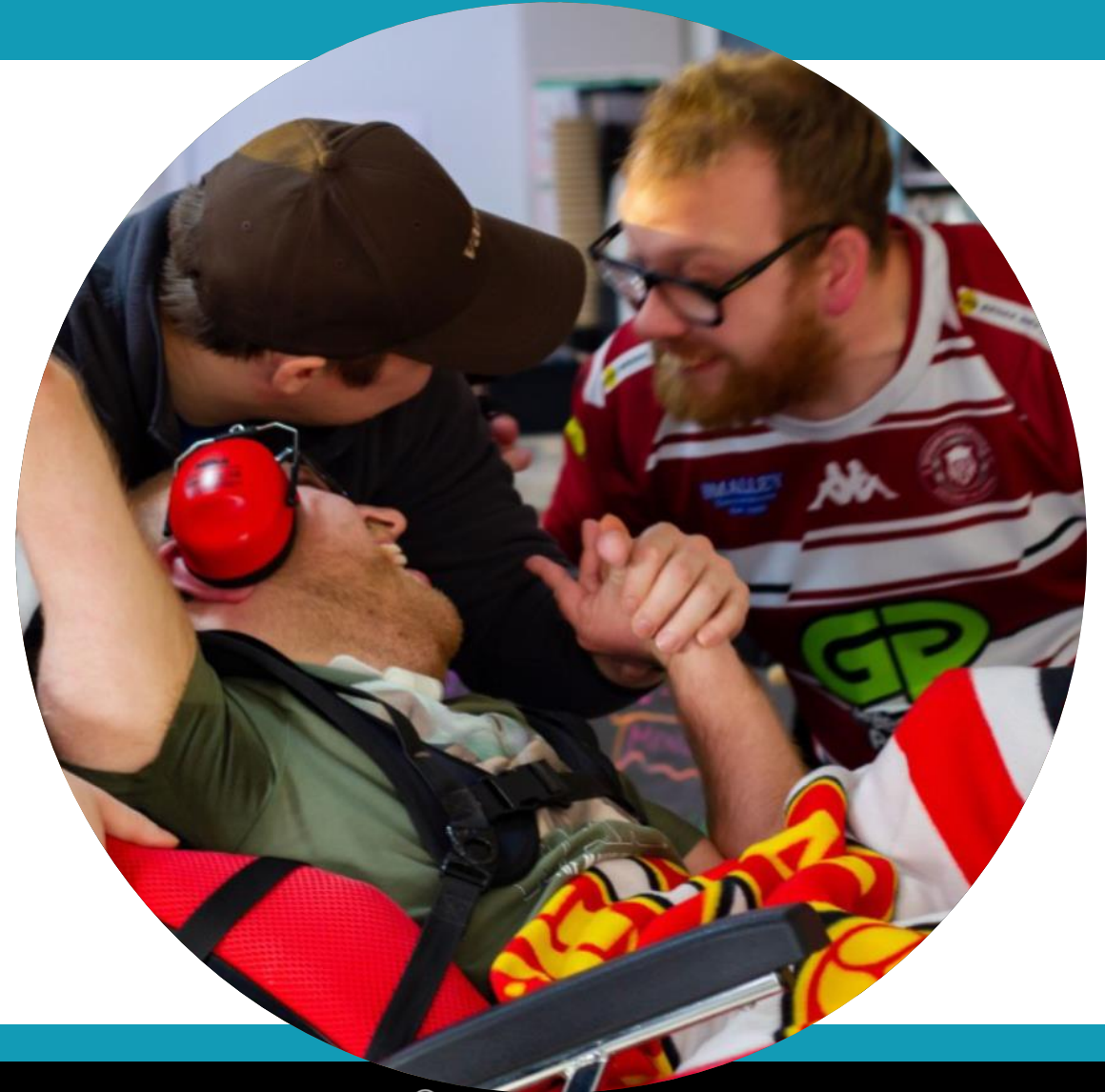
Led by and with communities, it is better connected and supportive services, opportunities and help. It aims to support primary care providers to link patients to a wider range of trusted community services that help with the non-medical issues which can contribute to a person's ill-health.

Live Well will ultimately free up more time in consulting rooms to focus on patients' clinical needs and ensure primary care is fully integrated into the local neighbourhood offer across all four disciplines of primary care: community pharmacy, dentistry, general practice and optometry.

It will do this by addressing unmet social needs – issues around housing, finances, welfare, employment, loneliness or isolation – and how they can impact a patient's health, such as support needed for smoking, diet, high blood pressure, diabetes and heart problems.

In Greater Manchester, Live Well is our model for Neighbourhood Health.

[You can find out more about Live Well here](#)





2. Reaching people who don't engage

Across General Practice, people who don't engage regularly account for a disproportionate level of unmet need and avoidable crisis care. These are often the same people who:

- Miss or decline appointments repeatedly
- Present late, in crisis, or via urgent care
- Have multiple long-term conditions alongside social, emotional or financial pressures
- Have had difficult past experiences of services, trauma, discrimination or exclusion

The BeCCoR scheme recognises that non-engagement is rarely a choice. It is usually a signal of wider barriers in someone's life — and of systems that are not designed around how people actually live.

This section focuses on what helps practices reach people who are least likely to engage, by working differently, not harder.

If you just read one resource on engagement...

Standard approaches to engaging people at risk of cardiovascular disease (CVD) work for many people. Women, older people and those from higher-income areas are more likely to attend NHS health checks.

Standard approaches are, however, not very effective for other people, especially those who experience inequalities and/or disadvantage.

To reduce inequalities in health and early death, primary care therefore needs to use alternative approaches to engaging diverse people, in order to reduce their risk and to manage their pre-existing conditions.

This **'tips and tricks' guide** from Unlimited Potential has some relatively easy to implement approaches that can engage people who are engageable – but not yet engaged.

[Download the guide here](#)



What better engagement could mean in practice

What this looks like in practice (examples)

- Men's health drop-ins held in libraries and community spaces, with no appointment or referral required
- More accessible, attractive communications
- Targeted outreach for under-served communities, using trusted connectors and culturally appropriate approaches
- Pop-up neighbourhood clinics offering health checks alongside housing, welfare and wellbeing support

Across these examples, success comes from: visibility and consistency; relationships over time; joined-up working across sectors.

Practices that adopt these approaches often see:

- Better engagement with reviews and prevention activity
- Earlier identification of risk
- Reduced avoidable urgent care use
- Improved staff satisfaction and morale
- Most importantly, they see people who were previously “hard to reach” begin to stay connected.

Next steps into action: Check out the examples from slide 21 in this pack, and talk to local partners, particularly the Voluntary Community Faith and Social Enterprise (VCFSE) sector, about opportunities to better reach people.

3. How we engage better in everyday practice

For people with long-term conditions, multiple needs or low trust in services, how we work with them often matters as much as what we do clinically.

Evidence consistently shows that:

- Good outcomes are not driven by clinical actions alone
- The quality of conversations, relationships and first points of contact strongly influences engagement
- Small changes in how staff communicate can significantly improve uptake, adherence and experience

Live Well places strong emphasis on relational, person-centred skills because these skills: improve engagement with cohort-based reviews; help reach people who are ambivalent, anxious or disengaged; reduce repeated attendances, DNAs and avoidable escalation

This section focuses on the core skills and approaches that make everyday interactions more effective across the whole practice and neighbourhood team.



