NHS

Primary Care Blueprint

Engagement draft - April 2023

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

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Executive summary

Executive summary

This Engagement Draft of our Primary Care Blueprint sets out the initial outputs of our work and will be used to support a programme of detailed engagement across our system over the period to the end of June.

The document is deliberately framed to facilitate discussion and in particular, to allow debate to take place with regard to the specific outcomes and measures which will form the basis of the production version of the Blueprint. On this basis, we have resisted the temptation to be too prescriptive in this version, recognising the importance of a co-produced approach to this development.

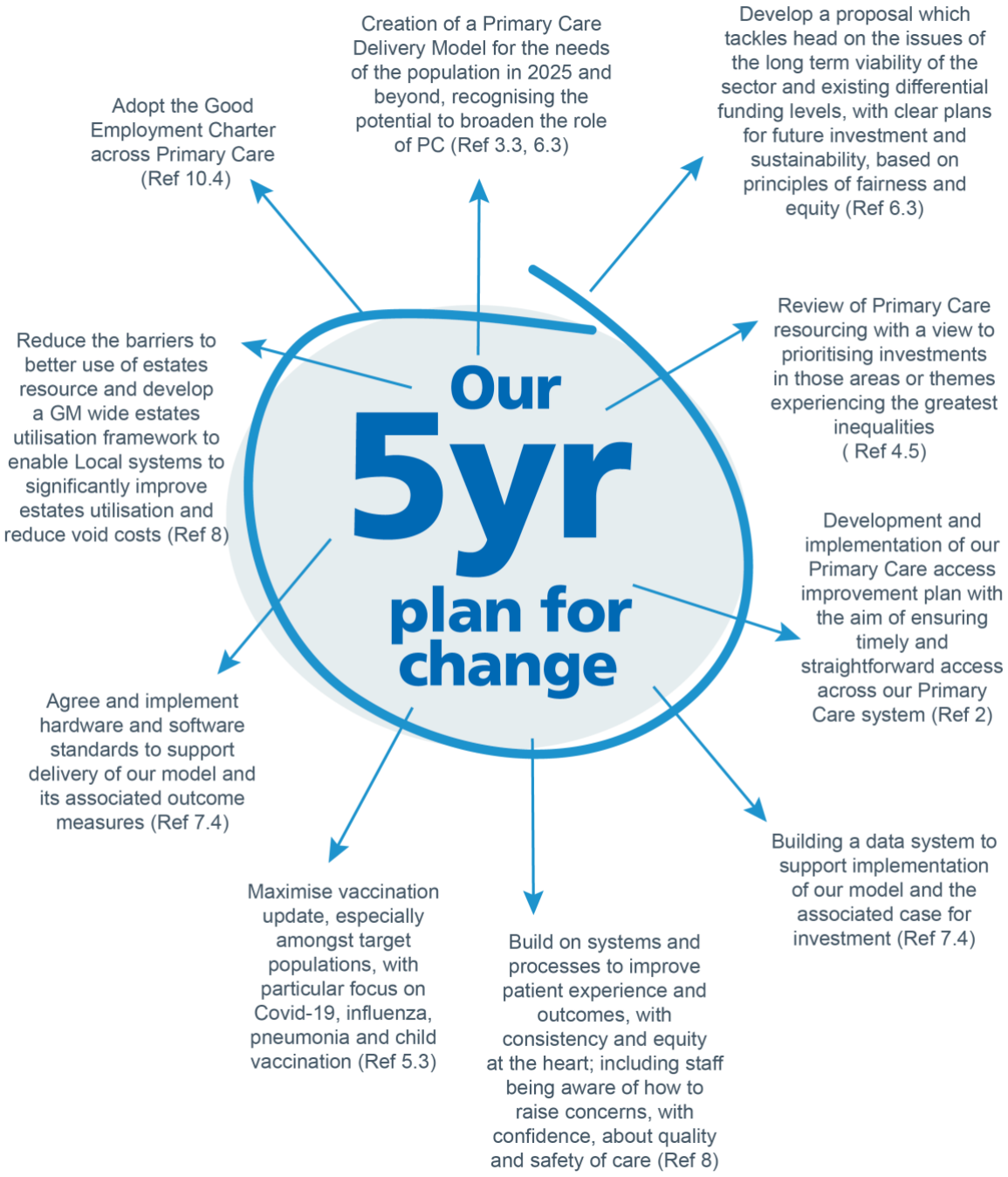
Developing our vision for Primary Care in Greater Manchester

Currently split across nine areas or chapters, (we will take a view as part of this engagement process as to how best to structure the production version), the Blueprint sets out a vision for a Greater Manchester Primary Care system which will:

✓	Provide timely appropriate access to care delivered by a system which has sufficient capacity to meet the needs of service users, where processes are simple and straight forward
✓	Be part of a wider neighbourhood team, where individuals and communities are supported to take more control over their own health and where providers work together with the shared aim of improving the health of the population
✓	Ensure that we do not exacerbate health inequalities and takes practical steps to tackle these inequalities wherever we can
✓	Help people to stay well and focuses on disease prevention, early detection and effective management of long-term conditions
✓	Be viable for the long term, ensuring that services are available when and where needed
✓	Empower citizens and providers with gold-standard, digitally enabled Primary Care
✓	Be delivered from facilities which are appropriate for the provision of 21st century Primary Care
✓	Be standards based, with a focus on quality improvement
✓	Be recognised as a career destination for a happy, healthy and engaged workforce, trained to a consistent standard with knowledge and expertise to meet the needs of our population and provide timely, exemplar services.

