



Fairer Health for All

Primary Care Inclusion Health Toolkit

*For commissioners and providers
of primary care services in GM*

January 2025 (v0.8 2025)



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Executive Summary



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Inclusion health is an umbrella term used to describe people who are socially excluded, who typically experience multiple overlapping risk factors for poor health, such as poverty, violence and complex trauma. This includes people who experience homelessness, drug and alcohol dependence, vulnerable migrants, Gypsy, Roma and Traveller communities, sex workers, people in contact with the justice system and victims of modern slavery.

People identified in inclusion groups, tend to have very poor health outcomes, often much worse than the general population and a lower average age of death. This contributes considerably to increasing health inequalities.

Poor access to health and care services and negative experiences can also be commonplace for inclusion health groups due to multiple barriers, often related to the way healthcare services are delivered.

NHS Greater Manchester (GM) has developed a Primary Care Blueprint, setting out how the ICB aims to deliver **fairer primary care services** for the population. To effectively reduce health inequalities across primary care services, it is essential that the needs of inclusion health groups in GM are adequately identified and addressed.

This toolkit has been designed to help commissioners and providers of primary care services in GM to ensure that services are planned and delivered in a way that meets the needs of inclusion health groups, and ultimately improves their health outcomes. The toolkit has been designed to help colleagues to deliver on the contractual requirements within the Primary Care Blueprint.

The toolkit has been produced by a GM-wide inclusion health working group, based on a stocktake exercise gathering current best practice across the 10 localities in GM, and offering the opportunity to share the learning.



The GM Primary Care Blueprint outlines our ambition to improve the health of our communities by accelerating prevention and strengthening our social models of care, including a commitment to develop an Inclusion Health toolkit

It is evident that individuals belonging to inclusion health groups experience extreme inequalities in healthcare, with;

- poorer access,
- experience and
- outcomes compared to the rest of the population.

To this end, the Inclusion Health Toolkit has been designed to help commissioners and providers of primary care services in GM to ensure that services are planned and delivered in a way that meets the needs of inclusion health groups and ultimately improves their health outcomes.

GM Commitments



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This toolkit supports commitments outlined in NHS GM's Primary Care Blueprint:



Health Inequalities Chapter

- Commitment for Inclusion Health best practice
- Aligns to Core20PLUS5 agenda and wider GM commissioning framework

Prevention Chapter

- Commitments to implementing social models of care, and ensuring that primary care staff have access to appropriate training to support this where required

The expectation is that there is **leadership and accountability** within localities in GM to utilise the GM Inclusion Health toolkit to **demonstrate effective delivery on these contractual commitments**

What is the Inclusion Health Toolkit



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- A set of “**best practice steps**” to help primary care partners think about inclusion health
- Includes examples of good practice and **practical guidance** on how to improve health and reduce inequalities for different inclusion groups
- Enables **shift to a social model for health**, focusing on the role of people and communities as well as health and care services
- Contains **tools** to help partners (commissioners and providers of primary care services alongside VCSE partners) to come together to;
 - ❖ develop policies and programs in a way that meets the **needs** of inclusion health groups (for patients and staff)
 - ❖ plan and deliver care that improves health outcomes **for all**
- **Equality Impact Assessment (EIA)** does not replace the Toolkit. The Toolkit may help add value to the EIA.

Fairer Health For All Principles

The Fairer Health for All principles were co-designed by Greater Manchester partners and speak to how we will share risk and resources in a way that considers a strengths-led approach, building on the needs of individuals, communities and partnerships and to collaborative decision making, so that resource can be targeted and tailored to achieve good health across diverse places and people.

 <p>People power</p> <p>We will work with people and communities, and listen to all voices – including people who often get left out.</p> <p>We will ask ‘what matters to you’ and ‘what has happened to you’ as well as ‘what is the matter with you’.</p> <p>We will build trust and collaboration and recognise that not all people have had equal life opportunities.</p>	 <p>Proportionate universalism</p> <p>We will co-design universal services (care for all) but with a scale and intensity that is proportionate to levels of need (focused and tailored to individual and community needs and strengths).</p> <p>We will change how we spend resources – so more resource is available to keep people healthy and for those with greatest need.</p>	 <p>Fairer Health for All is everyone’s business</p> <p>We will think about inclusion and equality of outcome in everything we do and how we do it.</p> <p>We will make sure how we work makes things better, and makes our environment better, for the future.</p> <p>We will tackle structural racism and systemic prejudice and discrimination.</p>	 <p>Representation</p> <p>The mix of people who work in our organisations will be similar to the people we provide services for.</p> <p>For example, the different races, religions, ages, gender, sexuality, disabled people and people with multiple severe disadvantages.</p> <p>We will create the space for people to share their unique voice and be involved in decision making.</p>	 <p>Health creating places</p> <p>As anchor institutions we will build on the strengths of our communities and leverage collective power – to support communities and local economies.</p> <p>We will focus on place and work collaboratively to tackle social, commercial, economic and environmental determinants of health.</p>
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The expectation is that there is **leadership and accountability** within localities in GM to utilise the GM Inclusion Health toolkit to **demonstrate effective delivery on these contractual commitments**