Use this section if...

Use this section if your practice is experiencing:

- Reviews that feel rushed, transactional or repetitive
- Patients attending but not making progress
- Low confidence among staff when conversations are complex or emotional
- High pressure at the front door (reception, triage, navigation)

Take a look at the following short summaries of approaches and consider which might be valuable for your team.

This section covers:

- Health coaching
- Motivational interviewing
- Trauma informed practice
- Making Every Contact Count (MECC)

Case studies at the end of this toolkit – from slide 30 - showcase models that have centred these approaches, such as Focused Care.



Health Coaching - Supporting people to build confidence, motivation and self-management

What it is:

Health coaching supports people to identify what matters to them, set realistic goals, and build the confidence and skills needed to manage their health over time.

Why it works

- It shifts people from passive recipients of care to active partners
- Improves outcomes for long-term conditions
- Supports prevention by encouraging earlier action

When to use it

- During Long-Term Condition reviews
- When people attend but struggle to make changes
- When motivation or confidence is low

Who can use it

Health coaching can be delivered by clinical and non-clinical staff in people-facing roles.



Next steps into action:

[PCI-Accredited Health Coaching \(Level 3\) from the GM training hub](#)

[Explore coaching modules from the Personalised Care Institute](#)

[Health Coaching Overview from GMMH](#)

Motivational Interviewing – reducing resistance and supporting behaviour change

What it is

Motivational Interviewing is a structured conversational approach that helps people explore ambivalence and strengthen their own reasons for change.

Why it works

- Reduces resistance and defensiveness
- Builds trust and rapport
- Works well in brief or repeated contacts

When to use it

- When advice isn't being followed
- When people appear disengaged or ambivalent
- When conversations feel stuck

Motivational Interviewing can be used as:

- A core part of health coaching
- A stand-alone approach in routine consultations

Next steps into action:

[GMTH – GM training Hub
PCI Level 3 Health Coaching
\(MI integrated\)](#)

[Personalised Care Institute:
MI-aligned modules](#)

[Personalised Care Training
Academy \(PCI-accredited\)](#)

The 4 Steps of Motivational Interviewing

MI is a conversation strategy that allows others to feel comfortable and safe to open up in a conversation.

The acronym OARS guides the listener to follow the 4 steps of MI:

O Asking open-ended questions that can't be answered with a simple "yes" or "no."

A Affirmation. Reinforcing your appreciation that the person has opened up to you.

R Reflective listening. Listening closely and reflecting back what they have said so they know you have heard them and feel understood.

S Summarizing. Ensures shared understanding and reinforces key points of the conversation.

Trauma-Informed Practice – creating safety, trust and empowerment

Those who experience ACEs/ trauma are:



Next steps into action:

- [Get involved with opportunities across our region through Trauma Responsive Greater Manchester](#)
- [Enrol yourself or a member of your team on a one-day course to learn more](#)
- [Find out about courses and best practice meetings at Greater Together](#)
- [Access the RCGP's safeguarding toolkit on adverse childhood experiences](#)

What it is

Trauma-informed practice recognises that many people — and staff — have experienced trauma, adversity or exclusion. This shapes how they respond to services.

Why it works

- Reduces re-traumatisation
- Improves engagement and experience
- Supports staff wellbeing as well as patient care

Key principles

- Safety
- Trust and transparency
- Choice and control
- Collaboration
- Empowerment

When to use it

- When people are anxious, angry or withdrawn
- When engagement has broken down
- When working with inclusion health groups

Not everyone who experiences adversity will have ongoing difficulties, but **understanding trauma helps services avoid causing harm and build more effective relationships.**

Making Every Contact Count (MECC) – embedding prevention into everyday actions

What it is

MECC enables brief, opportunistic conversations about health and wellbeing during routine contacts.

Why it works

- Makes prevention part of day-to-day practice
- Requires minimal additional time
- Works across clinical and non-clinical roles

When to use it

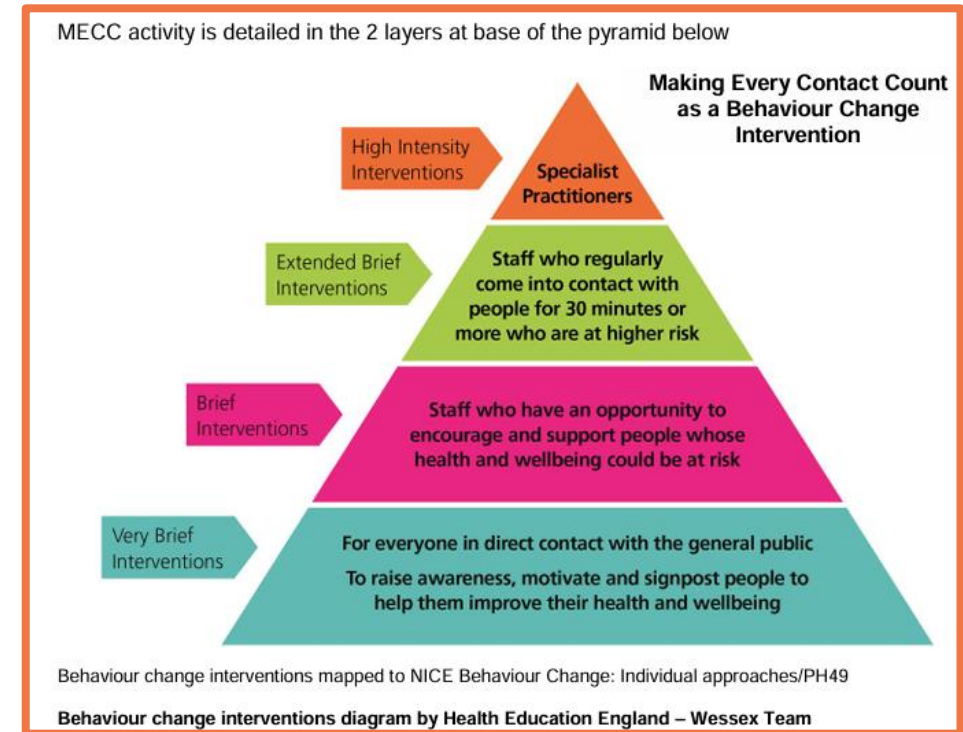
- Reception and front-of-house interactions
- Routine clinical reviews
- Opportunistic conversations

MECC works best when:

- Staff feel confident and supported
- Messages are consistent across the team

Next steps into action:

- [Access free training modules \(e-learning for healthcare\)](#)
- [Download this free toolkit](#)
- [Read this cross-system consensus statement](#)





4. Working with neighbourhoods and partners

Many of the people general practice is most concerned about — those with multiple long-term conditions, unmet need or low engagement — cannot be supported effectively by primary care alone.

They often need:

- Coordinated input across health, social care and the voluntary sector
- Support with housing, money, mental health or social connection
- Consistency and continuity across multiple offers

The 2026/7 BeCCoR scheme recognises that strong neighbourhood partnerships are essential to prevention, engagement and sustainability — not an optional add-on.

Use the Working with Neighbourhoods and Partners section if...