Our Manifesto for Change

The document sets out a wide ranging suite of ambitions, designed to deliver the vision set out above, as well as describing the current issues facing our Primary Care system and some of the risks to delivery. The list below draws out some of the big ideas contained in the document to give a sense of the key objectives we plan to deliver over the next five years. We will further test and develop each of these points as part of the engagement process:



Critical Success Factors

The main document starts to describe the key issues and deliverables across our nine chapters. Engagement to date has identified a series of overarching issues which we believe will be essential to the delivery of the Blueprint. These are set out below and will be further augmented and reviewed as part of this engagement process:

- Primary Care must be viewed as an integral part of each of our 10 localities, including via formal representation on Locality Boards and other locality governance
- Completion of the implementation of the financial flows model previously agreed where money flows to Primary Care providers as directly and smoothly as possible
- Securing full implementation and visibility of our Primary/ Secondary Care and GP/ Community Pharmacy interface principles which will be important in managing pressures in our system but also in cementing the joint working which will be crucial to the delivery of the Blueprint
- The implementation process will need to be supported by:
    - An agreed programme delivery approach
    - Clinical leadership engagement and development
    - An organisational development process
- We will work to ensure some "early wins" to move forward on a series of issues which have been in train for some time, including but not limited to:
    - Occupational Health provision
    - Phlebotomy Services
    - Implementation of an updated "Sitrep" pressures management process

Next Steps

Over the period to the end of June, we will:

✓	Deliver a wide ranging engagement programme, informed by the content of this document
✓	Develop a business case for the investment necessary to deliver the ambition set out in the Blueprint
✓	Focus on maximising our use of information to inform our implementation plan and to further support the business case for investment made by this document
✓	Develop an implementation plan to cover the full five year period of the Blueprint, with a particular emphasis on making tangible early progress during year one

We will continue to test the emerging document with our Primary Care Assembly and use the content to progress discussions with wider industry partners, VCSE colleagues and others, with a view to building a delivery system that maximises all of their contributions.

How to contribute and influence the final content

As indicated above, we are keen that this engagement draft leaves scope for the production version to be shaped by this next phase of engagement. We therefore seek as much feedback as possible in the period to the end of June. We don't wish to limit this input by issuing a set list of questions to answer and welcome feedback on any aspect of the document.

To give a broad steer, these may be some of the issues that colleagues wish to feedback on:

Q.	Q.	Q.
Have we correctly identified the priorties for delivery and if not, what should be included?	If we implement the key issues set out in the document, will this make a positive difference to your experience either as a provider, service user or delivery partner? What could be added to the document to improve on this?	What should be the key delivery metrics and how will they be measured?

We welcome all comments

These should be addressed to: alison.wheatley6@nhs.net by 30th June.

Primary Care Blueprint

Introduction

Introduction

Since our Primary Care Summit in September 2022, we have been working on this initial version of the GM Primary Care Blueprint, designed to support a period of engagement through to the end of June. The results of this engagement will inform a production version of the Blueprint, which will then proceed through into implementation.

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

Primary Care Provider Board	Locality Teams	GM Primary Care Team

The following principles have informed all of our work:

- Each chapter must reflect all parts of our Primary Care system (Dental, General Practice, Pharmacy and Optometry)
- It must align with the NHS GM Integrated Care Partnership Strategy, (as approved at the March 2023 Integrated Care Partnership Board) and other related strategies/plans, i.e. Estates, People and Culture, Digital, etc
- The content should align with relevant national strategies, specifically the Fuller Report published in May 2022
- As well as our Primary Care teams, we have been informed and advised by our Primary Care Assembly, drawn from our wider GM Integrated Care partners

The main document starts to describe the key issues and deliverables across our nine chapters. Engagement to date has identified a series of overarching issues which we believe will be essential to the delivery of the Blueprint. **These are set out below and will be further augmented and reviewed as part of this engagement process:**

- Primary Care must be viewed as an integral part of each of our 10 localities, including via formal representation on Locality Boards and other locality governance
- Completion of the implementation of the financial flows model previously agreed where money flows to Primary Care providers as directly and smoothly as possible
- Securing full implementation and visibility of our Primary/ Secondary Care and GP/ Community Pharmacy interface principles which will be important in managing pressures in our system but also in cementing the joint working which will be crucial to the delivery of the Blueprint

- The implementation process will need to be supported by:
    - An agreed programme delivery approach
    - Clinical leadership engagement and development
    - An organisational development process

- We will work to ensure some “early wins” to move forward on a series of issues which have been in train for some time, including but not limited to:
    - Occupational Health provision
    - Phlebotomy Services
    - Implementation of an updated “Sitrep” pressures management process

Over the three month period to the end of June, we will:

✓	Deliver a wide ranging engagement programme, informed by the content of this document
✓	Develop a business case for the investment necessary to deliver the ambition set out in the Blueprint
✓	Focus on maximising our use of information to inform our implementation plan and to further support the business case for investment made by this document
✓	Develop an implementation plan to cover the full five year period of the Blueprint

We will continue to test the emerging document with our Primary Care Assembly and use the content to progress discussions with wider industry partners, VCSE colleagues and others, with a view to building a delivery system that maximises all of their contributions.

Primary Care Blueprint

Demand, access and capacity

Demand, access and capacity

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

2.1 What do we mean by Demand, access and capacity

DEFINITIONS

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

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

In writing this chapter it is important to reflect that demand, access and capacity is different in the four disciplines of Primary Care and in some cases demand and access are merged due to the open-door nature of services. It is also important to acknowledge the role of preventative, screening, and wellness services which fundamentally change the shape of demand into services, keeping citizens well, supporting early diagnosis and promoting self-care.

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

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

2.2 Greater Manchester Pledges

In making these pledges in Greater Manchester we are considering the recommendations coming from the Fuller Report, national GP Contract, GM ICS Strategy, Primary Care Recovery Plan (which we anticipate being published in May 2023).

Whilst the current process of engagement will firm up our detailed priorities, outcome measures and plans for delivery, there are some clear issues relating to access which we believe are of key importance to our service users and are therefore set out here as likely cornerstones of our work as we move forward:

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

More generally, the following sets out how we will work together to realise our vision:

✓	We will create a culture where health, social care, the voluntary and third sector and local business will be committed to keeping neighbourhoods connected and wrap care around people, keeping people healthy and happy. This will support early presentation of illness and encourage uptake of prevention and social prescribing programmes, e.g., active initiatives, screening programmes and local groups such as gardening. Neighbourhoods will also be proactive in supporting people when they are living with long term and life limiting illness. This model of care will help us to manage the demand on our services, supporting people to make good decisions about their health and self-care. This point is emphasised in the ICP Strategy, which states that: *Our integrated neighbourhood teams work to connect all Primary Care services including GPs, dentists, pharmacists and optometrists with community, social and local acute care, local VCSE and wider public services (such as housing providers, schools, employment support and the local police and fire and rescue service). We will not miss the opportunity to maximise the enormous potential of community pharmacy* **(links to Neighbourhood, prevention and inequalities chapters)**
✓	Primary Care disciplines will work together, making every contact count and taking responsibility for those in their care by sign posting and undertaking checks such as blood pressure or giving simple advice. Contracts will be modernised so this can happen easily to the benefit of the person **(links to quality chapter)**
✓	Care records will be interlinked so that information is available to relevant practitioners when the person is happy for that to happen. People will also have access to their own information and be able to interact with it (**links to digital chapter)**
✓	Neighbourhood teams in health, social care and the voluntary sector will be

	co-located and available where people need them, working together for people and families. This approach will encourage shared caseloads and interactions between sectors **(links to estates and neighbourhood chapters)**
✓	We will work with our further education colleges and universities to create new roles which will emerge to support collaborative working. In doing this we will make the most of GM's One Workforce, One Model initiative **(links to workforce chapter)**
✓	We will establish good workforce planning so that we plan our future workforce to reflect our communities and their needs **(links to workforce chapter)**
✓	Primary Care will adopt digital technology to modernise access to care and case finding within neighbourhoods. Websites will be standardised and easy to navigate, telephony will be cloud based to enable calls to be picked up in different places, navigation tools will go hand in hand with good customer service and enable people to get to the right place and see the right professional in a seamless way. This will be helped by maximising the opportunities available in the NHS app **(links to digital chapter)**
✓	We will enable people to access our services in ways that suit them and how they understand, whether that be online, on the phone or at the door **(links to digital chapter)**
✓	We will create a data culture where we make the most of intelligence across the elements of demand, access and capacity, ensuring we understand our people and their preferences **(links to digital, prevention and inequalities chapters)**
✓	People will report a change in the way they experience our services and report a good experience. Where experiences are not so good, we will listen and respond with a culture of continuous improvement **(links to sustainability chapter)**

How will we know we are getting better?

Measuring the data we currently collect:
How many appointments are available/contacts made and in which modality (phone, face to face, virtual if applicable to discipline). We can then work out the profile against population and social economic status for each neighbourhood/locality.

By asking staff:
"Do you feel you have the right balance in your working day and are able to see the people you need to see and offer the service they need?"

By asking people who use our services:
"Did you receive the care you needed at a time convenient to you and with the most appropriate health/care professional?"

Primary Care Blueprint

Integrated working in neighbourhoods

Integrated working in neighbourhoods

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

3.1 Where are we now

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

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

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

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

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

These principles are very much paramount today and which we continue to base our delivery models, our ways of working and ethos upon them. A significant amount of work has taken place with numerous exemplar areas across Greater Manchester, yet we know that there is still variation across localities and across neighbourhoods. This is not necessarily due to a lack of aspiration but because of other factors.

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

3.2 Reiterating our reasons why – what would good like?

The benefits and rationale of integrated neighbourhood working have been well rehearsed and we believe these still resonate today, mainly that:

✓	People and communities within the neighbourhood are a fundamental part of the delivery model and are working with them, not to them
✓	Greater collaboration between providers can support better decision-making on resource allocation, reduced waste, increased efficiency and return on investment, higher quality, better outcomes and more sustainable services and a reduction of health inequalities
✓	Focus on the wider determinants of health, early intervention and prevention working with wider public sector, voluntary and business partners: • Schools • Employment • Housing • Fire and rescue Drugs and alcohol services • Local police • Criminal Justice system
✓	Utilising population health management tools and data to understand local populations, to proactively anticipate care needs and provide support and preventative care before crises occur. This approach to population health management will drive integrated care for people-especially with long term conditions and those most at risk
✓	Look for hidden communities, and offer tailored support and intervention to meet their specific needs. A neighbourhood model, typically serving 30-50,000 residents, centred around the GP list, connecting primary, community, social and local acute care with VCSE and wider public services, as can be seen on the next page.

Integration opportunities

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

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

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

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

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

1.3 How will we do this?

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

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

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

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

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

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

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

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

Priorities for 2023/24 – year one

- Understanding what works and sharing best practice via localities, PCNs, Providers (Primary, Secondary and Community Care, VCSE)
- Understanding what matters to the patient/public via ongoing patient/public engagement
- Prioritise wrapping care around the high users of health services, i.e. focussed care, care-co-ordination
- Supporting PCNs and Primary Care providers through a GM maturity matrix where PCNs can self-assess and identify areas of support
- Building on and enhancing the offer of support via PCN Development Programme
- Opportunities for different interface with people and communities, i.e. co-location, integrated 'primary/community hubs' with VCSE, particularly supporting prevention initiatives
- Survey in public spaces
- Influencing the enabling workstreams to support the continued development and delivery of integrated neighbourhood working, such as workforce, OD, Estates.
- Accelerate our digital programme such as:
    - Aiming toward a digitally connected neighbourhood – Community Providers, GPs, and social care frontline as the first priority
    - Enabling full use of NHS app by all practices for repeat prescriptions, booking and access to notes
    - Connect NHS app to all the triage platforms that sit behind it via booking mechanism
- Accelerate GP and Community Pharmacy Interface so that all areas have GP Community Pharmacy Consultation Services, (CPCS). Ensure there are connections with local Community Pharmacy. All PCNs meet with lead Community Pharmacy for neighbourhoods

- All PCNs identify high attenders / high users of urgent care and wrap care around them, such as Focussed Care, Care Co-ordination, pro-active care
- 'Getting the wiring right' – identifying and addressing infrastructure, i.e., contracts, regulatory frameworks, funding flows

From year two onwards, we will build on this foundation, continuing to take the learning and understanding which we have captured as part of the engagement, self-assessment and ongoing conversations with our people and communities.

We will build the digital model and look at automating processes.

We will evaluate the year 1 work.

We will focus on industry partnerships in NHDs.

To encapsulate the various programmes of work to ensure that consistency of offer to the population of GM.

To think differently and radically in terms of how we can support our population and our Primary Care workforce through a more resilient, sustainable model.

3.4 Benefits and outcomes

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

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

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

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

3.5 Risks and Barriers

Based on our learning and experience to date, risks and barriers to harnessing integrated neighbourhood teams however we anticipate capturing further risks and barriers as part of our engagement over the coming months.

