Proactive and **Personalised Care** toolkit

Part of Greater Manchester Integrated Care Partnership

Developed by NHS Greater Manchester Primary Care Provider Board with NHS Greater Manchester

A guide for Primary Care Networks

Introduction

The Proactive and Personalised Care Toolkit is an important step in our plan to improve primary care in Greater Manchester. Our goal is to make care more community-focused, driven by data, and centred around each person's needs.

This toolkit was created by Greater Manchester Primary Care Provider Board (GMPCB) and NHS Greater Manchester (NHS GM), in partnership with Peak Health Coaching. It brings together what we've learned from the Greater Manchester Proactive and Personalised Care Programme, including successful methods, tools, and examples of what worked well.

The programme included quality improvement (QI) approaches, coaching principles and place-based working.

It supported Primary Care Networks (PCNs) to:

- Use population health data meaningfully through platforms like Curator
- Design workforce models that optimise Additional Roles Reimbursement Scheme (ARRS) roles
- Employ health coaching to empower patients
- Apply QI tools to build iterative, measurable change

We've included case studies from two PCNs that show the impact of this approach.

SWAN PCN (Wigan) lowered high blood pressure rates by doing screening in the community. Victoria PCN (Stockport) found more people at risk of disease by using new ways to reach out to high-risk groups.

The toolkit contains QI templates, videos from our experts on workforce design and coaching, guidance on workforce planning, and ways to link data with community engagement.

We have structured these around a clear 'Why, What, How' framework, designed for both new and experienced teams.

Even with national and local pressures, PCNs saw real benefits. They found illnesses – and were able to intervene – earlier, used their workforce more efficiently, built stronger community connections, and helped patients take greater control of their health and use services more.

This programme shows that using coaching, data, and step-by-step improvements leads to better patient care and a stronger health system.

We recommend that this model is formally adopted across Greater Manchester, with full support to help PCNs use it as part of their everyday work.

Dr Nikesh Vallabh
Greater Manchester
Proactive Care
Clinical Lead

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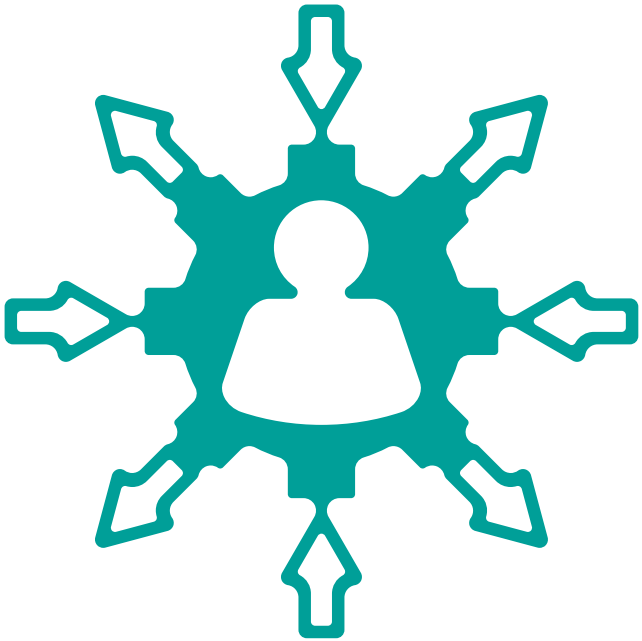
Shaping strategy ***from the ground up***



Chapter 1: **The 'why'**

Why adopt a proactive and personalised care approach?

1.1 What is proactive and personalised care?

Proactive and personalised care is an approach to health and wellbeing that identifies and supports people's needs before they reach a point of crisis. It focuses on early identification and intervention to keep individuals well, independent and connected to their communities for as long as possible.

Proactive and personalised care works best delivered in partnership with communities and tailored to local needs, using data, relationships and community assets to identify and support those at risk.

To deliver proactive and personalised care effectively, we need to place the individuals at the centre of decisions about their health and wellbeing, understanding what matters to them.

Proactive and personalised care also considers the wider social determinants of health, such as housing, employment, and education, to promote long-term wellbeing and reduce health risks.

1.2 Why is it important?

Proactive and personalised care is particularly important in Greater Manchester as it underpins the region's ambition to create a sustainable, person and community-focused health and care system.

It aligns closely with the *Greater Manchester Primary Care Blueprint* and the *Greater Manchester Live Well* model, which emphasises supporting people to live healthier, more independent lives through early intervention, prevention, and community-based support, recognising that many of the factors influencing wellbeing sit outside of clinical settings. Proactive and personalised care is not only vital to helping individuals lead healthier, longer lives but is also key to the long-term sustainability of our healthcare system by reducing avoidable demand on overstretched services, as advocated in the *Darzi Report* and more recently in the *NHS 10 Year Health Plan*.

Delivering proactive and personalised care at a neighbourhood level is crucial, as it allows interventions to be tailored to the unique needs of local populations and leverages local strengths, assets, and community networks.

This place-based approach builds resilience, tackles inequalities, and supports a more sustainable, person-focused health and care system.

1.3 About the Greater Manchester Proactive and Personalised Care Programme

The Greater Manchester Proactive and Personalised Care Programme was designed to help Primary Care Networks (PCNs) develop ways of improving patient care and health outcomes.

It equipped them with the skills to proactively tackle long-term conditions in their localities and ultimately reduce demand on primary and secondary care.

Participants chose one condition to focus on and were supported to develop person-centred approaches based on the specific needs of their local population.

Phase one of the programme focused on dementia, frailty and high-intensity users, while phase two featured cardiovascular disease (CVD) and diabetes.