Use this section if your practice or neighbourhood team is experiencing:

- High numbers of people with complex or overlapping needs
- Clinical issues driven by housing, poverty, isolation or mental health
- Repeated referrals that don't lead to sustained change
- Multi-disciplinary Teams that feel fragmented or overly clinical
- Pressure on primary care to “hold” complexity alone

Read on to consider:

- The foundations of successful partnership working
- How multi-disciplinary working in neighbourhoods can flourish
- How community-led prevention and outreach can give you greater reach and impact

...And then dive into the examples and additional tools at the back of this toolkit for more practical ideas



The foundations of successful partnership working

Successful neighbourhood partnerships are built deliberately. Across Greater Manchester, the strongest examples share the following foundations:

1. Shared purpose

Partners are clear about who they are working together to support and what they are trying to change, grounded in neighbourhood priorities and lived experience — not organisational boundaries.

2. Complementary roles

Each partner does what they do best:

- General practice and public services provide clinical leadership, continuity and coordination
- VCFSE and community organisations bring trust, reach and strengths-based support

Clarity of roles reduces duplication and improves experiences for people.

3. Trust and relationships

Partnerships work when relationships are consistent, respectful and long-term. Time invested in trust building enables honest conversations, shared problem-solving and better outcomes.

4. Working at neighbourhood scale

Partnerships are most effective when they are local enough to know people and places, but structured enough to act — using neighbourhood teams, MDTs and shared planning.

5. Early, preventative focus

Successful partnerships act before crisis, combining clinical and non-clinical support to address the wider drivers of poor health, in line with the Live Well approach.

6. Shared learning and responsibility

Partners learn together, adapt together and share responsibility for outcomes, rather than passing people between services.

Multi-disciplinary working – the right voices in the room

Effective Multi-disciplinary Teams (MDTs):

- Are built around defined cohorts or shared challenges
- Include public services and, where appropriate, VCFSE partners
- Focus on proactive planning rather than crisis discussion

VCFSE involvement helps MDTs:

- Understand why engagement may be difficult
- Identify non-clinical solutions early
- Support warm handovers into community support

Next steps into action:

[Look through this HEE Multidisciplinary Team Toolkit Working Differently Together](#)

[Visit NHS England's Guidance on neighbourhood multidisciplinary teams for children and young people](#)

[Make use of the Toolkit - An Implementation Guide for Proactive Care in Integrated Neighbourhood Teams](#)



Community-led prevention and outreach - Delivering support closer to everyday life

Many Live Well neighbourhoods use:

- Community venues and trusted spaces
- Outreach and drop-in models
- Joint clinical and non-clinical activity

These approaches work best when:

- Public services and VCFSE partners plan and deliver together
- Clinical input is available where needed
- Community organisations are supported, not overwhelmed

This helps reach people who may not engage with traditional appointment-based care.

Next steps into action:

Watch [this video from Oldham Family Practice](#) about their partnership with the local Voluntary Sector.

There is more detail about their work in the examples section, slide 39, along with a myriad of other examples, tools and resources.



5. Case studies and deeper dive tools and resources

This section includes local and national case studies, plus additional information and tools to explore the subjects in the previous sections in more depth.

They are colour coded to link to the main body of the toolkit:

Reaching people who don't engage

How we engage better in everyday practice

Working with neighbourhoods and partners



Case Study: Proactive Diabetes Care for Higher Blackley, Harpurhey & Charlestown

Joshua Thompson, PCN Manager for [Higher Blackley, Harpurhey & Charlestown](#), leads a targeted initiative to increase diabetes and hypertension reviews within the Black African Caribbean community. The project identified **350 at-risk patients** who have not received a structured clinical review in at least two years.

Challenges

- There is a systemic bias where standard healthcare education and practices are often tailored to "white British" demographics, leading to lower engagement and poorer outcomes for other communities.
- Significant additional funding is required to support the staff time and resources needed for proactive outreach.
- Complexities in ethnicity coding can result in misidentified patient records, meaning longer appointments to determine correct details and provide appropriate care.

Impact

- The project aims to increase diabetes and hypertension reviews within the Black African Caribbean community by 80% in 2026.
- Dedicated care coordinators mean patients can bypass busy GP practice phone lines, streamlining the process and reducing general administrative demand.
- By offering Saturday and evening windows, the project ensures that working patients and those with other barriers to accessing GPs can access preventative care.

Key Learning

Addressing health inequalities requires "slowing down" the process to build trust and provide truly person-centred support.

Effective prevention often involves going to the patient rather than expecting them to navigate traditional, potentially alienating, clinical routes.

Enhanced Appointment Access

Extended slots of 30–45 minutes, including evenings and weekends, so clinicians can co-produce a tailored management plan.

Alternative Communication

Targeted letters printed on pastel-coloured paper, which research suggests are more likely to be opened than standard white letters.

Innovative approaches

Community Booking

Appointments available at local community events, including cultural days and faith group gatherings, removing barriers to access.

Specialised MDT

A GP and pharmacist specialising in diabetes provide expert reviews during flexible evening and Saturday clinics.

Case Study: Be Well Men`s Drop-Ins

Meeting men where they are



Be Well has spent the last 18 months running men’s health and wellbeing drop-ins in local community spaces like Withington Library and No. 93.

This grew from a simple realisation; only a third of our social prescribing referrals were from men. So, we stopped, listened, and reshaped how we show up.

The drop-ins are informal, visible, and easy to access – no referral, no appointment, just a friendly space to start a conversation. Funded by Manchester City Council Public Health and shaped through a dedicated male engagement working group, the sessions help us reach men who might not walk through traditional routes.

So far 102 men have been supported, leading to 254 social prescriptions. The Withington Library drop-in runs on the last Friday of each month and there’s real energy behind expanding this model.

What is different?

Being visible in trusted community places reaches different people. Active outreach brings in those who will not come via referral alone. And this is Live Well at its best – strength-based, preventative and rooted in what matters to people before things escalate.



Case Study: Integrated Neighbourhood Pop-Up Clinics – North East London

Overview

Dr Jagan John leads monthly integrated, personalised neighbourhood GP pop-up clinics in the London Borough of Barking and Dagenham. These clinics operate out of alternating local community hubs, offering a one-stop single access point for thousands of residents to receive health checks and social support without an appointment.

Challenges

The initiative seeks to overcome deep-seated barriers to trust between residents and professionals. It requires extensive coordination to bring multiple community groups and professionals together in a single location to treat issues collectively.

Key Learning

Addressing health inequalities requires moving healthcare into the heart of the community. Creating an accessible, social and trusted environment means residents can have more control over their own care and be supported to address social issues that impact their health in a way that traditional clinical settings cannot.

Health care done differently

IF you'd told me I would be the community lead designing and organising an award-winning project with NHS clinical director, GP Dr Jagan John, GP Dr Nadia Saeed and the LBBD's head of universal services Zoinul Abidin, that would change how healthcare is delivered in the borough! I would have laughed you right out of my workshop.

It was never in my plan to be a community worker, I am the owner of a small business HouseofJoulee.co.uk creating African print clothing and gifts for all.

Work allowed me to spend time getting involved in my local community like Friends of The Ripple Nature Reserve, engaging in talks with local stakeholders to ensure it's re-opened.

I wanted to make a positive impact, so when offered the opportunity to join Thames Life as their health outreach officer it felt like the universe was taunting me.