- Time and dedicated capacity, recommending that each PCN will need a Transformation Manager
- Demonstrable outcome and impact
- Ability to remove 'organisational walls'
- Resources – people, estates, funding
- Cost/ benefit and risk sharing
- Information Governance / Data Sharing
- Incompatible IT systems
- Infrastructure, i.e. regulatory frameworks, contracts
- Financial flows

Primary Care Blueprint

Health inequalities

Health inequalities

Ensuring that we do not exacerbate health inequalities and taking practical steps to tackle these inequalities wherever we can

4.1 What is driving inequalities?

Poverty and structural inequalities are key drivers of health inequalities and lead to unjust differences in opportunities to live a healthy life (a result of the interplay between individual, family, community and societal characteristics such as race, gender, disability).

The way we currently do things can make inequalities worse:

- Primary Care contractual and performance arrangements do not always ensure that resources (including capital, programmes and workforce) are targeted to communities and neighbourhoods with the greatest need
- Who does 'what', where and how we work as a system across organisations prevents progress on reducing inequalities e.g., there aren't mechanisms to scale up good practice or use a shared care record

4.2 What will good look like?

- Performance, contracting and quality systems are owned collaboratively at place and PCN level across all providers focusing on improving outcomes for all communities not simply focusing on outputs and population averages with shared accountability
- Primary Care workforce capacity and capability strengthened in areas of greatest need
- All resource is prioritised to reduce inequalities
- Primary Care pathways are co-designed with people who are digitally, financially or culturally disadvantaged and excluded and tools that promote access and engagement are adequately resourced e.g., through free GP phone lines or multilingual receptionists and through different delivery models/points of access such as hyper-local community settings that people trust and are familiar with for example schools, community centres, etc
- Mechanisms to scale up examples of good practice are used by default and to learn and share across VCSE and public sector
- Transparent mechanisms for accountability are natively digital and check and challenge is collective

4.3 How will we do this?

- Population Health Management tools - These tools will be hosted online (GM Health and Care Intelligence Hub) to plan, deliver, monitor and evaluate Primary Care. A range of tools are required to support:
  - Risk stratification
  - Reidentification
  - Performance improvement and recovery
  - Cost benefit analysis

    - Impact assessments
- Fundamentally revising accountability for reducing health inequalities – refocusing this so it sits equally across localities, ICB team and Primary Care providers
- Develop cross-sectoral system leadership – aligning leadership programmes that focus on inequalities, equalities and sustainability (NHS Net Zero) through a GM Population Health and Inequalities Academy
- Establish cross-sectoral Communities of Practice with other workstreams to co-design guidance and workforce development tools on integrated neighbourhood working and review key neighbourhood functions to address inequalities, including:
    - Community development
    - Neighbourhood planning and engagement with neighbourhood boards
    - Co-design and co-delivery
    - Targeted outreach (understanding and responding to appointment non-attendance and hidden harm)
- Push the boundaries of provision – make the most of every access point in every community. Develop multimodal approach for Primary Care and simplify points of access: Standardised and core offer clearly communicated, working with communities to co-design and co-deliver communication and engagement plans
- Develop an agreed workforce plan that aligns to the health needs of communities (interest, identity and geography) that is adequately resourced for inclusive recruitment, retention and workforce development
- Ensure the totality of the Primary Care workforce can access the GM Shared Care Record
- Establish a GM wide Business resource for wider Primary Care to enable
    - access to GM Care Record for all Primary Care
    - Single source of information (data lake)
    - Workforce planning and training provision
    - recruitment and retention including best practice and approved terms and conditions
- Locality boards to co-produce inequality reduction plan with locality GP/ Primary Care boards

The final version will incorporate a number of case studies to illustrate how we will increase access and engagement with Primary Care for different communities e.g.:

a. Targeted pop-up clinics
b. Partnerships with the 3rd sector, religious and community leaders
c. Making phone calls to GP practices on behalf of patients, albeit not sustainable
d. Multilingual and culturally aware staff

4.4 Benefits and outcomes

- Primary Care resource is distributed according to need (advocating nationally when national contracting/funding allocation is not proportionate and being clear what is in scope within GM to change)
- PCN/Localities/LCO/Provider Federation are supported to consider workforce constraints - Capacity/capability alongside wider Primary Care and neighbourhood workforce (including VCSE)

- Primary Care workforce paid the living wage – which will improve retention and improve health and well-being of the workforce
- Mechanisms to share and learn across clinical/organisational boundaries will lead to greater innovation, collaboration and less duplication of effort e.g. Bolton GP Federation already has these mechanisms in place through GM Training Hub. How can wider-GM utilise?

4.5 Risks and barriers

- How do we ensure equitable resource distribution (£ and people)? Is there commitment to differential investment to achieve desired outcomes? And at what geographical level is this decided at?
- How can we ensure Primary Care workforce are representative?
    a. Adequate re/training regarding race and gender?
    b. More transparency of workforce data e.g., to be published more frequently to understand patterns e.g., using Virtual Workforce Information System (VWIS)
    c. How can we encourage staff to move/work in more deprived areas?
    d. Would GM wide recruitment guidelines be useful?
- How can we support staff well-being? How can we support Primary Care organisations to become members of the Good Employment Charter?
- GM localities to explore and review best practices on how to spend budgets e.g., ARRS underspend/spillage
- How can the target operating model focus on outcomes and principles?

Primary Care Blueprint

Prevention

Prevention

A Primary Care system which helps people to stay well and focuses on the prevention and early detection of ill health, and the effective management of long-term conditions.

5.1 Where are we now?

In GM, people become ill earlier, spend more time in poor health, and die earlier than the national average. Life expectancy and healthy life expectancy for people born in GM is significantly lower than the England average. There are also significant health inequalities within the city-region. For example, a male born in Manchester can expect to live an average of almost 5 years less than a male born in Trafford. For healthy life expectancy there is almost 10 years difference between individual local authority areas. Much of the burden of poor health and early death (borne disproportionately by our most deprived and vulnerable communities) in GM can be attributed to conditions that are preventable (including many cardiovascular and respiratory diseases, type 2 diabetes, and some cancers). It is estimated that 42% of morbidity and premature mortality in England is attributable to modifiable risk factors.