Through a mixture of face-to-face workshops and online sessions, they learned how to interpret local data, shared learning with other PCNs, and understood how to adapt their workforce, including how to maximise the roles under the Additional Roles Reimbursement Scheme (ARRS).

They also received a range of quality improvement (QI) tools and templates, and benefited from health coaching principles to help maintain structure and focus for their individual proactive and personalised care projects.

The programme was delivered by Greater Manchester Primary Care Provider Board (GMPCB) and NHS Greater Manchester (NHS GM) in partnership with Peak Health Coaching.

In addition, Made By Mortals, a company that brings lived experience to life, delivered a theatrical interactive audio workshop called 'Stuck'.

[three minutes]

This toolkit highlights the best resources from the GM programme and displays them on the GMPCB website.

You can use the whole guide, as a framework for your own proactive and personalised care project, or dip in and out of the sections most relevant to you.

Following the structure of the programme, the toolkit sets out the 'why', the 'what' and the 'how' approaches taken.

Chapter 2: **The 'what'**

What's available to help you take a proactive and personalised care approach?

2.1 Using data to understand and engage your populations

Using data effectively is key to making proactive and personalised care work for your community.

Data helps us understand exactly where the problems are, who needs support, and how well we're doing to improve things. However, data itself isn't enough – we need to connect the numbers to real people and real lives.

Initially, data helps us find the right group of people to focus on. By considering factors such as age, ethnicity, or local circumstances, we can identify who might benefit most from our efforts. This means our care and attention is directed exactly where needed.

Data also helps us spot important differences. Often these differences are expected - such as older people having more health issues - but sometimes, they can surprise us.

For example, if data shows fewer health issues in poorer areas than we'd expect, it tells us we need to look deeper. Differences in how healthcare is delivered should always concern us, because they can indicate unfairness and inequality.

Engaging your community is where data truly becomes powerful. When people see that their unique circumstances are understood, they feel respected and involved.

Clear data can open up meaningful conversations, build trust and lead to care that's genuinely helpful and relevant.

Proactive and personalised care is about continuously checking what's working, what's not, and adjusting your actions accordingly.

Regularly reviewing the data with your community ensures the care provided stays effective, fair, and truly meets people's needs.

Each locality will have access to data via its intelligence health hub. In Greater Manchester the platform is called Curator, which is part of Tableau.

Dr Aseem Mishra, GM's CVD prevention lead, led the programme's sessions on data. ***In this video, he explains how data can help you understand and identify different groups.***

[eight minutes]

2.2 Workforce matters

Having the correct workforce in place is vital to delivering the best service to patients, and workforce planning and redesign are key elements to achieving this. Proactive and personalised care projects can benefit from thinking creatively about the workforce you have in your practice.

The Additional Roles Reimbursement Scheme (ARRS), in particular, provides an opportunity for general practice to think differently about how it can support patients.

Lynn Marsland, Greater Manchester Primary Care Provider Board's strategic lead for HR, Workforce and Organisational Development, explains how to approach creating the best team to deliver services.

Video 1 describes the first five Rs: right size; right shape; right skills; right site; right spend.

[seven minutes]

Video 2 describes the second five Rs: refresh; recruit; re-train; re-focus; release.

[13 minutes]

Chapter 3: **The 'how'**

How to develop a proactive and personalised care model

3.1 The coaching approach and why it works

Engaging and empowering your patients to look after themselves well is an essential ingredient in any health system. The recent Lord Darzi review of the NHS highlighted this as his key recommendation for reviving the NHS.

Health coaching is widely recognised as a set of skills and a way of working - a mindset - that is focused on building patient autonomy and agency.

Its central focus is to build confidence and capability of people to look after themselves. In doing so, they become a key asset to themselves and to us as service providers.

Peak Health Coaching is a company set up by GPs Ollie Hart and Tim Williams. Over their careers and through training thousands of staff in the NHS, they have seen the value of applying health coaching, to enable patients to be more active and effective participants in their care.

PEAK HEALTH
COACHING

The Greater Manchester Proactive and Personalised Care Programme included an overview of health coaching principles, including the island-hopping metaphor. The island-hopping theme was used to weave in coaching skills and approaches, helping to shape how the whole project was delivered.

One of the legacies of this programme was a greater appreciation of the value and feasibility of health coaching. ***In this YouTube video, Dr Ollie Hart describes the health coaching approach – calling it 'island style'!***

[nine minutes]

3.2 Quality improvement tools and templates

Quality improvement (QI) empowers those closest to the issues affecting care quality by providing them with the time, permission, skills, and resources needed to address and solve these challenges.

It involves a systematic and coordinated approach to solving a problem using specific methods and tools with the aim of delivering a measurable improvement.

Several QI methods were introduced as part of the proactive and personalised care programme, and PCNs were encouraged to use them in designing their projects to improve health outcomes for patients.

The QI sessions were led by Dr Joanna Bircher, Clinical Director for the Greater Manchester Primary Care Provider Board's GP Excellence Programme.

In her video, Dr Bircher explains the QI approach.

[14 minutes]

QI templates:

- Aim statement
- Process map
- Fishbone diagram
- Model for improvement
- Driver diagram
- Project plan
- Plan-Do-Study-Act (PDSA)

Our PCN proactive care aim statement

This form may be helpful to help you create your project aim statement. Try to involve as many people as you can in the creation of the aim statement, particularly those who will be involved in the delivery of the project. If possible, find ways of including people who might be impacted by the project.

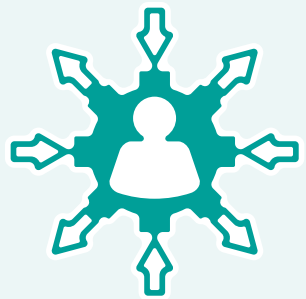
1. **What?** What is the problem you are trying to improve?