A year and a half later, 13 drop-in clinics delivered, winning the Royal College of GP's Northeast London Faculty Recognition Award for best Collaborative Project of The Year 2023, I've worked with the most community passionate people I've ever connected with, championed the whole way by Thames Life CEO Matt Scott.

The Drop-in-Clinics were a simple pop-up for health checks and seeing a doctor, however after our first clinic it was clear we were missing the trick!

Forty per cent of attendees didn't need to see a doctor but couldn't get help anywhere else - I knew what I had to do. There were already groups working to support the health and social needs in our community

Thames Life health outreach officer **Lucy Lee** explains how as a resident she has got involved to improve the health and wellbeing of the community with an award-winning scheme



and if we brought the council services on board, we might just have something!

Now, not only are you able to see a doctor without an appointment in a local hub, you also can relax, enjoy yummy food, play board games, socialise with other residents, children can play comfortably whilst accessing multiple services such as a free hand or shoulder massage, housing and financial advice, mental health support and free local activities - basically a health and wellbeing bonanza.

Word on the clinics success got around which resulted in sponsorship from Barking Riverside Limited, with our larger council funded clinics focused on the African and Caribbean community, children and families, rough sleepers and asylum seekers and diabetes patients.

Our next drop-in clinics:

☐ June 27: Barking Learning Centre, 1.00-4.30pm (rough sleepers and asylum seekers)

☐ July 26: Thames Community Hub - 12-5pm (open to all)



One of the award-winning drop-in clinics run by Thames Life

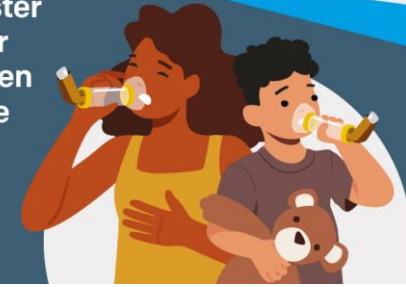
Case study: engaging children with asthma in schools

Asthma Friendly Schools in Greater Manchester

- Asthma is the most common long-term medical condition in children in the UK, with around 1 in 11 children and young people living with asthma.
- Outcomes are worse for children and young people living in the most deprived areas.
- View [video](#) about Asthma Friendly Schools which aim to improve outcomes for children living with chronic asthma and to enable schools to achieve recognition and meet agreed standards of care.
- The initial pilot evaluation showed schools found Asthma Friendly Schools a very worthwhile initiative, allowing them to audit their practice and make improvements. The impact included a reduction in breathing related A&E attendances, as well as a reduction of 27% in hospital admissions.
- The Asthma Friendly Schools programme has now expanded and is in Bury, Oldham and Manchester where 23 schools have achieved accreditation, with a further 54 going through the final process before they achieve accreditation.

Greater Manchester
schools' guide for
the care of children
and young people
with asthma

– preschool, primary
and secondary years



NHS
Greater Manchester
and Eastern Cheshire
Strategic Clinical Networks

Next steps into action:

For training related to asthma please see: [Asthma \(Children and young people\) - elearning for healthcare](#)

To find out more: [NHS England — North West » Asthma friendly schools](#)

Case Study: Integrated Neighbourhood Pop-Up Clinics – North East London

Free Drop-in Clinic
AVAILABLE ON THE DAY:

- Health Checks
- Social Wellbeing Advice
- Talking Therapy
- Diabetes Checks
- Hand & Shoulder Massage
- Support From Local Community Groups
- Blood Pressure Checks
- Baby Weigh-in

See a local DOCTOR no appointment needed

Next Clinic: Friday 22nd November 12PM – 5PM

Thames Community Hub
 Bastable Avenue
 Barking
 IG11 OLG

Brought to you by: **Thames Life**, **HEAL STUDIO**, **Barking & Dagenham**, **NHS**, **Aurora Medicare**, **BARKING RIVERSIDE**

Do you run a free local activity or want to volunteer at the Drop-in Clinics?
 Email: info@thames-life.org.uk

Next Free Drop-in Clinic
Friday 22nd November 12PM – 5PM
 Thames Community Hub
 Bastable Avenue
 Barking
 IG11 OLG

More dates to follow

COMMUNITY SUPPORT
 In addition to the Drop-in Clinic, you can also connect with the groups below to access
 *free: Fitness & Socials
 Activities for all ages
 Mental Health Support
 Children's Activities
 Housing Advice & more
*Some activities may require a small fee.

VACCINATIONS
 Drop-in to arrange any of the following vaccines your child may have missed:
 ✓ Measles
 ✓ Mumps
 ✓ Rubella

CLINIC 4 of 6

DANCE BDYD, **Green Shoes Arts**, **the VILLAGE**, **Centre Stage**, **NELFT**, **NHS** North East London, **nice bunch**, **RADIANT AMBITIONS**, **BARKING FOOD FOREST**, **TALKING Therapies**

Please note this service is not for emergencies. For urgent assistance, please call 999.

Innovative Approaches

<p>"Health and Wellbeing Bonanza" Clinics move beyond a clinical feel by incorporating food, board games, and massages, allowing residents to socialise while accessing services.</p>	<p>Integrated Professional Support Clinical services (blood pressure and diabetes checks) are co-located with non-clinical support, including housing and financial advice, mental health support, and social welfare.</p>
<p>Active Social Prescribing The model acts as a "giant personalised care prescription," using community groups to address wider social needs and begin conversations that enable lifestyle changes.</p>	<p>Targeted Outreach Specific clinics are tailored for high-risk cohorts, including African and Caribbean communities, rough sleepers, asylum seekers, and families.</p>

Impact

<p>Directly reduce A&E attendances and emergency admissions by identifying and treating issues before they reach a crisis point.</p>	<p>Recent events have identified new cancer diagnoses, treated infections and connected residents to exercise and healthy eating programmes.</p>
<p>Give "joy and refocus" to staff and encourage young people to consider future careers in the NHS and social care.</p>	

Case Study – The Ageing in Place Pathfinder

The Ageing in Place Pathfinder was a collaboration led by GMCA, Manchester Metropolitan University and nine lead organisations working with Greater Manchester residents and partners.

The Ageing in Place Pathfinder shows how bringing residents, the NHS, local councils, and the VCFSE sector together at neighbourhood level can strengthen wellbeing, reduce inequalities and create more responsive local support. The model relies on listening to residents, working in the places they live, and building long-term partnerships that deliver health, social connection, and practical support close to home.

By listening to older people, understanding what matters and building on local strengths across the Ageing in Place Pathfinder neighbourhoods the programme has:

- Reached over 3,850 people aged 50 and over.
- Started 140 local projects and activities.
- Involved 86 residents and 89 organisations in partnership boards.
- Trained 19 residents in community reporting.
- Set out our ambition to grow this approach with our Live Well in Later Life Blueprint, part of GM Live Well.



Next steps into action: [The Ageing in Place Pathfinder - Greater Manchester Combined Authority](#)

Diving deeper: An introduction to 'missingness'

- We define "missingness" as the repeated tendency not to take up offers of care such that it has a negative impact on the person and their life chances. We seek to frame this across services and within the wider context of people's lives and life experiences.
- Missed appointments represent a significant risk marker for all-cause mortality, particularly in patients with mental health conditions. For these patients, existing primary healthcare appointment systems are ineffective.
- Future interventions should be developed with a particular focus on increasing attendance by these patients, applying a missingness lens to this work.