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

5.2 What does good look like?

Our goals are to:

✓	Support individuals across the city region to protect, maintain and improve their mental and physical health, wellbeing, resilience, and social connections
✓	Create a culture where prevention is seen as 'everyone's business' across the Primary Care workforce (including General Practice (GP), pharmacy, dentistry and optometry), and neighbourhood teams, and enable staff to take action
✓	Detect illness at an early stage and ensure it is proactively managed to reduce the risk of progression
✓	Ensure that long-term conditions are effectively managed to reduce their impact on individuals and the wider system
✓	Tackle health inequalities by working with system partners to address the wider determinants of health and wellbeing through integrated neighbourhood working
✓	Expand culturally appropriate, locally led preventative services that better reach into disadvantaged communities, and those not in contact with NHS services
✓	Shift the focus of activities and resources away from urgent and emergency care and towards prevention
✓	Achieve widespread implementation of upstream models of care, which means delivering care that is: person-centred, preventative, integrated with wider welfare

	and social support, trauma responsive, targeted and proportionate to need, and environmentally and socially sustainable

5.3 How will we do this?

Our areas of focus can be divided into four categories:

1. **Prevent** or reduce the risk of ill health
   - Utilise learning from the COVID-19 pandemic to maximise vaccination uptake, especially among target populations (focusing on COVID-19, influenza, pneumonia, and childhood vaccination)
   - Maximise the role of Primary Care in ensuring every child in GM has the best start in life (focusing on breastfeeding and perinatal and parent-infant mental health/relationships)
   - Work with the PCCA team and GM Primary Care Board to implement approaches to personalised care and support across PCNs through a common framework. Ensure all Primary Care staff are skilled and confident in practicing personalised care, including increasing uptake of health coaching and motivational interviewing training
   - Maximise the use of 'Making Every Contact Count' across all Primary Care disciplines to enable staff to support behaviour change, signpost to local services and provide very brief or brief advice during patient contacts
   - Improve interdisciplinary referral pathways for Primary Care and enable wider Primary Care teams to refer directly into social prescribing initiatives, behaviour change services, and wider welfare support
   - Optimise prevention programmes to improve oral health (particularly in children and young people and end of life care), including implementation of the Delivering Better Oral Health toolkit, and roll-out of the Mouthcare Matters training package
2. **Detect** conditions, or risk factors for disease, at an early stage
   - Increase the uptake, reach, quality, and impact of NHS health checks across GM, with an initial focus on high-risk and inclusion health groups
   - Work in partnership to improve hypertension/ atrial fibrillation (AF) case finding and diagnosis pathways in wider Primary Care (building on the current work in community pharmacies), and non-NHS settings, with a focus on CORE20+ groups
   - Optimise the Severe Mental Illness (SMI) and Learning Disabilities (LD) Health Check Programmes, with a focus on CORE20+5 groups
   - Optimise the early cancer diagnosis programme (PCN Directed Enhanced Service (DES), with a focus on improving access and reducing inequalities in uptake and experience
   - Increase the proportion of patients identified early for End of Life (EoL) care by rolling out tools and resources to support this
3. **Protect** people from worsening ill health by effectively managing conditions or risk factors for disease at an early stage
   - Work with the Strategic Clinical Networks (SCN) to develop and promote a range of tools and resources to optimise the management of hypertension, hyperlipidaemia, and AF across GM

- Ensure all Primary Care staff have access to trauma responsive training and develop pathways to improve identification of victims of Gender Based Violence and referral into support
- Carry out targeted work with PCNs to embed and reaffirm an approach to early intervention and prevention. Taking our learning from models such as proactive care, focussed care and high intensity users to describe a single model for GM which we will mainstream over time. This will be driven through a population health approach targeting those cohorts and conditions that drive demand through integrated neighbourhood working utilising ARRS roles and multi-disciplinary teams (MDTs) within local neighbourhoods.
- Through proactive care and the Aging Well Programme, work with the GM Combined Authority (the Aging Hub), and Falls Collaborative to prevent falls through early intervention

4. Manage long-term conditions effectively.
    - Create a GM standard for the management of chronic respiratory conditions (asthma/ Chronic Obstructive Pulmonary Disease (COPD)), cardiovascular disease, and diabetes
    - Promote environmentally sustainable approaches to prescribing across GM (such as green inhaler initiatives, awareness of air pollution impacts, and green social prescribing) in line with the 10-step plan, adhering to and exceeding national targets as defined annually
    - Support staff to have person centred holistic long term condition reviews, that integrate consideration for wider welfare and social support, and improve referral pathways into support services (social, financial, emotional, housing)
    - Increase use of digital solutions to support self-management e.g., Blood Pressure (BP) monitoring, blood sugar, pulse oximetry

This work will be enabled through:

✓	Strengthening relationships at place between Primary Care and Health and Wellbeing Boards and locality public health teams
✓	Partnering with our residents and communities and utilising innovative data architecture and capability to develop interventions and models of care that better target and engage those from higher risk populations
✓	Mapping current provision, and agreeing a standardised prevention offer across all ten localities, which can be flexed according to local need
✓	Ensuring all Primary Care staff have access to appropriate training on topics such as Making Every Contact Count (MECC), trauma-responsive care and personalised care

5.4 What are the benefits?

There are significant potential benefits of this work, which reach across the whole health and care system. In the short-term, we might expect to see improvements in wellbeing, stronger, more connected communities, and a reduction in health-harming behaviours (such as smoking, unhealthy diets, physical inactivity and alcohol excess). In the medium and longer

term, we would expect to see a reduction in the prevalence and exacerbation of long-term conditions and an associated drop in the demand for urgent and routine care. This will lead to cost savings for the NHS, increased productivity, and wider economic growth.