2. **How much?** By how much will you improve it – or 'how good' do you want to get it?

3. **By when?** What is the date by which you will achieve the level of improvement you've set out to accomplish?

4. **For whom?** Who is in your target cohort?

5. **Complete Aim statement** – include steps 1–4 in a single sentence, starting with 'We will…'



Process mapping and value stream mapping

Process mapping

Day-to-day general practice work involves many processes to ensure safe, effective delivery of care for patients. These can include a variety of things such as the management of repeat prescriptions, the referral process, managing clinical information, handling test results and sorting the post.

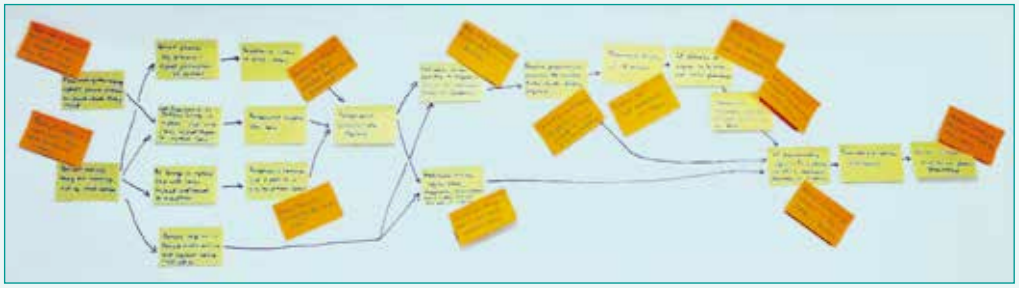
Each task includes lots of steps involving many people, including patients. At every stage there is always the possibility of error. Errors can lead to patient harm, but more often they lead to inefficiencies and wasted time. Process mapping creates a visual representation of all the steps in a particular process (see Figure 1 below).

Changing processes, especially those that may be well-established but inefficient, can be complex and difficult. For effective improvement to take place the first step is for everyone involved to fully understand the existing process.

Process mapping can help everyone to:

- understand the stages of a process they are not directly involved in
- quickly identify bottlenecks
- identify steps that appear to be a waste of time
- co-design revisions to a process
- engage in change
- contribute to improvements
- take ownership of the new or revised process - which will help with buy-in

Figure 1: Example process map



How to

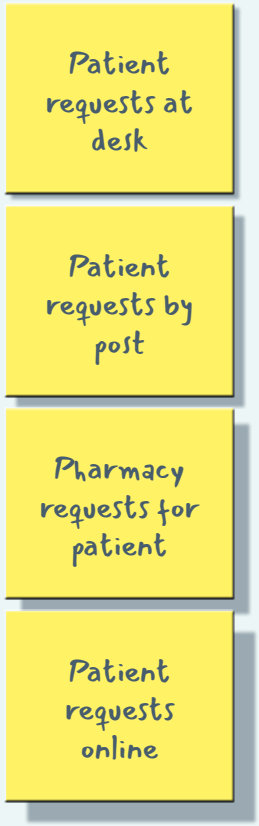
Preparation stage:

- **Step 1:** decide which process is to be mapped
- **Step 2:** arrange a convenient date for everyone to meet. Invite anyone involved in the process to participate in the mapping exercise, including patient representatives where relevant
- **Step 3:** choose a facilitator. This person needs to be able to explain the exercise to the rest of the team. They do not need to have a detailed understanding of the process that is to be mapped
- **Step 4:** collect the materials. You will need pens and post-it notes in different colours

During the session:

- **Step 5:** the facilitator explains process mapping to the participants, making it clear that each step needs to be broken down. The more detailed the better because this will identify waste
- **Step 6:** define the start and end point of the process. For example, with repeat prescribing the start point could be the patient requesting a repeat prescription. The end point could be the patient collecting the prescription (see below)

- **Step 7:** If one step can be done in several different ways, this is added vertically. For example, in the repeat prescribing process the patient may request a prescription in several different ways as per the diagram below



- **Step 8:** once the map is created, the facilitator asks the group to consider where the problems arise. The participants then note the problems on a different coloured post-it note and attach these at the appropriate point on the map
- **Step 9:** participants are then asked to identify solutions. These are noted on a different coloured post-it note. They are placed over the problems that were identified
- **Step 10:** the process will have identified areas for improvement and generated new ideas to try out. The group should decide if they will try out the changes one at a time, or several together. They will also decide what measurements they will use to identify if there is an improvement over time. Using run charts is one way you might measure and track change to identify which improve the process and should be sustained
- **Step 11:** a further process map is then created by the group to illustrate the agreed new process

After the session:

By the end of the session you will have created a visual display of an improvement to an existing process. The exercise often highlights that the more steps there are in a process, the more likely it is that there is inefficiency. It is a good idea to leave the map on display for a few weeks so that any issues that arise during implementation can be easily discussed.

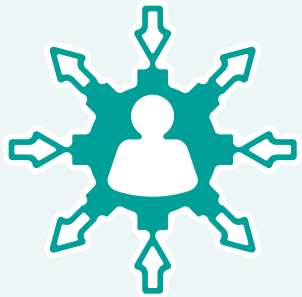
Value stream mapping

This is a visual map of a process or system. It has similarities to process mapping, but includes more detail such as the length of time between steps in the process and how long each step usually takes.

Its purpose is to identify waste to help streamline processes. The objective is to reduce or eliminate activities that don't appear to be adding any value to the whole process, or to the patient.