This short video is an introduction to 'missingness' in healthcare.

Useful further information:

- 1) This [Missingness in healthcare CPD resource](#) can help you take the first steps in addressing missingness.
- 2) Video on causes of missingness [Missingness in Healthcare: Research Results | Causes of Missingness](#)
- 3) [University of Glasgow - Research - Developing interventions to reduce "missingness" in healthcare](#)

Case study: Focused Care Approach

The Focused Care approach is a relational, hands-on model that supports people and families with complex or overlapping needs. It prioritises trust, continuity and seeing the whole person, not just the problem.

Focused Care practitioners help people tackle challenges like housing, money worries, trauma, family pressures or long-term conditions by coordinating support across health, social care and community services. They act as a single, consistent point of contact, reducing fragmentation and making it easier for people to regain stability and control.

The approach targets households and neighbourhoods with the greatest need, addressing root causes of health inequality that clinical care alone can't solve. Working with GPs and community partners, practitioners build practical plans that improve wellbeing, resilience and connection to wider support, helping reduce unplanned care and strengthening patient confidence and engagement.

Dive deeper into the detail:

Manchester Local Care Organisation – Focused Care Intro Pack Gives an overview of the model, the practitioner role, and how Focused Care supports households with complex social and clinical needs.

SQW Qualitative Evaluation of Focused Care (2019) Independent evaluation covering outcomes, impact on high-need households, and how the model reduces fragmentation across agencies.

Person-Centred Care Model

Focussed Care prioritises the individual, building trust and sustaining engagement through relational support.

Cross-Agency Coordination

Practitioners coordinate support across health, social care, and community sectors to reduce service fragmentation.

Addressing Root Causes

The approach targets underlying causes of health inequities, focusing on high-need households and neighbourhoods.

Strengthening Community Links

Focussed Care strengthens partnerships with GPs, voluntary organisations, and community services for wellbeing.

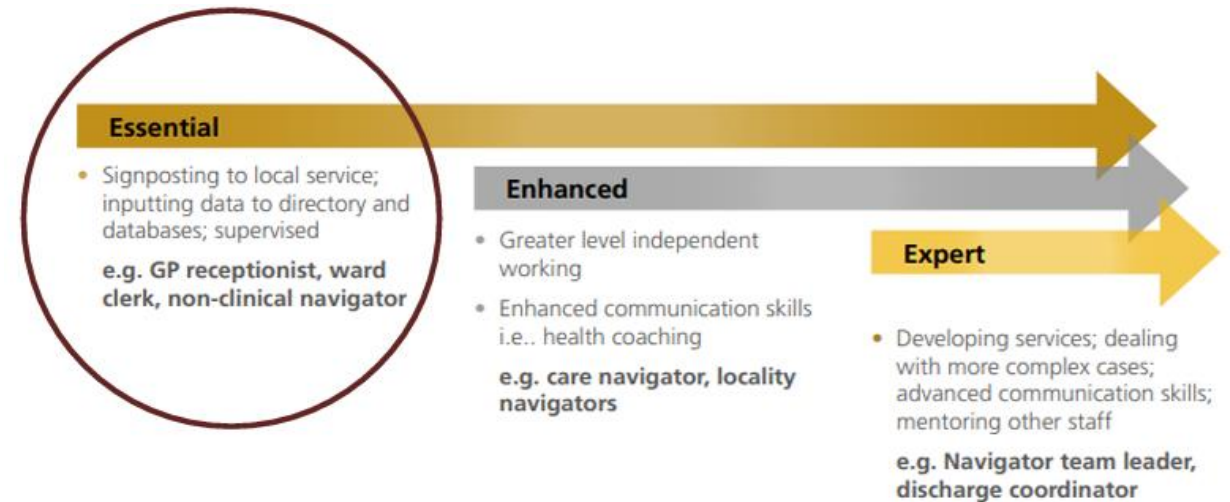
Case Study: Salford's Unified Approach to Care Navigation



A whole-system approach across Salford practices focused on **standardising care navigation at the GP front door.**

What they did:

- Worked with receptionists, practice managers, PCNs and VCFSE partners to redesign navigation “at first point of contact.”
- Co-designed tools, scripts, definitions and principles.
- Identified what “good” looks like and created a model that practices could adopt.



For more information and details of the approach: [Care-navigation.pdf](#)



Case Study: Improving CVD Prevention Through Communication (1/2)

Dr Aseem Mishra, Clinical Lead for CVD Prevention in Greater Manchester, is leading a collaborative effort to redesign clinical pathways by focusing on patient motivation, empathy and positive communication and looking at the underlying social and behavioural determinants of people's heart health.

Innovative Approaches

- **Applying behavioural psychology** to patient communication, such as using text messages with emojis and affirming language, which significantly increased return readings for home blood pressure monitoring.
- **Starting patients on two medications concurrently** to achieve blood pressure control quicker, noting that patients stay motivated when they see results.
- **Using poetry and rap** to articulate messages about health inequalities to capture the attention of both clinicians and the public.
- **Employing community fieldworkers** to collect qualitative insights and co-produce health literature, ensuring engagement is rooted in local values.
- **Partnering with the voluntary sector** to hold monthly events in community spaces with cooking lessons, flu jabs and blood pressure monitoring.
- **Developing a visual map to describe data**, combining the impact of treatment with a composite score of multiple conditions taken from patient records, so health issues more visible by postcode.



FREE COMMUNITY BLOOD PRESSURE CHECKS
Drop in on one of the following days

OUR OFFER TO YOU:

- FREE Blood Pressure Check
- Health & Lifestyle Information
- Cultural Consideration
- Community Focus
- Convenient Learning

Drop in dates:

- Tue 2nd July - 12:00PM - 14:30PM
- Wed 3rd July - 16:00PM - 18:00PM
- Tue 9th July - 12:00PM - 14:30PM
- Wed 10th July - 16:00PM - 18:00PM
- Tue 16th July - 12:00PM - 14:30PM
- Wed 17th July - 16:00PM - 18:00PM
- Tue 23rd July - 12:00PM - 14:30PM
- Wed 24th July - 16:00PM - 18:00PM
- Tue 30th July - 12:00PM - 14:30PM
- Wed 31st July - 16:00PM - 18:00PM

111 Rusholme HQ
232 Cleaver Rd
M14 4TS

For more information, contact our community worker on 0758 4139591 or email info@healthyandhearty.org.uk

BHA CAHN



HEALTHY and Hearty

Improving heart health of the Caribbean community

Providing services to people 40+ in Moss Side, Rusholme, Hulme, Ardwick, Longsight, Openshaw and Clayton.

What We Offer:

- Health Information and Health Assessment: Free blood pressure check.
- Cultural Consideration: A better understanding of your health issues, tailored to your cultural heritage.
- Community Focus: Learn why heart problems are more common in our Black communities and how we can manage them together.
- Convenient Learning: Engage in informative sessions and ask questions in local venues accessible to you.

Contact our community workers on 07752 283681 or 07787 096695. Or email info@HealthyandHearty.org.uk.

CAHN BHA

Case Study: Improving CVD Prevention Through Communication (2/2)

Challenges

Shifting the culture away from alienating language, such as referring to individuals as "patients" or "bed blockers," which can be detrimental to trust.

Managing limited resources while trying to influence long-standing clinical habits and attitudes.