5.5 What are the risks?

The risks to this work include:

- Pressure on Primary Care capacity and workforce challenges
- Different Primary Care contracts and incentives, which can result in silo working and target/performance driven-care
- Limited access to integrated datasets for population health management
- Long term benefit realisation to see impact
- Limited funding

Primary Care Blueprint

Sustainability

Sustainability

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

6.1 Introduction

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

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

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

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

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

6.2 What is the problem and the current position?

i. Viability

a. Business viability
    i. for each service provider model
    ii. Individual provider organisations
b. Resilient delivery and business models
c. Appropriate funding which enables longer term planning and delivery, with less reliance on short term, non-recurrent funding models

ii. System Development

a. *Culture*
    i. Citizen involvement and engagement
    ii. The creation of a culture where citizen involvement and engagement is the norm, where health and care is responsive to what is important to citizens and where there is a real feeling of working together
    iii. Strength of leadership
    iv. At provider, sector and system level
    v. Sharing of good practice
    vi. Spreading what we know works across neighbourhoods and localities?

b. *Information and Intelligence*
    i. Development of outcome based information as evidence for commissioning decisions
c. *Integrated model of care*
    i. The mobilisation of a large collection of individuals, groups, and organisations towards an integrated model of care

iii. Primary Care Delivery Model

a. Facing the challenge of a system response to the demands of the population
b. Meeting the needs of the GM population
c. Developing role and contribution of Primary Care

iv. Environmental Sustainability

a. Primary Care contribution to environmental sustainability and delivery of the NHS GM Green Plan to achieve net zero carbon footprint by 2038
b. Building on, and further development of existing Primary Care plans

6.3 Our ambition for the future

- **Viability** – Ensuring that our Primary Care providers are engaged in a way which supports the long term viability of the sector, with less reliance on short term, non-recurrent funding models and clear plans for future investment and sustainability
- **System Development** – To achieve a viable and flourishing Primary Care system for the future will require a programme of change management including support for:

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

- Creation of a **Primary Care Delivery Model** for the needs of the population in 2025 and beyond, recognising the potential to broaden the role of Primary Care, as part of a wider redesign of our public service delivery model
- A focus on **environmental sustainability** recognising the wider NHS ambition to become the first net zero health service in the world

6.4 What we need to do to achieve this

To achieve a sustainable Primary Care system for the future requires a widespread change in our systems culture.

- Strategically we must use a system view and outcome information as evidence for commissioning decisions – remove barriers, pool resources
- Operationally we must mobilise a large collection of individuals, groups, and organisations towards an integrated model of care
- Collaboration through place-based care affords the best opportunity for systems to meet the needs of their populations
- Organisations should work together to govern the common resources available for improving health and care in their area
- The approach taken to develop pathways and services should be local and bespoke
- Commissioning needs to be outcome based and integrated
- Place-based integration (PBI) is a person-centred, 'bottom-up' approach used to meet the unique needs of people in one given location
- It is a way of working, owned by the whole system, not any one service or team

This is achieved by collaboration

✓	Public, community and health services working together to use the best available resources whilst collaborating to share local knowledge and insight
✓	Working in partnership with residents, it aims to build a picture of the system from a local perspective, taking an asset-based approach that highlights the strengths, capacity, and knowledge of all individuals and groups involved

Primary Care Blueprint

Digital

Digital

Empowers citizens and providers with gold-standard, digitally enabled Primary Care.

7.1 Context

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

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

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

7.2 What is the problem and the current position?

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

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

7.3 What would good look like if we solved the problem?

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

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

7.4 What will we do to achieve this and what is within our gift?

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

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

7.5 What are the benefits for the ICS, organisations, individual and patient?

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

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

7.6 What are the risks and potential barriers?

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

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

Primary Care Blueprint

Estates

Estates

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

8.1 What is the problem and the current position?

- There are access challenges, particularly in areas with significant health inequalities and deprivation
- There are challenges and variation across GM in the condition, compliance, and fitness for purpose of Primary Care estate
- Some premises do not meet contractual standards for Primary Care service delivery and some significantly fall short
- It is difficult to assess and quantify the baseline utilisation of existing estate as very little data on actual use is available for demise and bookable
- Sensors and data are in place for some NHS Property Services (NHS PS) buildings on the Open Space system for bookable rooms which shows massive disparity between rooms block booked in advance and those actually used
- The cost burden for voids and unused accommodation lies with NHS GM which indicates significant wasted underutilised estates resource which could otherwise be invested in estates improvements
- There are lease issues in many NHS PS and Community Health Partnerships (CHP) buildings with unclear documentation on responsibilities, requirements and occupational costs
- There are undocumented Primary Care estate occupiers which put the provider at risk of that occupation being terminated
- Implications and restrictions of the Local Improvement Finance Trust (LIFTCo) funding models that prevent cost effective premises variations
- There are some material debt issues identified by the property companies that act as a barrier to tenants increasing the level of or making changes to accommodation
- There has been variation in the level of estates investment over time across the different localities
- There is inequitable contribution by practices to premises costs with differing levels of historic subsidies
- There is a national requirement to meet sustainability & BREEAM targets by 2038/2040 and there has been limited national funding routes for Primary Care

8.3 What would good look like if we solved the problem?

✓	There would be a clear understanding of the challenges of Primary Care estate and how these can be dealt with
✓	All Primary Care premises should as a minimum meet statutory compliance requirements and ideally be configured to support optimal flow

✓	There would be efficient and effective collaborative ways of working across Integrated Neighbourhood Teams, and PCNs supporting new models of care and more efficient use of estate, particularly patient facing estate
✓	Clear prioritisation criteria developed preferably aligned to national guidelines. Thus providing a clear understanding of the prioritised premises schemes for improvement and investment
✓	Clear agreements to enable property companies to charge effectively and reduce occupancy, lease and debt issues
✓	Effective collaboration between Local Authorities, Place and Community to develop robust integrated system plans and facilitate actions to deliver GMICP strategic priorities
✓	Improving utilisation of paid for estate in owned, demised and bookable accommodation, in and outside of core hours
✓	Reducing voids to an absolute minimum
✓	Achieving a high level of utilisation mid-week, and increased utilisation at weekends and evenings also to sweat current estate
✓	Increased utilisation of community buildings to support social value for VCSE and community groups
✓	A better understanding of the estates opportunities under the various contracts ensuring that responsibility for estates is known whilst making sure patients have access to services
✓	All Primary Care providers in CHP, NHS PS and third party owned premises are within a lease agreement; and all GP partner owned premises have a lease agreement with the GP practice
✓	Have a clear Primary Care premises subsidy policy and processes to access support on a fairer and more reasonable basis
✓	Clear and transparent contribution by all GP practices to a fair proportion of premises costs
✓	Be in a position to address estates sustainability, develop a forward plan and be ready and in a position to apply for potential national funding that may be available with partners