GM Commitments: GM Integrated Care Partnership Strategy



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This toolkit supports all six missions within the GM Integrated Care Partnership Strategy:

 <p>Our strategy missions</p>	 <p>Our strategy missions</p>	 <p>Our strategy missions</p>	 <p>Our strategy missions</p>	 <p>Our strategy missions</p>	 <p>Our strategy missions</p>
<p>Strengthen our communities</p> <p>We will help people, families and communities feel more confident in managing their own health</p>	<p>Help people to stay well and detect illness earlier</p> <p>We will work together to prevent illness and reduce risk and inequalities</p>	<p>Help people get into, and stay in, good work</p> <p>We will expand and support access to good work, employment and employee wellbeing</p>	<p>Recover core health and care services</p> <p>We will continue to improve access to high quality services and reduce long waits</p>	<p>Support our workforce and carers at home</p> <p>We will ensure we have a sustainable, supported workforce including those caring at home</p>	<p>Achieve financial sustainability</p> <p>We will manage public money well to achieve our objectives</p>

The expectation is that there is **leadership and accountability** within localities in GM to utilise the GM Inclusion Health toolkit to **demonstrate effective delivery on these contractual commitments** -

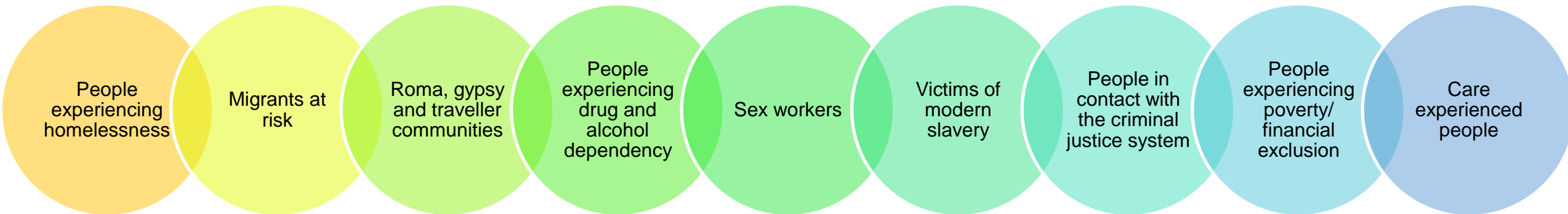
What do we mean by inclusion health?



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We consider “**inclusion health**” to incorporate any population in GM experiencing social exclusion. This includes, but is not limited to, the following groups:



Commissioning for inclusion describes taking an “inclusive” approach, that helps to deliver on and align to [GM’s Fairer Health for All](#) and helps services adopt a **social model for health**, focusing on the role of **people and communities** as well as health and care services. We consider commissioning to incorporate the planning, delivery and re-design of services.

Significant inequalities in GM



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Inequalities At a Glance in GM



There are
2.8
million people
in GM

Nearly 40%
of the
population in
GM

1.1 million of these
residents live in the
20% most deprived
areas of the UK



**Female healthy
life expectancy
in GM is 60.9 years**
vs England average of 63.9

A female born in Salford could expect to live **9.5 years less** in good health than a female born in Trafford.



**Male healthy
life expectancy
in GM is 61.4 years**
vs England average of 63.1

A male born in Oldham could expect to live **10.3 years less** in good health than a male born in Trafford.

There are differences within localities too:



A woman living in Salford in the **most deprived neighbourhoods** can expect to live **11.1 years less** than a woman living in the wealthier neighbourhoods.



A man living in Salford in the **most deprived neighbourhoods** can expect to live **11.7 years less** than a man living in the wealthier neighbourhoods.



68,200 people
in GM are unemployed
5% compared to 3.5% UK average.



1/3 of the GM population
are children and young people (CYP)
around 1 in 4
live in poverty



117,400 residents
are economically inactive due
to long term sickness. 30% of our
productivity gap is due to ill health.



40% of children
living in poverty in GM live in a smoking
household. Children living in a smoking household
are **4 times more likely to start smoking.**