Recognising historical mistrust of services in some communities, that requires more intensive relationship building rather than a "one-size-fits-all" approach.

Impact

Higher participation in self-monitoring due to more positive and affirming text message templates used by staff to communicate with patients, compared to generic messages.

Earlier intervention before conditions escalate because high-risk populations have been identified through visual data and community outreach.

Clinical effectiveness: The dual-medication pathway provides a faster route to stability, improving the likelihood that patients adhere to their treatment plans.

Key Learning

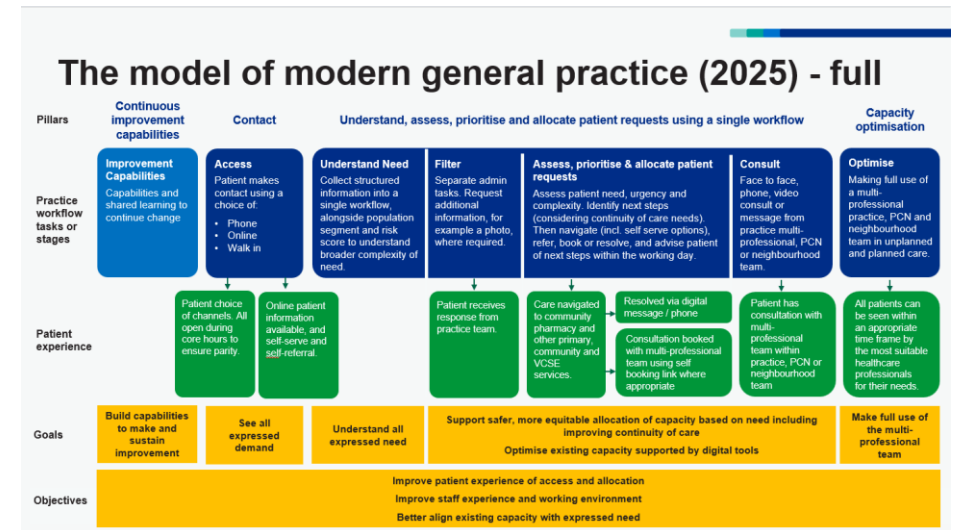
Interpersonal effectiveness is critical: If a person does not feel cared for or that their values are shared, they are less likely to accept medicine or attend clinics, regardless of clinical accuracy.

Reframing CVD as an illness of inequality, not just a matter of clinical quantity or quality.

Person-Centred language reminds professionals that patients are "people" with specific social contexts and behaviours that can have an impact on their health.

Diving deeper: Front-of-House Development

- Care navigation is about helping people get to the right support, first time — but it's also much more than that. It strengthens the relationships between primary care and the communities we serve by having everyday conversations that build trust.
- It gives staff such as receptionists the confidence and skills to guide people well, using approaches like MECC to make every interaction count.
- By upskilling the wider team, we're not only improving access, but we're also creating a more connected, person-centred system where people feel understood and supported from the moment they get in touch.



Next steps into action:

NHSE "How to Improve Care Navigation in General Practice"

A practical guide for improving care navigation processes in practices and PCNs.

Diving deeper: How do we find solutions to challenges together with the people we most need to reach?

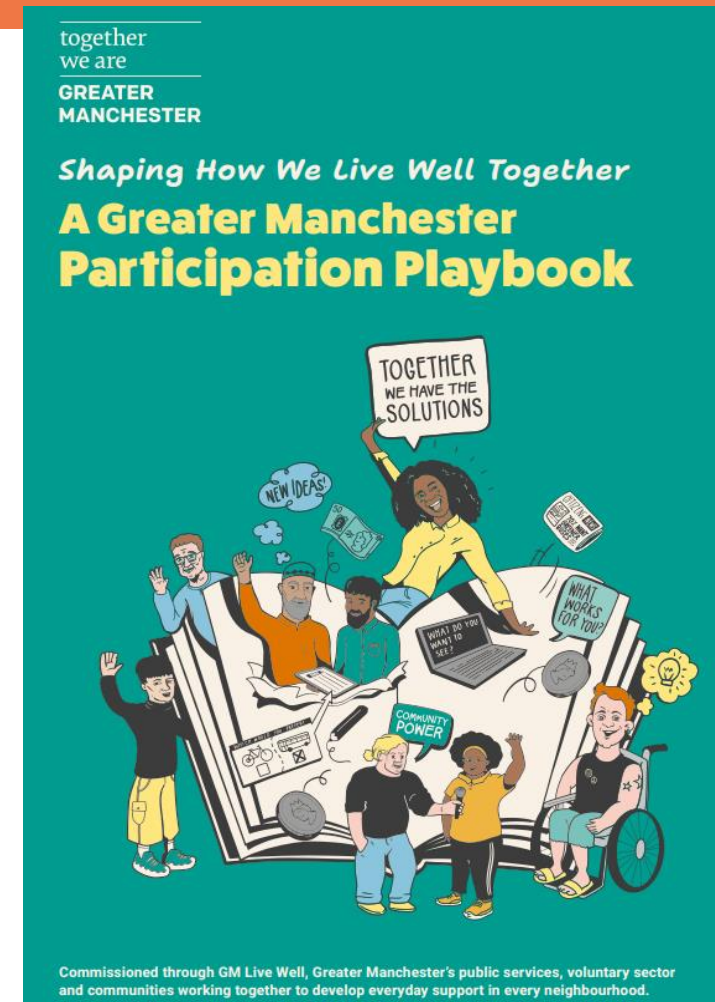
The Participation Playbook is:

- For anyone asking how do we face today's biggest challenges, and how do we do it together?
- It's for those who want to rebuild trust, shift power closer to communities, and find practical ways to involve residents in shaping the decisions that affect their lives.
- Whether we're sharing information, inviting ideas, or co-creating solutions, every interaction should start with a spirit of openness and collaboration.

The playbook has a range of **participatory tools and methods** along with examples that **can support communities and decision-makers to work collaboratively, shaping how we live well together.**

Next steps into action:

Take a look through the playbook, consider whether you'd find these approaches helpful. Reach out to VCFSE organisations who may wish to work with you on them.



Dive deeper: Toolkit Proactive and Personalised Care Toolkit

The Proactive and Personalised Care Toolkit was created by Greater Manchester Primary Care Provider Board (GMPCB) and NHS Greater Manchester (NHS GM), in partnership with Peak Health Coaching.

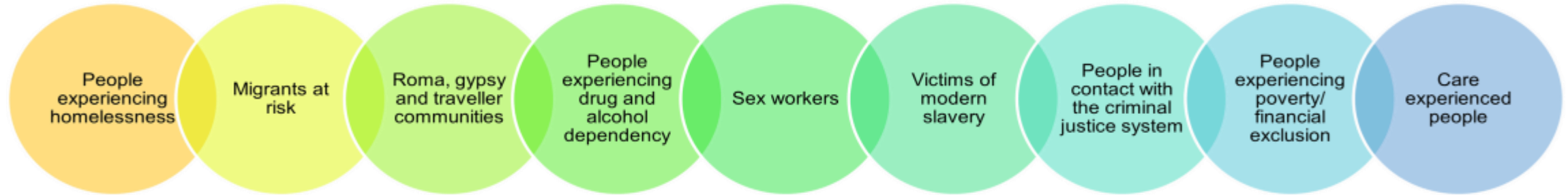
The toolkit highlights the best resources from the Greater Manchester Proactive and Personalised Care Programme which included quality improvement (QI) approaches, coaching principles, and place-based working. It includes short video explainers to get a good understanding of the techniques used.