8.4 What will we do to achieve this and what is within our gift?

- Completion of the GM Estates Infrastructure Strategy in 2023/24
- Completion of the Locality Asset Review refresh to enable local system Strategic Estates Groups (SEG) to identify use of surplus estate or estate for disinvestment
- Prioritisation criteria developed to enable fair and transparent prioritisation of estate to access the limited funding based on most effective use of resource
- Completion of PCN clinical and estates plans by summer 2023 and the development of ten prioritised Locality plans and an overarching ICB prioritisation plan by Sept 2023
- Relaunch the SEGs ensuring consistent and effective strategic estates arrangements in place including Primary Care representation
- Provide assessment of current premises compliance and actions that are needed for example, through the 3 & 6 facet surveys collation and PCN estates toolkit implementation

- Progress development of an overarching GM utilisation framework to include utilisation principles to be adopted across GM e.g., in relation to protocols for block bookings
- Improve the utilisation of existing estate including internal reconfiguration of premises with longer term occupational commitment
- Removal, or where not possible, mitigation against barriers to improved use e.g., understanding LIFTCo covenants vs model flexibilities including lifecycle costing
- Collecting data on use and sharing this with localities and Strategic Estates Groups to enable actions to deliver improvements
- Identify specific buildings to target utilisation studies / manual data collection
- Plan for the conversion of former patient records storage footprint to clinical rooms and secure use of NHS PS and CHP capital for reconfigurations
- Continue to bid for external funds to support investment and for other use such as towards achieving improved utilisation and increasing clinical capacity e.g. One Public Estate (OPE) funding and Section 106 monies
- Review current position and consider options for GM policy approach for tenant subsidies
- Under the terms of the Premises Cost Directions (PCD) reimbursement costs only have to be paid to a GP practice if a lease is in place or if partners in the practice own the premises. Practices should have lease agreements to receive reimbursement costs

8.5 What are the benefits for the ICS, organisations, individual and patient?

- Enabling plans that will deliver most effective use of resource to provide maximum outcomes for patients and improved health inequalities
- Effective system working to facilitate best use of public estate resource – improving utilisation and access to clinical services, and disinvesting in surplus premises
- Enable additional clinical activity to be undertaken in the funded estate including bringing service delivery out of hospital
- Enabling / assuring patient safety and accessibility to services, as paramount
- Provide physical configuration to maximise service flow and efficiency for Primary Care providers ultimately enabling greater productivity
- Commissioner has a consistent policy to enable consideration of applications for non-mandatory financial assistance and provides resilience and clarity to providers
- GP practices are in appropriate leases thereby providing security of tenure and clear reimbursement in line with the terms and conditions of the Premises Cost Directions

8.6 What are the risks and potential barriers?

- Without an improvement grant prioritisation process and matrix we will not address the estates issues in the areas where they are needed most
- Lack of leadership representation from stakeholders at the SEGs such that key strategic priorities are not delivered e.g. agreement on investment and disinvestment
- May not be sufficient challenge to the future models of care and potential estates solutions in the PCN toolkit to ensure all possibilities explored to demonstrate best use of public money; including use of property outside core hours to sweat assets

- Insufficient access to external funding e.g. national improvement grant slippage and section 106 monies
- Unaffordable to continue to fund high levels of underutilised fit for purpose Primary Care premises
- Unable to remove occupational Property Company barriers
- Do not deliver improvements in IT and the digitisation of patient records to free up and convert records storage accommodation
- Patient safety risk under NHSE contracts where minimum practice standards aren't adhered to, to ensure safe, compliant and accessible premises
- If access to services outside of the core GP contracted hours is limited or patients have to travel there may be an increase in DNAs and health outcomes will be poorly affected
- If no changes are progressed LIFTCo constraints will remain which will impact on changes to occupancy restricting use of accommodation
- Without leases in place a practice has less security of occupation, however where practices enter leases there will be associated legal costs and Stamp Duty Land Tax (SDLT) to pay
- Some Locality areas will have more estates expertise than others, lack of capacity and capability to progress improvements

Primary Care Blueprint

Quality, improvement and innovation

Quality, improvement and innovation

Is standards based, with a focus on quality improvement

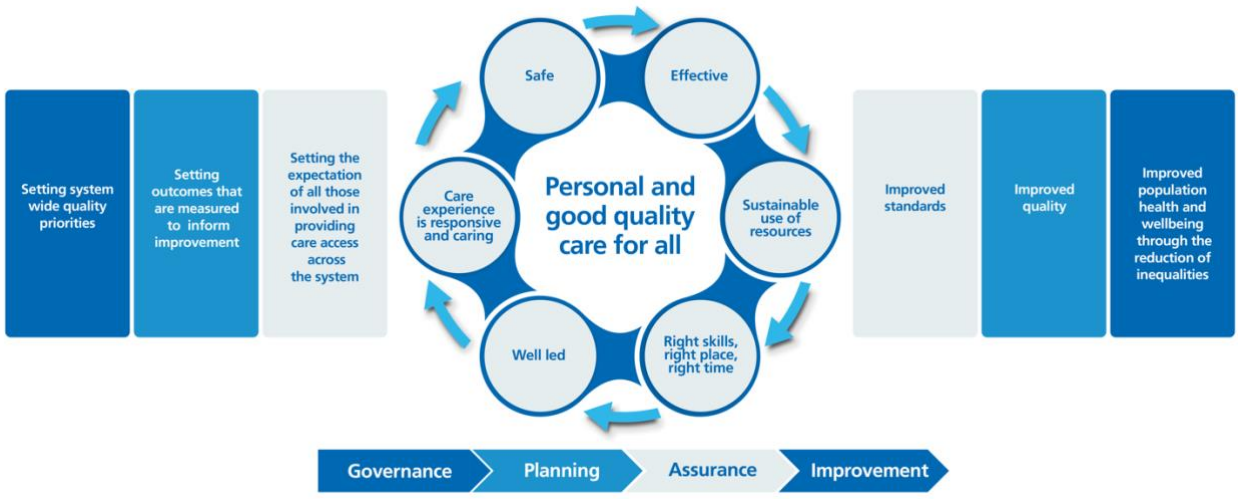
In Greater Manchester we aspire to embed and espouse good quality as the basis for everything that we do. The opportunities presented through the Greater Manchester Integrated Care Partnership will build on systems and processes to improve patient experience and outcomes, with consistency and equity at the heart.