How to

- Follow Steps 1–7 of the process-mapping guidance
- On the map, record the time it takes to complete each step and the time taken between steps. Once all the steps have been identified, decide which are value-added, value-enabling (activities that do not add direct value, but are necessary to the process) or non-value added
- Once the value stream map has been created, the group will generate ideas about how to eliminate steps in the process that are not value-adding or value-enabling, or reduce the time it takes to complete each step, or interval between steps



Fishbone diagram

What is a fishbone diagram?

Fishbone diagrams (also called cause and effect analysis) are used to help identify and display the root causes of a problem. They are useful when there are multiple causes of a problem and help to ensure important potential factors are not ignored.

How to create a fishbone diagram

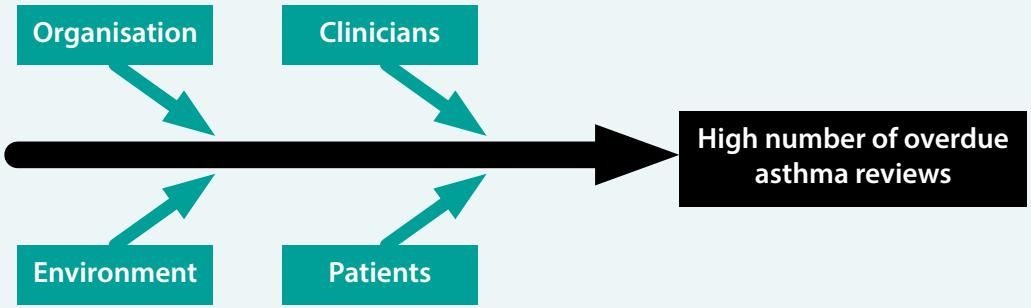
The example below shows the use of a fishbone diagram to understand why there are so many overdue asthma reviews.

Identify the problem

This becomes the head of the fish – 'High number of overdue asthma reviews'.

High number of overdue asthma reviews

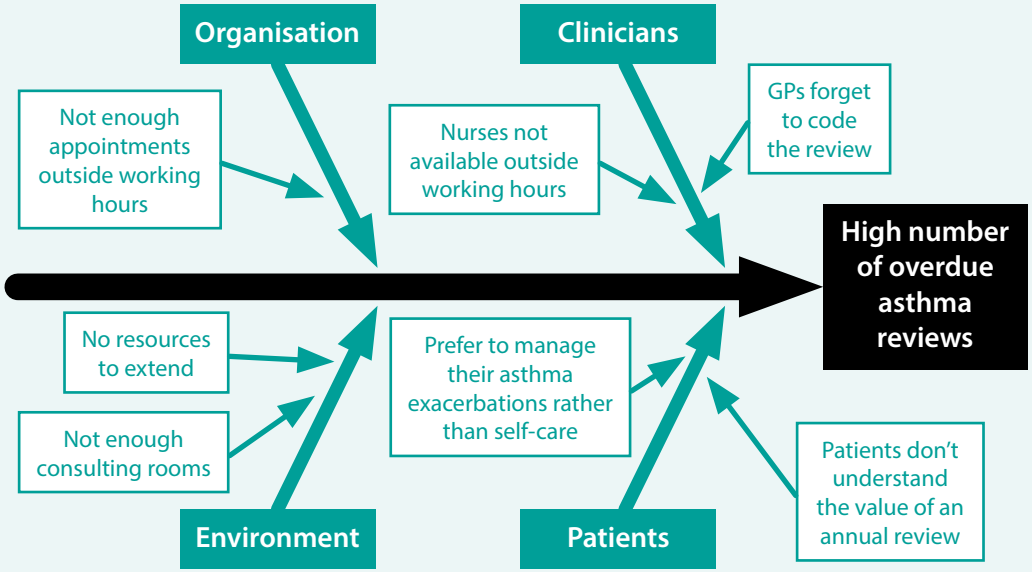
Gather the relevant people together and generate the major categories of potential causes. In the example shown these are environment, organisation, clinicians and patients. Other useful categories include equipment and time. These form the spines of the fish.



Discuss each major category, adding the ideas generated as sub-branches. Each sub-branch may be further broken down into its contributing factors.

For every spine and sub-branch identified, ask yourself 'Why does this happen?' and consider the question from different perspectives such as patient, administrator, nurse, doctor, Integrated Care Board (ICB). This will produce the layers of causes that will help you to fully understand the root of the problem and its dependencies.

Use your completed diagram to help you to generate ideas for improvement, which may then result in the development of a driver diagram to plan your improvements.



Model for Improvement

The Model for Improvement is useful once you have decided what area of patient care or practice process you would like to improve. The Model for Improvement gives you three questions to answer before you start testing changes:

1. **What are we trying to accomplish?**
2. **How will we know if a change has been an improvement?**
3. **What changes can we make that will result in an improvement?**

Your changes are more likely to succeed if you and the team are very clear and specific about what you want to improve and how you will know if you have been successful. This method ensures this is established before embarking on an intervention.

How to create a Model for Improvement

The example below uses the Model for Improvement approach to reduce antibiotic prescribing.

Question 1:

What are we trying to accomplish? This needs to be specific and include 'by how much?' and 'by when?'

"To reduce our antibiotic prescribing to be in line with the national average in six months time."

Question 2:

How will we know if a change has been an improvement?