NHS
Greater Manchester
Primary Care Provider Board
The partnership of primary care providers

**Proactive and
Personalised
Care Toolkit**



Diving deeper: Inclusion Health Toolkit



A Primary Care **Inclusion Health Toolkit** has been designed to help commissioners and providers of primary care services in GM to ensure that services are planned and delivered in a way that meets the needs of inclusion health groups and ultimately improves their health outcomes. The toolkit has been designed with useful tips and suggestions as well case studies of good practice seen locally and nationally.

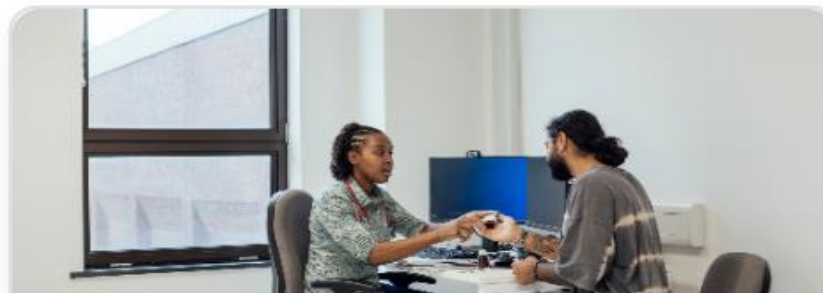
Diving deeper: Fairer Practice Toolkit

The Fairer Practice Toolkit is designed to support GP practices in taking meaningful, practical steps to reduce health inequalities. On the page you'll find several resources as well as a short video explaining the toolkit. Whether you're just beginning or already leading the way, you'll find clear guidance, evidence-informed actions, and the structure to turn commitment into lasting change.

Separate from the RCGP website, the Fairer Practice website contains a tracker designed to make it easier for you to use the toolkit and demonstrate your progress, helping practices implement the RCGP's Fairer Practice Toolkit.



Understanding the Fairer Practice Toolkit (Module)



An overview of the Fairer Practice Toolkit (Screencast)



Understanding the Fairer Practice Themes (Screencast)

Case Study: Community-led Health Improvement in Oldham

Overview & Community Context

Oldham Family Practice and Action Together are working in partnership to improve community health and prevent cardiovascular disease (CVD). They are developing a more holistic, person-centred model of care that recognises the impact of inequality, culture, trust and lived experience on people's health. The practice serves 4,500 patients in central Oldham, an area with high deprivation and diverse cultures. Major health issues include cardiac problems, obesity, and challenges in managing long-term conditions. Many people come to the GP with non-medical needs, not knowing where else to go.

Innovative Approaches

1. Holistic, Person-Centred Care

- Moving beyond a medical model to address social, emotional and lifestyle factors.
- Asking people what matters to them and involving them in their care planning.
- Supporting people before a crisis happens.

2. Community Case Management

- Health checks delivered in community settings, including BMI, smoking, lifestyle, mental health and kidney function.
- Focus on “Healthy Heart, Healthy Mind, Healthy Kidneys”.
- Early identification of risk and better signposting to support.

3. Building Trust Through Presence

- Staff attend community activities like yoga at Greenhill Community Centre, mainly used by local Asian women.
- Offering health talks based on topics people request (e.g., bone health, hormones).
- Creating safe, women-only spaces for health conversations.

4. Culturally Appropriate Engagement

- Running education sessions in community centres (diabetes, menopause).
- Including activities such as cooking, makeup or sewing to make sessions welcoming.
- Producing materials in Bengali and Urdu to improve accessibility.

5. Partnership Working

- Close collaboration with Action Together, whose link workers (including Urdu and Bangladeshi speakers) help bridge gaps between health and community services.
- Shared data helps identify trends and tailor support.

Key Challenges

- Rising demand on primary care.
- Language barriers, cultural differences and low trust in services.
- Limited awareness of available community support.
- Need for staff to adapt to new ways of working.

Impact

- Stronger community relationships and increasing trust.
- People are more informed and more involved in their own health.
- Earlier identification of risk factors and better signposting.
- Staff gaining new insights through lived experience stories—not just data.

Key Learning

“There’s a person in the middle of all this—how do we stop carving them into five pieces and see them as a whole?” — Julie
This work shows the potential of community-embedded, collaborative approaches to address inequality, improve prevention, and support healthier lives. [Watch the video](#)

Case Study: Breathe Better Get Togethers

Since Summer 2023, Manchester Active and the NHS Community Respiratory Team have run monthly Breathe Better Get-Togethers to support people in Manchester living with Chronic Obstructive Pulmonary Diseases (COPD).

These relaxed, clinician-supported sessions offer social, physical and educational activities to help attendees stay active and informed.

Proactive GP invitations and community partnerships have boosted participation, with many first-time attendees going on to join pulmonary rehab.

The programme shows how a friendly, community-based approach can help people breathe better, feel connected and live well with COPD.



Next steps into action:

Read the [Story of Change: Breathe Better Get Togethers | FHFA Academy](#)

Diving deeper: Active Practices

RCGP & GM Active Practice – sign up your practice!

Active Practices

We want to support more GP surgeries across Greater Manchester to join our movement for moving more and sitting less.



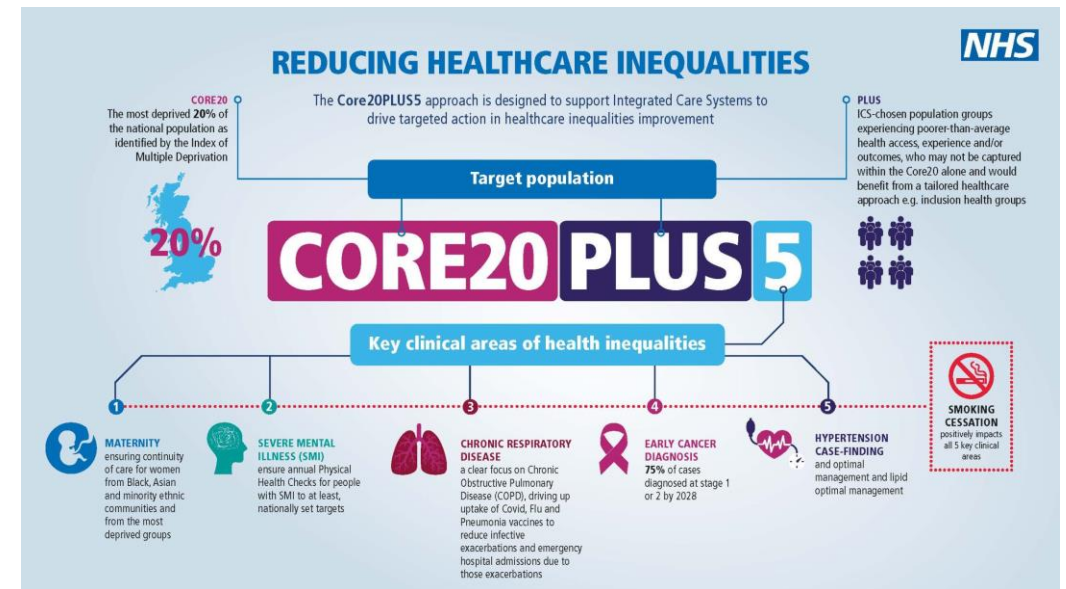
The Active Practice Charter is an initiative from The Royal College of GPs (RCGP) and Sport England to inspire and celebrate GP practices that commit to increasing activity and reducing sedentary behavior in staff and patients.