In Greater Manchester**,** Primary Care provision is delivered across 4 disciplines and c1700 practices and it is therefore not unexpected that there is variation in the way that services are delivered to patients. This variation may be warranted, particularly where the outcomes and experience for patients is consistent and of an expected level. However, where there is variation there is also potential for this to be unwarranted, evidenced in the relative health outcomes within communities, individuals' experiences in accessing services

In developing this chapter, it is acknowledged that we are also working from a position of different interpretations of quality and what it means to individuals. Across the four Primary Care disciplines there are different ways of operating and regulatory frameworks, however we are working in the context of a clear willingness to work together to improve quality, reduce unwarranted variation and reduce health inequalities.

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

The diagram below illustrates the shared purpose for quality.



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

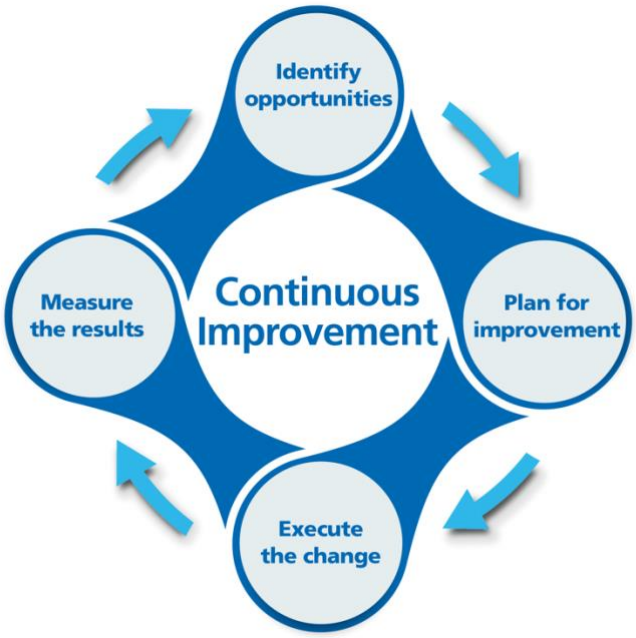
How will we deliver quality, improvement and innovation for Primary Care in Greater Manchester?

	Building on the opportunities presented through the Greater Manchester Integrated Care Partnership, the overarching principles that underpin delivery of this plan are:
✓	Embed a culture of supportive improvement through shared learning and peer-based improvement
✓	Central data dashboards will be available to a range of stakeholders
✓	Assigning resources will be managed with evidence-based decision making through clear governance
✓	The use of data to provide the evidence-base for flexible and innovative commissioning as a key enabler to improvement, with continuous improvement at the heart

The Primary Care Blueprint sets out the ambition over the next five years for Greater Manchester. A number of tangible deliverables are set out below; the delivery plan will be inclusive but not limited to these activities and workstreams:

- Implementation of the Patient Safety Incident Reporting Framework (PSIRF) across Primary Care
- Development of a consistent set of GM Primary Care Quality Standards, applied to all four disciplines as appropriate to the relative commissioning opportunities and regulatory frameworks that exist
- In conjunction with the GM Quality Directorate, establish a clear process for reporting, escalation and assurance to support patients, providers, localities and GM teams
- Establish a 'go-to' data repository within tableau, to enable reporting and analysis across the many data and information sources that are available
- Establish and embed shared learning forums through in-person and online forums, where needed to facilitate good communication, relationship building and sharing of good practice
- Develop a robust process for risk management at GM and locality level
- Continuous improvement through shared learning with a supportive, assurance-based approach

In order to deliver on these areas of work (expected to be delivered in years 1 and 2), there will need to be an understanding of the relative roles and responsibilities across our Primary Care system. Quality has been identified as an enabler within the blueprint, as improving quality of health and care for our population runs through everything that we do.



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

Success factors: quantitative and qualitative indicators to that will impact. This section is subject to further work to fully understand how we can measure impact and success across Primary Care.

- Staff being aware of how to raise concerns, with confidence, about quality and safety of care
- Improved patient satisfaction across all of Primary Care (for example, friends and family test, GP Patient Survey etc)
- Reporting and data capture seen through established reporting routes and governance
- Improved dental access and numbers of related complaints over time
- Reduced referrals for child dental general anaesthesia (GA)

Primary Care Blueprint

Workforce

WORKFORCE

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

10.1 What is the problem and the current position?

'Growing workforce crisis linked to individuals not choosing Primary Care as a career destination, workforce not growing fast enough to support demands, attrition of existing staff leaving a workforce shortage across general practice, community pharmacy, dentistry and optometry.'

- **Recruitment** - Working in Primary Care is incredibly challenging linked to (but not exhaustive) public expectations, central demands, variation in standards of employment and wider employment options which impact on our ability to recruit and retain: Primary Care and the NHS are not perceived as an attractive career option

- **Retention -** For the same reasons it is difficult to recruit, retaining staff is further exacerbated by the impact of COVID, recovery and external pressures such as competition from other employment sectors particularly around pay and conditions (for example dental nurses). This impact is apparent across the whole of Primary Care, but data also highlights certain roles (for example general practice nurses) being disproportionally affected due to aging workforce

- **Education and development** - Priority is placed on clinical skills, but importance is placed on areas such as leadership, wellbeing resilience and personal development. There is little evidence of consistency of emphasis on and approach to succession planning. There is also significant disparity across GM in the investment of funding to support the education and development across all four Primary Care disciplines (for example business / practice managers)

10.2 What would good look like if we solved the problem?

'GM Primary Care recognised as a career destination, a happy and healthy PRIMARY CARE workforce, trained to a consistent standard with enough knowledge and expertise to meet the needs of our population and provide timely, world-class services.'

- **Recruitment** - Flexible, inclusive recruitment models at all levels which attract and respond to both individual career aspirations and the needs of the population, ensuring the workforce is reflective of the population it serves. Clear understanding of the breath of roles, both clinical and non-clinical to ensure Primary Care is valued as a career destination for all. Understanding priorities, and the need to align both short and longer-term workforce planning, service development and cross sector working, including VCSE organisations

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

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

10.3 What are the risks and potential barriers?

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

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

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

10.4 How will we achieve our overall aim?

'Recruitment, Retention and Development of the Primary Care workforce, enabling the workforce to deliver health in a changing, innovative, and digital environment to provide better population health outcomes.'

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

- **Retention** - Encourage all organisation to adopt the GM Good Employment Charter and support Primary Care organisations to achieve the standards (The Charter | GM Good Employment Charter). Identifying and sharing best practice on workforce health and wellbeing terms and conditions and good leadership

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

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