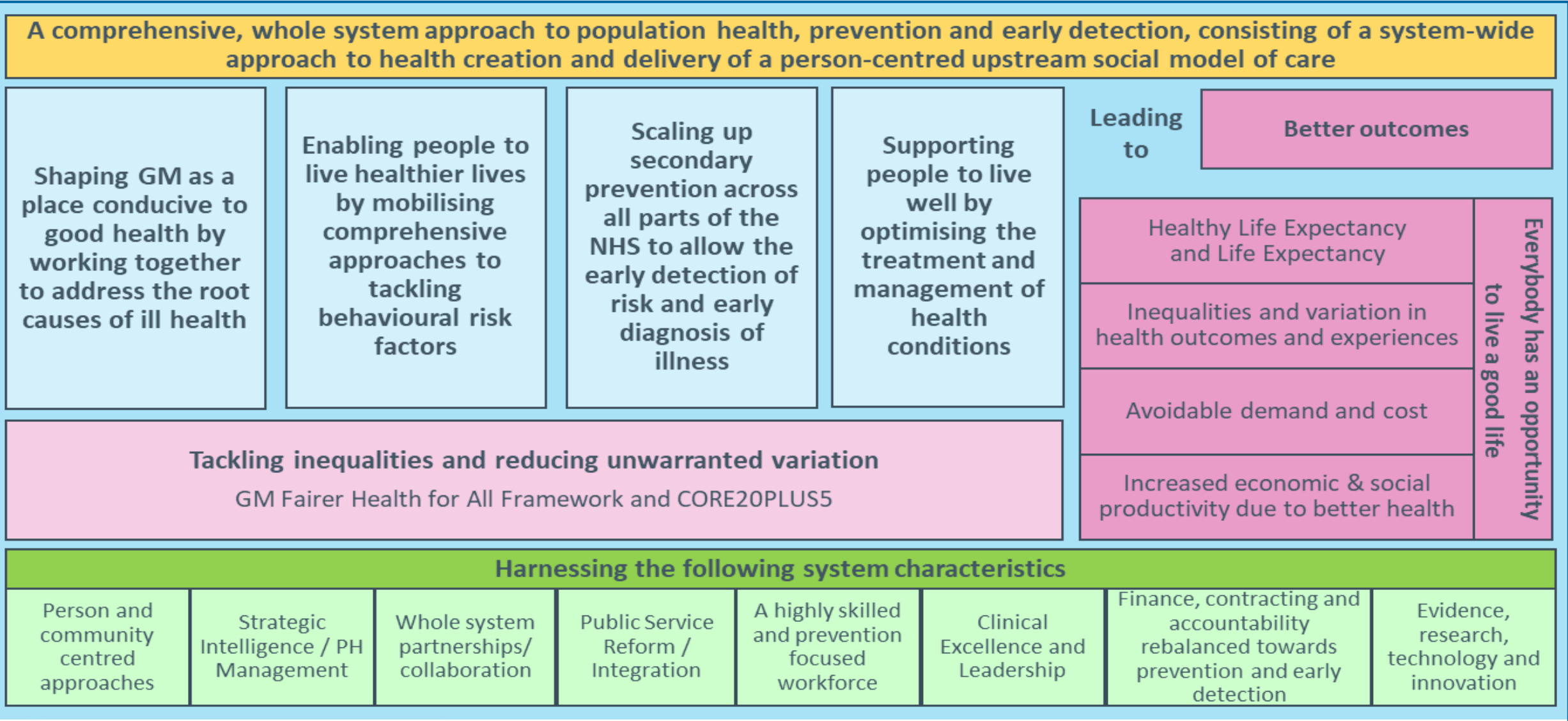


Asthma-related hospital admissions for CYP
is consistently high in GM and **50% higher for
CYP from disadvantaged GM communities.**
Twice the rate of the national average.

GM Prevention and Early Intervention Framework:
A comprehensive, whole system Population Health approach



Greater Manchester



National Commitments



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This toolkit is underpinned by the **national strategic context**:-



NHSE: Tackling
Neighbourhood
Inequalities DES

NHS Constitution for
England

The Public Sector
Equality Duty

Classification: Official

Publication approval reference: PR00157

Tackling Neighbourhood Health Inequalities

Supplementary guidance

Version 2.0 1 April 2023



[Home](#) > [Government](#) > [Government efficiency, transparency and accountability](#)

Transparency data

Public sector equality duty

The Public sector equality duty came in to force in April 2011.

From: [Ministry of Justice](#)

Published 6 July 2012



Guidance

The NHS Constitution for England

Updated 17 August 2023

Leadership and Accountability



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It is recognised that for this toolkit to be adopted widely across the system, there must be both **leadership** and **accountability** for its use.

Leadership from the very top is required to both **raise awareness** of the toolkit, and to **facilitate its implementation** in commissioning, recommissioning and evaluation of services across primary care in GM.

There is an opportunity for colleagues across primary care to **innovate** and **drive improvement** through **trailing** the toolkit. Contributions through **sharing case study examples of best practice** will enable us to **share learning** and to **showcase** best practice in relation to commissioning for inclusion.