Decide what you are going to measure. Some organisations provide us with data, and this can be very helpful in deciding on the overall success of a project, however this data is often slow to arrive and may not be provided frequently enough to judge the success of each individual change. Continuing the antibiotic example:

- Data about antibiotic prescribing compared to national averages is being provided every three months in England by the local medicines management team and this will be used to assess the overall success of the project after six months
- This externally collected data is not useful for judging whether our small changes have been successful
- It is more useful to gather 'real-time' data, for example recording the number of antibiotics prescriptions issued each week by running a search at 6pm every Friday

Question 3:

What changes can we make that will result in improvement? Consider all the ideas for change and you can select those that you would like to test. In our example, the practice agrees to test three ideas:

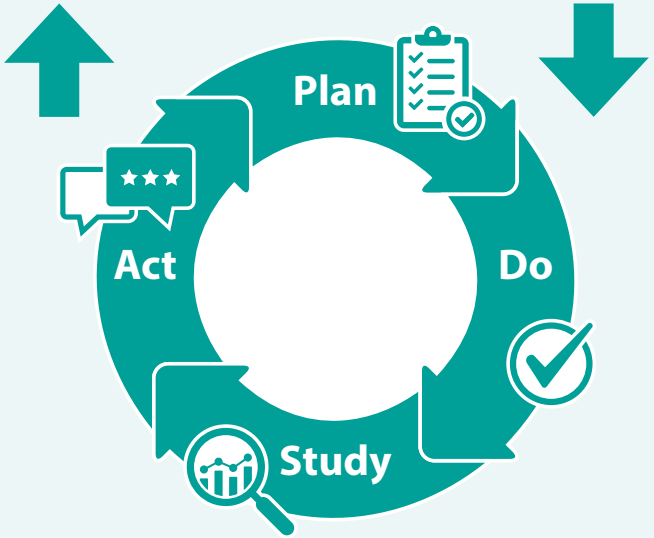
- Put a poster in the waiting room explaining to patients why antibiotics are not useful for most coughs and colds
- Benchmark the prescribing habits of the individual GPs in the practice – number of antibiotics prescribed per 10 consultations
- Provide all chronic pulmonary obstructive disease (COPD) patients with a leaflet explaining that most exacerbations should be treated with steroids first, and only use antibiotics if sputum becomes purulent

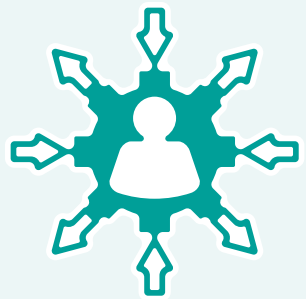
You can take one of these changes into a Plan-Do-Study-Act (PDSA) cycle prior to its introduction.

What are we trying to achieve?

How will we know that a change is an improvement?

What changes can we make that will result in improvement?





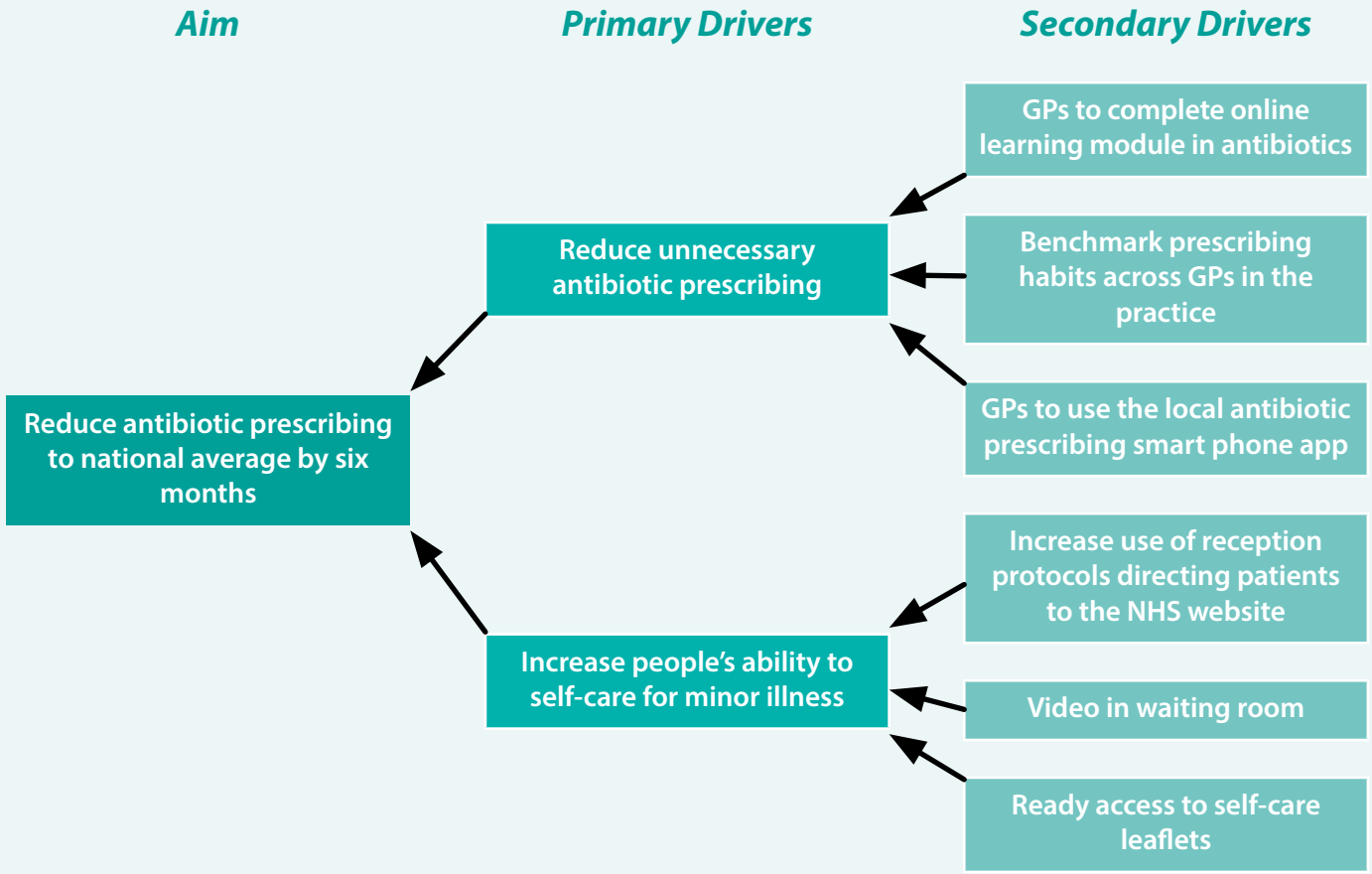
Driver diagrams

What is a driver diagram?