- One in four people saying they would be more active if it was recommended by a GP or nurse. Greater Manchester Moving want to support more GP practices throughout the city region to join our movement and become an Active Practice.
- Simple changes can make a big difference in improving the physical and mental wellbeing of patients and staff, at relatively low cost.
- Moving Medicine The ultimate resource to help healthcare professionals integrate physical activity conversations into routine clinical health care.

Case study: Core20PLUS Connectors

Connectors are trusted members of the community who help link local people to NHS services. With unique insight into the everyday challenges and barriers their communities' face, they guide healthcare teams in creating services that are more accessible, inclusive, and responsive to real needs.

The Caribbean & African Health Network (CAHN) were commissioned to lead the Core20PLUS5 initiative across Greater Manchester. In collaboration with Caribbean and African communities, CAHN is co-designed, co-produced, and evaluated health pathways that support more equitable and effective care. Visit the [CAHN website](#) to read more about this programme.



To read more about Core20PLUS5 see academy page: [Core20PLUS5 | FHFA Academy](#) including information about Core20PLUS5 for adults, children and young people, as well as a useful resources supporting Core20PLUS5.

Case study: GM WorkWell Partnership Programme

The GM WorkWell Partnership Programme is part of a £64 million national pilot funded by the Department for Work and Pensions (DWP) and the Department of Health and Social Care (DHSC), with Greater Manchester being one of the 15 areas delivering the programme. The initiative aims to improve health and employment outcomes by addressing the growing impact of health-related barriers to work.

The WorkWell service takes a personalised approach by matching individuals with a dedicated work and health coach. These coaches help people access the right services to improve their wellbeing and job prospects. They offer guidance on overcoming barriers to work and can refer individuals to healthcare professionals for support with physical and mental health needs, including musculoskeletal conditions (MSK) and anxiety. By offering early support, such as physiotherapy, talking therapies, and lifestyle advice, WorkWell helps people stay well and prevent their health needs from getting worse



GM WorkWell is available to anyone:

- Aged 16 or older
- Eligible to work in the UK
- Living or working in Greater Manchester

To read more about the GM WorkWell Partnership Programme, including how to refer, visit the [GM WorkWell website](#) or read the [GM WorkWell Story of Change](#).

Case Studies: Community-led prevention



Neighbourhood Health Case Study The reality of extreme deprivation on people's health outcomes, and the impact on those who support them (*Julia and Johns Story*)

Improving kidney health and building trust with Brent's Black community through community-based events

The In-Reach Model for Achieving Health Equity in North-west London - developing and testing a model that deliberately shifts healthcare out of clinics into trusted community spaces.

Willsden Early Years Asthma Clinic Pilot Tackling childhood health inequalities through personalised care

Neighbourhood Health Programme Brent's Child Health Hub Model providing faster, holistic care to the children and families who need it most

Case Study: Community-led Prevention & Wellbeing in South Manchester

The **South Manchester Muslim Walking Group** is an independent, faith-based group created to encourage physical activity, improve mental wellbeing and spark opportunities for social connection outside traditional clinical settings.

Led by Dr Amir Hannan, a GP in South Manchester, the group meets people near where they live and uses local landmarks, such as the GM Ringway, to make exercise affordable and accessible.

It's an informal community initiative that supports Dr Hannan's mission to creating a health society that is focused on wellbeing and targeting the rising prevalence of Type 2 diabetes.

Dr Hannan also advocates a focus on workforce wellbeing, where NHS staff are encouraged to look after their own health so that they, in turn, can support local patients to adopt the changes in behaviour needed to take a greater role in managing their own health.

The project addresses the challenges of:

- **Environmental factors** that get in the way of tackling the social determinants of health, especially in areas where healthy options are limited, such as neighbourhoods with high concentrations of takeaways and pubs.
- **Workforce burnout** where NHS staff are "maxed out" and lack the time and capacity to maintain their own health.



Impact

- **Proactively addressing the rapid rise in diabetes by focusing preventative health initiatives** especially for patients who are at the pre-diabetes stage.
- **Restoring trust** so patients experience more holistic, ongoing relationships that build their trust, rather than "transactional" doctor-patient interactions.
- **Reducing demand** because people are better supported to manage their own health through community-led initiatives, which are often more popular and engaging than traditional medical routes.

Key Learning

Faith-based and independent groups can address health issues in ways the formal NHS structure cannot, if they are supported and integrated into the wider neighbourhood model.

"Focus on engaging people in the community where they live. The demand is there and the people love it." – Dr Amir Hannan

Case studies: peer support and community champions

Community-Led Peer Support in Action

PCN-based model reducing admissions and boosting wellbeing through co-produced peer support and local assets.

[NHS Confederation – LiveWell Case Study](#)

Community Champions

Trusted residents who bridge gaps between services and disadvantaged communities. Helps build trust, engagement and reduce health inequalities.

[GOV.UK Community Champions Guidance](#)

Peer Support Models (NHSE)

People with similar lived experience supporting each other through informal groups, formal programmes, one-to-one or online. Builds confidence, resilience and reduces pressure on services.

[NHSE Peer Support Guide](#)



Diving deeper: how can you support patients experiencing poverty?

The [Tackling Poverty Toolkit](#) developed by NHS Greater Manchester, with support from [Resolve Poverty](#), is a practical and resource to help address poverty as a determinant of poor health and inequalities.

Attendance Allowance helps with extra costs if an individual has a disability or health condition severe enough that they need someone to help look after them.

- The Stockport [Attendance Allowance Toolkit](#) is aimed at councils and GP practices to share practice and learning to help increase the uptake of Attendance Allowance, one of the most underclaimed benefits.
- There is an accompanying [Appendix to the Attendance Allowance Toolkit](#) which contains frequently asked questions and useful information for GPs.
- [Attendance Allowance: Overview - GOV.UK](#)

This internet page [Helping Hand - Greater Manchester Combined Authority](#) contains the link to each of the 10 local authority council website pages specifically on cost-of-living support.

You may wish to also use the interactive money advice referral tool (MART): [MART - Resolve Poverty](#).

The MART is a financial support finder available for people living in Bolton, Bury, Manchester, Oldham, Tameside, Trafford and Wigan. It's designed for any agency that works with people on low incomes, including GP surgeries, schools, hospitals and local community groups, as well as people seeking financial support for themselves.

Training and resources to find out about supporting people with no access to public funds are available through [Restricted Eligibility Support Service \(RESS\)](#)

The RESS is funded by GMCA to provide training and peer support to frontline professionals in Greater Manchester who are working with people facing barriers because of their immigration status.



Feedback

We would love to hear from you, especially if you have any:

- Local examples, case studies or stories of change
- National or local good practice that has guided your work
- Toolkits or resources you have developed to share
- Feedback on this toolkit –is it useful? What's missing?

Please email:

gmlivewell@greatermanchester-ca.gov.uk