Key principles relating to the use of the toolkit include:-

- Commitment to **adopt and test the toolkit** where opportunities arise e.g. through the commissioning, redesign or evaluation of primary care services
- Commitment to **sharing examples of best practice** to facilitate shared learning across the system



5 Best Practice Steps

1

Use **data and insights** to identify the inclusion health groups in your population, and understand their needs and assets

2

Engage inclusion health groups in service, policy and programme design, commissioning **with**, not for, inclusion health groups

3

Plan care **flexibly** to encompass a range of needs and to improve access to and experience of primary care services

4

Prioritise workforce development opportunities and training to enable services to be **culturally competent**, and **improve representation** of inclusion health groups within our workforce

5

Develop a culture of **reflective learning and sharing** within and between localities, to drive continuous quality improvement



A set of “best practice steps” to help primary care partners think about inclusion health

The toolkit contains 5 best practice steps to help commission and deliver services, policies, and programmes in an inclusive way,

For each step there are;

- Links to tools and resources
- Best practice examples and inspiration with “stories of change”.
- Key actions to take / follow up.



Utilising the data can help you to **define** and **identify** population groups who are experiencing inequity. There are several tools and resources available including:-

- The [GM Health and Care Intelligence Hub](#), containing data at an individual patient level across primary and secondary care, including VCFSE and social prescribing data from PCNs, Core20PLUS dashboard and further development planned.
- **Voluntary Community Faith or Social Enterprise (VCFSE) data**, including how to find which VCFSE organisations work in your area (link to follow), and a summary of VCSE data/capacity building programmes NHS GM are commissioning next year
- **Locally collected insights, Health Equity Assessments (HEAs) and Joint Strategic Needs Assessments (JSNAs) (e.g. Manchester's JSNAs [Health and Homelessness](#), [Gypsy, Roma and Traveller communities](#) and [Armed Forces Community](#))***
- **Equality Impact Assessments**
- **Census data (with informed analysis of what the data tells us)**
- **National sources: Fingertips [Local Authority Health Profiles](#) and [SPOTLIGHT](#) tools**



Beyond simply collecting and reporting the data, it is also important to consider **how** the data we use can be **inclusive**. This involves building **trust** so that communities are willing to share their data. It is also important to understand how and why we are using the data, utilising it to inform service design and improvement and sharing results of analysis and insight accessible to all e.g. through JSNAs.

Key resources to facilitate this include

- [The Inclusive Data Taskforce Implementation Plan](#), including the [The Inclusive Data Taskforce recommendations report](#) ("Leaving no one behind – How can we be more inclusive in our data?"), listing 8 Inclusive Data Principles:
 1. Create an environment of **trust** and trustworthiness
 2. Take a **collaborative whole system approach** to improve the UK data infrastructure
 3. Ensure that **groups are robustly captured**
 4. Ensure that **sufficient data** are available for robust and reliable disaggregation and intersectional analysis
 5. Ensure that **concepts are appropriate and clear**
 6. **Broaden the range of methods** used and **create new approaches** to understand everyone's experiences
 7. Review **harmonised standards** regularly adapting to evolving social norms and needs
 8. Ensure that UK data and evidence are equally **accessible** to all



Best Practice Examples

[GM Proactive Care Programme](#), 10GM

Background

Targeted support to 20 PCNs in GM to develop new models of proactive care for local populations. Each PCN has chosen one of three high impact patient cohorts – dementia, frailty, or high intensity users. The programme has run from August 2023 to February 2024, aiming to improve patient outcomes and reduce demand on primary care and secondary care.

Results

Learning has been through both virtual and face-to-face workshops, with drop in and network sessions, supporting PCNs to:-

- understand how to access, navigate and interpret clinical insight and service data based on population health needs to develop new models of proactive care
- increase interest among healthcare professionals in data-driven service redesign leading to more personalised, proactive care
- build innovation capability and empower colleagues to lead change
- develop a person-centred culture
- optimise personalised care ARRS roles and ensure they align to patient and workforce needs
- identify system partners to collaborate with to optimise proactive care pathways and benefits to patients

PQRSS primary care incentive scheme (built into QOF),

Background

Rumworth PCN ran a pilot to increase the uptake of cancer screening, based on a model used during the Covid-19 vaccination programme. Initially, the project focused on a geographic area (i.e. a PCN or area around a practice with the lowest uptake), widening to reach non-geographical cohorts and specific **vulnerable populations** (such as people with learning disabilities, carers, and deaf people).

Results

The pilot saw women coming forward for smear tests for the first time, while also receiving Covid-19 vaccines and health checks opportunistically. Involving members of communities helped clinics to be in **untraditional but accessible non-clinical locations** including daycare centres, community centres and a primary school. The pilot reached some of Bolton's most vulnerable populations.

Success factors include:

- utilising insights from partners, e.g. through consultations, surveys and feedback channels
- co-designing model with vulnerable and under-served communities in a place where they feel **comfortable** and is **culturally congruent**, at a **time which is convenient** with **no appointment needed**, with someone they **trust** and who has **time to talk**
- pro-actively **partnering with VCFSE** to build on existing routes into key communities
- focusing on **increasing confidence and trust to empower people** to access health services via mainstream routes such as through their GP

Best Practice Examples cont.

Urban Village Homeless Health Service, Manchester

Background

Based in Manchester (Ancoats), this practice operates a **homelessness** inclusion health service, with strong connections to rough sleeping outreach and other support services. The practice offer a range of primary healthcare services following a “needs led” approach for people experiencing homelessness in Manchester.