A driver diagram is a tool to help you to organise your improvements in a logical way, so that everyone involved can see how the planned changes will lead to the desired improvement. It is particularly useful when you are aware of several changes that need to happen before you are likely to see improvement.

Making a more complex project easy to visualise helps to engage others in the changes. Some organisations use a driver diagram to plan the direction of their work following development of a vision or mission statement.

Figure 1: Driver diagram to reduce antibiotic prescribing



How to create a driver diagram

Step 1: Define your aim

Step 2: Generate ideas

Use the whole team to generate ideas (or 'drivers') that are likely to move you towards your aim.

Step 3: Group the ideas into themes

Once you've generated the ideas, group them into themes:

- 'Primary drivers' - an agreed set of high-level factors that help you towards your aim. Make sure you use language like 'improve' or 'decrease' and that each driver is clearly defined (and potentially measurable)
- 'Secondary drivers' - ideas that help you to achieve your primary drivers. Arrange in the second column of your diagram. Each primary driver will be influenced by several secondary drivers

Step 4: Add actions or interventions for each driver

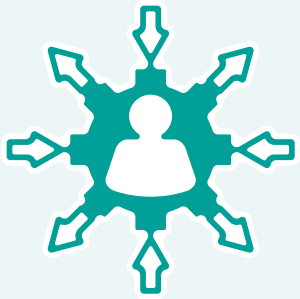
Step 5: Add measurements

Finally, decide which drivers and interventions you want to measure and add those to the diagram.

When completed, the diagram provides a change strategy that can be shared and understood, and can provide the basis for planning the individual projects or interventions. It should not be considered 'fixed' and can change over time as improvements are generated.

Figure 2: Driver diagram to reduce antibiotic prescribing (example actions and measures)

Primary Drivers	Secondary Drivers	Actions/Measures
Reduce unnecessary antibiotic prescribing	GPs to complete online learning module in antibiotics	Practice pharmacist runs search on last day of each month and calculates number of prescriptions issued per 10 consultations by GP. Then create bar chart and email to all GPs
Increase people's ability to self-care for minor illness	Benchmark prescribing habits across GPs in the practice	
	Increase use of reception protocols directing patients to the NHS website	Reception manager to source self-help videos and bring to next meeting for approval
	Video in waiting room	Reception manager to start a tally chart for reception staff to count the number of appointment request dealt with by signposting to self-help
	Ready access to self-care leaflets	



Project plan

Our Aim Statement

Change idea	Score (Relevance, Impact and Ease)	What needs to be done	By who?	By when?

Measures – how will we know we have achieved our aim?

Plan-Do-Study-Act (PDSA)

What is a Plan-Do-Study-Act process?

The Plan-Do-Study-Act (PDSA) process helps you to test improvements in a controlled way so that change can occur gradually, with an awareness of unintended consequences. It is a cycle of four stages:

- **Stage 1: Plan:** where introduction of your change is carefully planned
- **Stage 2: Do:** where you carry out your plan
- **Stage 3: Study:** where you analyse your measurements and decide if it has been successful
- **Stage 4: Act:** where you decide whether you implement your intervention, or make any changes to it, and/or consider introducing any further interventions

When we want to improve things in our practices, we often come up with a lot of ideas, but cannot be sure which will result in the change we want to see. The PDSA approach accepts the fact that not all our ideas will work and allows us to test them out in a controlled way. We can then continue with the ideas that work, and stop doing those that do not. It starts at small scale and so is a cost-effective approach.

How to create a PDSA process

The example of reducing antibiotic prescribing will be described to demonstrate how to use a PDSA cycle.

Stage 1: Plan

- Identify the change you wish to implement in order to bring about an improvement
- Identify who will be responsible for the change
- When it will be carried out
- Over what timescale
- How the measurement will be conducted
- Involve all stakeholders in the process from the start as this helps to persuade any reluctant team members to participate
- Look out for the unexpected, for example checking that a reduction in antibiotic prescribing does not cause an increase in chronic pulmonary obstructive disease (COPD) admissions. This is called a 'balance measure'

In our example, the practice identified three changes it would test out:

- A poster in the waiting room
- Benchmarking the GPs' prescribing habits
- A leaflet for COPD patients

Stage 2: Do

Collect your baseline data to monitor the existing state of play. You might do this as part of 'planning' or 'doing'.

- Ensure that all individuals who are conducting the measurements understand what data is being collected and how to collect it
- After sufficient time, continue to collect the data but introduce the agreed change
- Usually introduce one change at a time so that the effect of each can be measured. By introducing only a small change you are likely to encounter less resistance, and, if unsuccessful, adaptions can be made more quickly. The scale at which you test your change should also be kept small at first. Any problems encountered, and any unexpected consequences, can be recorded as implementation progresses

In our example for the second change, the practice decided to run a search every Friday at 5pm to gather the number of antibiotic prescriptions issued that week.

Stage 3: Study

The success or failure of the change is assessed at this stage, both quantitatively (by looking at the data collected) and qualitatively (by discussing how everyone experienced the change). As the number of antibiotic prescriptions normally varies from week to week, a run chart will help you to understand the normal variability before you introduce your change.