Results

The practice provides individuals experiencing homelessness access to professionals and services, including drug and alcohol workers, counsellors, community psychiatric nurses (CPN), GPs and midwives. Additionally, they offer referrals to other services such as housing advice agencies and outreach programmes

Manchester’s JSNAs:

Health and Homelessness

The JSNA provides a summary of the evidence and data regarding the health of people who are rough sleeping or experiencing homelessness in Manchester.

Gypsy, Roma and Traveller communities

The JSNA provides a summary of the evidence and data regarding the Gypsy, Roma and Traveller (GRT) communities JSNA outlines the current and anticipated future health and social care needs of individuals who identify their ethnicity as Gypsy, Roma or Traveller and are resident in Manchester

Armed Forces Community

This Joint Strategic Needs Assessment (JSNA) provides a summary of the evidence and data regarding the health of the armed forces community. It describes some of the health issues that may affect members of the armed forces community and what the data from the 2021 Census tells us about UK armed forces veterans living in Manchester



Key Actions

1. **Register** with the GM Health and Care Intelligence Hub. Access to the hub can be requested via https://www.gmtableau.nhs.uk/gmportal/new_Request and is open to all VCSE and public sector partners.
2. **Access the data** to understand the needs and assets of inclusion health groups in your population
3. Identify data **gaps**, and consider how these could be **filled** (e.g. community participation panels, qualitative research)
4. Identify **local VCSE organisations** and explore methods of **engagement**



Key resources to help you to engage with Inclusion Health groups:-

- Making use of the [VCSE Accord](#), a three-way collaboration agreement between GMCA, NHS GM and the GM VCSE sector, represented by the GM VCSE Leadership Group, to further develop how we work together to improve outcomes for Greater Manchester's communities and citizens
- Learning from best practice examples e.g. [PCN-VCSE partnership work](#), involving 5 Test & Learn sites to improve VCSE-PCN relationships and to understand ways of addressing health inequalities
- Utilising principles outlined in [GM's people and communities participation strategy](#)
- [GM Equality Alliance](#), containing reports, toolkits and guides to help influence policy making in GM. For example, guidance (currently in development) on the voice of lived experience in policymaking led by GMVCO.

Our principles

Throughout our participation work, we will adopt NHS England's 10 principles for working with people and communities to support integrated care systems.



Source: [GM People and Communities participation Strategy](#)



Best Practice Examples

PCN-VCSE partnerships, 10GM

5 Test and Learn sites were funded to explore how VCFSE and GPs can work together to tackle health inequality. The partnerships explored how VCFSE organisations could be service providers alongside PCNs, and also act as community connectors for community health building.

Afrocats and Ardwick and Longsight PCN and CAHN, Manchester

Background

Established to address barriers to maternity care for Eastern African women through culturally specific dance and creative movement. A total of 30 women engaged with the pilot. 8 sessions were delivered by 5 professionals (midwife, social prescriber, clinician/nurse and health visitor) and 1 community connector.

Results

The sessions provided a safe environment where women felt confident to ask questions. Sessions helped to raise awareness of services available to women within their community. Key challenges limiting access to healthcare experienced by these women include language barriers, experiences of multiple disadvantage and limited childcare support, high levels of distrust in healthcare services and professionals, and lack of GP signposting to free frontline services on offer. Creative sessions such as dance and exercise proved essential tools to break down barriers to access and improve health outcomes.

“Smears Mean Years” Cancer Screening Pilot, Rumworth PCN (Bolton)

Background

Rumworth PCN ran a pilot to increase the uptake of cancer screening, based on a model used during the Covid-19 vaccination programme. Initially, the project focused on a geographic area (i.e. a PCN or area around a practice with the lowest uptake), widening to reach non-geographical cohorts and specific vulnerable populations (such as people with learning disabilities, carers, and deaf people).

Results

The pilot saw women coming forward for smear tests for the first time, while also receiving Covid-19 vaccines and health checks opportunistically. Involving members of communities helped clinics to be in **untraditional but accessible non-clinical locations** including daycare centres, community centres and a primary school. The pilot reached some of Bolton’s most vulnerable populations.

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- co-designing model with vulnerable and under-served communities in a place where they feel **comfortable** and is **culturally congruent**, at a **time which is convenient** with **no appointment needed**, with someone they **trust** and who has **time to talk**
- pro-actively **partnering with VCFSE** to build on existing routes into key communities
- focusing on **increasing confidence and trust to empower people** to access health services via mainstream routes such as through their GP

Case study



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Cancer screening resources for Gypsy, Roma and Traveler communities

Friends, Families and Travelers, support individuals and families with the issues that matter most to them, at the same time as working to transform systems and institutions to address the root causes of inequalities faced by Gypsy, Roma and Traveler people. Working to end racism and discrimination against Gypsy, Roma and Traveller people and to protect the right to pursue a nomadic way of life.

IMPACT

Friends, Families and Travellers have produced an extensive list of policy, publications and information on issues affecting Gypsies and Travellers

Inclusion health group: Gypsies and Travelers

Locality: Greater Manchester

Case study



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Showmen Health and social care film

This film that has been developed in partnership with the Showmen's Mental health Charity and was based on the research findings of Anglia Ruskin University. The film and the research are the first that has explored the access to health and social care by the community. The film was developed in response to focus groups in bringing together about the understanding of practitioners of the Showmen community. Key issue with the community highlighted the Showmen's lack of confidence in disclosing their identity for fear of discrimination.

IMPACT

This is a community that along with many of the travelling communities is often overlooked and hard to quantify yet experience wide ranging inequalities so using the tool of media to share the voices of the community more widely. The film is intended as a short introduction to the community and it was filmed on locations around Manchester with the Showmen living both on the Cheetham and Crumpsall Yards

Inclusion health group: Gypsies and Travelers

Locality: Manchester

Case study



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Engagement Toolkit - Tameside and Glossop

This toolkit provides practical guidance and templates that help plan and deliver Care Together engagement activities across Tameside and Glossop and ensure a single shared approach to Communications, Engagement and Consultation

IMPACT

The specific aims of the toolkit are to:

- Raise awareness of the value of engagement as a core part of the Care Together programme.
- Provide practical guidance to enable staff and key stakeholders to undertake effective and meaningful engagement activity.
- Provide guidance enabling wider engagement including with those who are 'seldom heard' and with the poorest health.
- To provide programme-wide templates to add programme-wide consistency to engagement activity.

Inclusion health group: All groups

Locality: Tameside



Engagement Toolkit

Delivering joined up health and social care services
for people in Tameside and Glossop.

Published June 2016


Tameside and Glossop
Clinical Commissioning Group


Tameside Hospital
NHS Foundation Trust


Tameside
Metropolitan Borough

Case study



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Fuel poverty toolkit

Health Innovation Northwest Coast and NHS Cheshire and Merseyside joined forces to explore ways of supporting people whose health condition made them particularly vulnerable to fuel poverty. The project team has assembled a suite of resources in a toolkit that aims to help other teams implement similar schemes in their areas. This toolkit brings together assets developed with the teams across Cheshire and Merseyside to identify, engage and support those at greatest risk.

Read about related case studies [here](#)

Inclusion health group: People experiencing poverty/ financial exclusion

Locality: Regional

Case study



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Engagement with Disabled people - Planning Guide

Published by the Equality and Human Rights Commission

Event planning checklist. The following checklists highlight things to consider when planning an engagement event involving disabled people. Facilitator's guide. Easy capacity-building suggestions for access groups. Access groups often need help to become established.

Inclusion health group: People with disabilities

Locality: National



Case study



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Greater Manchester Women's Support Alliance (GMWSA)

The Greater Manchester Women's Support Alliance (GMWSA) acts as a strategic support system for services that help women overcome any challenges they might be facing with domestic abuse, homelessness, mental health and substance misuse. All nine women's centers in our Alliance provide services that are delivered with a trauma-responsive approach.

IMPACT

Aims to fund and provide high-quality services to support, safeguard and empower women experiencing multiple disadvantage, including poverty, homelessness, substance misuse, abuse or being involved in the criminal justice system. Helping them take control of and rebuild their lives and focusing on early intervention and prevention of statutory intervention.

Inclusion health group: People experiencing homelessness, People experiencing drug and alcohol dependency, People in contact with the criminal justice system, People experiencing poverty/ financial exclusion

Locality: Greater Manchester



Best Practice Examples

High Intensity use of A&E Services, Manchester Foundation Trust Pilot

Background

- A report from the British Red Cross shows that people from the most deprived areas of the UK are more likely to be in poor health and are most likely to attend A&E most frequently.
- The British Red Cross provides High Intensity Use services across all 7 NHS regions in order to reduce A&E attendance and non-elective admissions among people who frequently attend A&E.
- These non-clinical services work with people to understand the reasons behind repeat visits to A&E and provide personalised support.

Results

- The British Red Cross is calling for action in areas including:
- Putting in place more dedicated “High Intensity Use” Services across the country, with particular focus on areas of deprivation
- Improving access to community-based support to prevent people reaching crisis point, including investment in VCSE provision linked to social prescribing, as well as increasing training and support for GPs and other health care professionals to identify and respond to those at risk of high intensity use
- MFT is planning a pilot to explore high intensity use of A&E services, the correlation with poverty and health inequalities

For further information on case studies, please click [here](#)

Inclusion health group:, People experiencing poverty/ financial exclusion

Locality: Manchester

Case study



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[Refugee and asylum seeker patient health toolkit](#)

What you'll get from this guide;

- Learn about the experiences of refugees and asylum seekers who come to the UK and how this impacts their health needs.
- Understand refugees' and asylum seekers' entitlement to NHS care.
- Learn about the unique health challenges faced by asylum seekers and refugees and ways to overcome the barriers they face when attempting to access care

IMPACT

This guidance will provide you with the key legal, ethical and practical considerations you need to take into account when treating a patient who is a refugee or asylum seeker, and signposts to other sources of support and information.