You should compare the results with the predictions you made and document any learning, including a record of the reasons for success or failure. Not all changes result in improvement, but you will always learn something from the test.

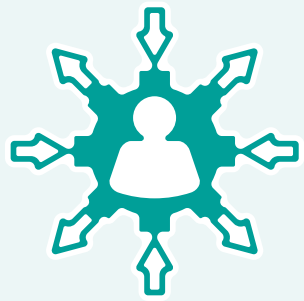
In this example the practice discovered the poster made no impact on the number of antibiotic prescriptions issued, but the benchmarking of GPs' prescribing habits did result in a reduction.

Stage 4: Act

In this stage, decide whether you just need to adapt what you have tried or whether you might try something completely new instead.

In our example the decision was made not to keep the poster in the waiting room, but to continue the benchmarking exercise every two months.

It is best to test small changes and then do multiple cycles. Learning from one cycle informs the next.



Chapter 4: **Case studies**

Providing peer support and collaboration was a key element of this programme, and we've captured some of this sentiment in case studies. There's also *a podcast which focuses on proactive and personalised care* and the work SWAN PCN did on dementia, as part of cohort one of the programme.

4.1 SWAN Primary Care Network, Wigan

Aim statement

Identify patients with a recorded high blood pressure (BP) of more than 180/120 and reduce by 25 per cent, over nine months.

Also, increase awareness of cardiovascular disease (CVD) and diabetes and provide health checks closer to home, in two specific postcode areas.

What we did

- Used Blood Pressure lists to conduct system searches to identify patients with a raised BP
- Work resulted in bringing the BP reading in target for 46 per cent of those who engaged
- 14 per cent required no further action, and 19 per cent are awaiting Home Blood Pressure Monitoring (HBPM)
- Used data from the heat map on Curator (the Greater Manchester intelligence health hub) to identify patients with poor outcomes from CVD
- Mapped local area postcodes
- Worked with PCN community steering group, which includes representatives from the Voluntary Community and Social Enterprise (VCSE) sector, local council, primary care, social care and personalised care roles within the PCN
- Liaised with local supermarkets, churches and clubs to set up blood pressure clinics

How the proactive and personalised care programme helped

- Access to live, high-quality personalised data that allows us to target the right groups of patients
- Ability to analyse own data through Curator was refreshing and empowered us to target groups of the highest need
- Helped shift from solely practice-based data and an individual practice approach to a collective data and neighbourhood approach
- Actively seek people with a health need, that they may not even be aware of
- Engaged in a way that is right for the patient, rather than what is best for us
- Learned a lot about our local neighbourhood

Next steps

We want to embed these methods to address the CVD/diabetes needs of our local people and adapt them so we can apply them to any health need, therefore delivering proactive and preventative care.

We have generated lots of ideas to take this forward on a larger scale, and will use our PCN nursing associate, social prescribers and PCN GP assistants to undertake targeted work such as holding clinics in alternative settings, signposting to holistic services, running regular data searches and building on community connections.

NHS
SWAN Primary Care Network

4.2 Victoria Primary Care Network, Stockport

Aim statement

Use data to help predict and prevent cardiovascular disease (CVD) and diabetes within the prevalence of QRISK outcomes, such as heart attacks and strokes.

We aimed to reduce CVD prevalence by 10 per cent, and increase the prevalence of diabetes by 10 per cent, as well as identify incidences of pre-diabetes, within the next 12 months.

What we did

- Used EMIS to identify patients at high risk, not already taking statins
- Used the Q-diabetes calculator to identify all patients with a risk of more than 50 per cent of developing diabetes
- Invited patients to health check clinics on a Saturday and in the evening
- Reviewed our aim and made changes at the mid-way point
- Saw a 600 per cent increase in chronic kidney disease (CKD), a 533 per cent increase in diabetes and a 314 per cent increase in pre-diabetes, plus a 500 per cent increase in fatty liver disease
- Had 300-plus more patients attending for checks, and made 200-plus more diagnoses compared to the previous year
- Recognised the importance of using tools to support the stratification of patients into suitably convenient clinics
- Patients appreciated the choice of convenient appointments at weekends or in the evening, at a selection of locations
- Empowered patients to manage their conditions through early identification
- Broadened the outcome for patients and supported better health benefits

How the proactive and personalised care programme helped

- Allowed us to have protected thinking time
- Learned how to use new tools to support the visualisation of our project
- Developed a focused project plan, driver diagram, and highlighted where problems might occur and how to combat them
- Helped the PCN to focus when we found we were stumbling
- Useful and inspirational networking with other PCNs
- Devoted senior clinical time away from practice to focus on quality improvement (QI) and problem-solving
- Additional support from a proactive Advanced Clinical Practitioner and the project senior team, as well as Clinical Director (Senior GP partner)

Next steps

We want to continue to build on the success of the project and develop multiple clear projects for all practices in the PCN, enabling this tried and tested approach to become 'best practice' and business-as-usual for us.

We believe keeping wider stakeholders informed, celebrating our successes and having the right ethos will help focus our PCN plans for neighbourhood planning and population health management for the year ahead.

We will continue to review our data on a monthly basis, and support our staff and patients to improve health outcomes.

VICTORIA
PRIMARY CARE NETWORK
(STOCKPORT) LIMITED

Chapter 5: **Evaluation summary**

How do we measure success?

The main objectives of the Greater Manchester Proactive and Personalised Care Programme were to:

- Improve management of high-risk and long-term conditions
- Use data to identify, stratify, and proactively engage patient cohorts
- Develop PCN-level approaches to support sustainable care transformation
- Build capacity through workforce development and community partnerships

A total of 26 PCNs completed the programme, from an initial cohort of 30, and PCNs faced numerous challenges along the way, including workforce issues, limited capacity within teams, engaging with communities, access to technology, quality of data, and skills to interpret data.