Inclusion health group: Refugee and Asylum seekers

Locality: National



Tools can facilitate engagement with communities, such as:-

- [VCSE Inclusion Health Audit Tool](#), to audit your organisation's engagement with Inclusion Health groups, and to receive a tailored guide to help to embed action on tackling health inequalities into everyday activities
- [TS4SE Training Toolkit](#), providing information and tips for engaging with migrants at risk and Roma communities

Tips: how to engage with people in flexible ways

- Ensure individuals feel welcome and listened to, taking into account what is important to them
- Minimise travel distance, difficulty or cost, making people aware of community transport options
- Make timing flexible, e.g. options of appointment times or open sessions, with text reminders
- Use clear, simple messages about the importance and benefits of attending, in terms that will be important to the person while also sharing stories of relatable people
- Use plain language in verbal, written and digital communication, using means comfortable for each individual and with translations / interpreters available when needed
- Actively encourage people to come together or with someone they trust
- Offer reassurance and work with individuals to overcome fear in attending
- Consider non-clinical venues for appointments such as supermarkets, community centres or places of worship
- Engage with local community or religious leaders to endorse or promote your offer

Source: adapted from [Unlimited Potential](#)

Case study



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[Refugee and Migrant health toolkit](#)

Refugee and Migrant Health Toolkit (the Toolkit) developed by World Health Organisation (WHO) Health and Migration Programme is a comprehensive, operational and user-friendly source of information, guidance and tools supporting implementation of health and migration related activities including the Global Action Plan (GAP): promoting the health of refugees and migrants 2019–2030

IMPACT

The Toolkit aims to provide in a single place the key tools and resources to support efforts in strengthening refugee and migrant health care in alignment with the priority actions in the GAP; these can then be quickly and easily accessed to guide action.

Inclusion health group: Refugee and Asylum seekers

Locality: International

Case study



Fairer Health
For All

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Integrated Care
Partnership

Migrant health guide

Advice and guidance on the health needs of migrant patients for healthcare practitioners.

- Access to healthcare
- Assessing and treating patients
- Vulnerable migrant groups
- Communicable diseases
- Outbreak management
- Non-communicable diseases
- Nutrition

Inclusion health group: Refugee and Asylum seekers

Locality: National



Key Actions

1. Make use of available **tools** to actively engage inclusion health groups
2. Develop **PCN-VCFSE relationships, for example:-**
 - a) Ensure that **PCN Health Inequality Lead contact information is up-to-date** and visible for VCSE organisations to make contact
 - b) Utilise **wider activities** and **non-clinical spaces** to stimulate conversations about health, and to sustain relationships with individuals and communities
 - c) Engage with **VCFSE infrastructure organisations** in the design of activities, drawing upon the Core20PLUS5 framework
3. **Capture and utilise the learning** from these activities to better inform step 3 (*Plan care **flexibly** to encompass a range of needs and to improve access to and experience of primary care services*)



Health care should be planned in a way that is **flexible** and **tailored** to the **overlapping needs** across Inclusion Health groups.

There are a range of **tools** available to help you to consider the needs and assets of inclusion health groups, and how to tailor services appropriately in the planning, delivery and evaluation of health care services, policies and programmes.

In order to improve access for Inclusion Health groups, the NHS has produced “**How to Register with a GP**” guides, available here:

- [Asylum seekers and refugees](#)
- [People experiencing homelessness](#)

Groundswell has also produced “**my right to healthcare**” cards, to help people to register with a GP. Available [here](#).

Inclusion health group: Refugee and Asylum seekers, People experiencing homelessness

Locality: National



Information on planning care flexibly is included in the **Core20PLUS5 GM Plans:-**

Core20PLUS5 Clinical Areas	Further details
Maternity	<u>GM Maternity Equity and Equality Action Plan 2022-2027</u>
SMI	<u>GM Mental and Wellbeing Strategy</u>
Chronic respiratory disease – COVID and flu uptake	<u>Data quality report: national flu and COVID-19 surveillance report</u>
Early cancer diagnosis	<u>GM CVD Prevention Plan</u>
Hypertension / lipids	<u>GM CVD Prevention Plan</u>
Asthma	<u>GM Asthma Prevention Plan</u>
Diabetes	<u>GM Diabetes Strategy</u>
Epilepsy	<u>Epilepsy</u>
Oral health	<u>GM Putting the mouth back in the body report</u>
Mental health	<u>GM Mental and Wellbeing Strategy</u>





Best Practice Examples

Manchester Covid-19 Vaccination Programme, GM

Background

Manchester's Covid-19 vaccination programme gave an opportunity to work closely at a neighbourhood level to meet local needs. Manchester worked with local neighbourhood teams, GP practices, community pharmacies, public health, and voluntary organisations to deliver more than more than 2,000 winter vaccines during autumn/winter 2022/3 in 84 pop-up vaccination clinics. Clinics were based in markets, mosques, community centres, asylum accommodation, sex worker health clinics, supermarket car parks, student centres and warm hubs.