Despite the challenges, PCNs worked hard to overcome them and embraced what the programme offered in terms of health coaching and guidance, practical QI tools, and support with data identification and analysis.

Each PCN celebrated individual achievements within their project, such as:

- Higher levels of engagement and attendance
- Increased identification of cases
- More testing and referrals
- Better relationships with community partners
- Development of workforce roles
- Education and empowerment of patients
- Established new models of care

The overall success of the programme was assessed based on its alignment with Greater Manchester priorities, achievement of objectives, efficient use of time and resources, impact on people's health outcomes, and its potential for long-term success.

While there was variation across PCNs, we concluded that using a data-driven, community-engaged, and iterative approach achieves better patient outcomes.

We would like to develop the proactive and personalised care programme model into a pillar of population health transformation across Greater Manchester, with the appropriate support and some minor adjustments.

Meet the *Proactive and Personalised Care Programme* team

Dr Nikesh Vallabh

Nikesh Vallabh is a GP partner at South Wigan Medical Practice in Wigan and serves as the Clinical Director for SWAN Primary Care Network.

Nikesh has been active in primary care workforce development through efforts to support recruitment, retention, and training as the Greater Manchester Primary Care Workforce Clinical Lead, across all primary care disciplines.

Alongside this, Nikesh is also the Greater Manchester Proactive Care Clinical Lead, a role which focuses on improving patient outcomes through early intervention delivered by integrated Multi-Disciplinary Teams (MDTs) at neighbourhood level to address health inequalities within our communities.

Andrew Binnie

Andrew is an experienced NHS programme manager, currently serving as Programme Manager at Greater Manchester Primary Care Provider Board (GMPCB).

He led the design, delivery, and strategic oversight of the Greater Manchester Proactive and Personalised Care Programme, working in partnership with NHS Greater Manchester and national bodies.

His work focuses on supporting Primary Care Networks (PCNs) across Greater Manchester to develop proactive population health interventions targeting dementia, frailty, and high intensity users - a mission involving a mix of virtual and face-to-face workshops, and network learning sessions.

As part of GMPCB's delivery team, he collaborates with colleagues to embed a proactive care ethos across primary care systems.

Andrew has more than 20 years' experience working in health and programme management. He has delivered programmes at Salford Royal NHS Foundation Trust, East Cheshire Clinical Commissioning Group, and Manchester University NHS Foundation Trust.

Dr Joanna Bircher MB ChB FRCGP

Joanna Bircher is a GP in Greater Manchester. She is Clinical Director of Greater Manchester GP Excellence Programme, Clinical Lead for Quality Improvement at NHS Greater Manchester: Tameside locality, a Generation Q Fellow of the Health Foundation and a Royal College of General Practitioners (RCGP) Clinical Adviser.

She has a Masters degree in Leadership for Quality Improvement from Ashridge Business School and is co-author of the RCGP Guide to Quality Improvement.

Her particular interest is in making established QI methodology relevant and accessible for primary care and encouraging all who work within healthcare to develop their leadership skills.

In 2020, she co-authored 'The Leadership Hike: Shaping Primary Care Together' published by CRC Press, followed by the companion book 'Leading Primary Care – Tales from the Leadership Hikers' in 2024.

Lynn Marsland

Lynn is a seasoned Human Resources (HR) and Organisational Development (OD) professional, having achieved her career goal of operating at Board level as an executive director of HR, Workforce and OD within several organisations in the NHS.

Lynn is experienced in working across the broad health and social care sector, including acute, primary care, mental health, local authority social care, Voluntary Community Faith and Social Enterprise (VCFSE) organisations, along with private healthcare providers.

In her early career, Lynn led the design, development and delivery of leadership and management development courses for individuals across all levels, ranging from first-time leaders to board and executive team levels, spanning both public and private sectors. She also led and facilitated various OD projects, such as company mergers and acquisitions, along with service redesign work.

Dr Aseem Mishra

Aseem is an academic GP at Bowland Medical Practice, Wythenshawe and Clinical Lead for Cardiovascular Disease Prevention (CVD) at the Greater Manchester Integrated Care Board (ICB).

He works at the intersection of healthcare, technology, and human behaviour, using health informatics, systems thinking, and behavioural science to deliver real-world change.

Through the Greater Manchester CVD Prevention programme, he has led initiatives including the CVNeed analytics approach, Greater Manchester's cardiovascular clinical guidelines, the System Transformational Fund, and primary care incentive schemes.

His work is grounded in a whole-systems, complexity-informed approach, aimed at reducing unwarranted variation, tackling inequalities, and translating rich data into practical, equitable improvements in population health.

Dr Ollie Hart

Dr Ollie Hart is a GP from Sheffield, where he is the Clinical Director for a Primary Care Network, covering 42,000 patients.

He has a core professional interest in person-centred care. Over the last 10 years he has held a range of national roles in this area, co-chairing NHS England's strategy board for supported self-management, and being a national champion for the Royal College of General Practitioners (RCGP) in their Collaborative Care and Support Planning programme, clinical lead for personalised care for the NHS in Sheffield, and a member of South Yorkshire Social Prescribing Board.

He is a Director for Peak Health Coaching, a company that specialises in health coaching training and organisational development for person-centred care. Peak Health Coaching was the first company nationally to be accredited for Health Coaching training by the NHS's Personalised Care Institute, and has trained more than 2,000 people in coaching skills.

He is one of two global health and wellbeing ambassadors for 'parkrun'. If not at his standing desk, Ollie is most at home running or biking in the Peak District.

Contact us

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