Results

- A “How to” guide was developed for meeting the **needs of asylum seekers, refugees and migrants**
- A partnership delivery model was developed e.g. a **homelessness** vaccination service commissioned by the team from Urban Village Medical Practice with VCSE organisations, including MASH and The Men's Room who work with **sex workers**.
- Community volunteers, social media messaging and text messages from GPs brought people through the door with 42% being ‘opportunistic’, and 30% of these saying they would not have had the vaccine had it not been there.
- Manchester is now using this experience to replicate a range of primary care services with a focus on reducing inequalities.

Success factors

- Engaging VCSE partners helped to identify barriers to delivering care.
- Working with representatives from specific communities and inclusion health groups as ‘sounding boards’ for direction and advice, and as trusted ‘messengers’ within communities demonstrably closed the gap in vaccination coverage across communities.

Inclusion health group: Refugee and Asylum seekers, People experiencing homelessness, Sex Workers

Locality: Manchester



Best Practice Examples

[COVID-19 Health Equity Manchester \(CHEM\) Sounding Boards](#)

Background

Following a successful application to the Department for Housing, Communities and Local Government (DHCLG) for Community Champions funds, Manchester was awarded funds to build on the work of COVID-19 Health Equity Manchester group (CHEM). Given the urgent need to boost local vaccination coverage, the fund was combined with local resources to enable the delivery of 'Covid-Chat' conversations with Manchester residents through a volunteer programme working with anchor institutions from the VSCE sector, youth organisations, schools and places of worship.

Results

The CHEM group has developed trusted relationships with representatives of 'at risk' communities and now has a framework of engagement known as Sounding Boards. The remit of the Sounding Boards is to provide community reach; to feedback intelligence from the communities to ensure that Covid messaging is reaching communities and is making a difference to help reduce disproportionate impact.

Four Sounding Boards have been developed which meet every other week, including an Inclusion Health Sounding Board, made up of representatives from migrant groups; Roma, Gypsy, Traveller communities, asylum seekers, refugees and also sex workers. In addition to the actions set out within the Addressing Inequalities programme, the Inclusion Team has continued to support rapid Equality Impact Assessment of services which form part of the wider MHCC Operational Plan and Covid Response and Recovery plans.

Success factors:

- Shared intelligence facilitating targeted and tailored engagement for vaccine coverage
- Improved primary care demographic data

Inclusion health group: All

Locality: Manchester

Case study



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[Henshaws](#) is a Greater Manchester Sight Loss Charity

Henshaws is a northern charity supporting people living with sight loss and a range of other disabilities to go beyond expectations.

They believe that, wherever they are, everyone has the right to an independent and fulfilling life. The support, advice and training enables people and their families to build skills, develop confidence, help each other and look forward to a more positive future

For case studies outlining the impact of its work, click [here](#)

Inclusion health group: Disability group

Locality: Greater Manchester



Best Practice Examples

Reducing the inequalities faced by Salford's d/Deaf community

Background

In 2019, commissioners from Salford held a focus session for members of Salford's **d/Deaf** community to gain insights into challenges faced in accessing **primary care services**

Results

An action plan was developed based on this insight, including commissioning "SignLive" (an online BSL interpretation service to help d/Deaf patients to contact their practice over the phone), a practice staff training session to highlight the vulnerabilities of this community, and implementing changes to the interpretation and translation providers' SLA requiring the use of fully qualified interpreters for all Salford bookings

For further information on case studies, please click [here](#)

Inclusion health group: Disability group

Locality: Greater Manchester

Case study



Fairer Health
For All

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[The Homeless and Inclusion Health Barometer 2024](#)

This report, the first of its kind from Pathway & Crisis, reveals how the national crisis facing both our health and housing systems leads to worsening health for people in inclusion health groups. **Focussing** on; street discharge, digital health inclusion, housing, policy and legislation, integrated care, addictions, intermediate care and primary care

IMPACT

Drawing on 85 pieces of published literature from the past two years, and a survey of frontline medical and healthcare professionals, the findings reveal how those who are most excluded in our society struggle to access health services due to inflexibility, discrimination and stigma.

It calls on Government, along with NHS England, to lead reform of mainstream health services and to increase the availability of specialist care. It further calls for a commitment to deliver the social housing needed to ensure that everyone has a safe and healthy home.

Inclusion health group: People experiencing homelessness

Locality: National

Case study



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Services for People experiencing homelessness

Salford Primary Care Together.

The service operates as a micro-GP practice, based in a day centre in Salford with a caseload consisting solely of people experiencing homelessness.

Inclusion health group:

Homelessness

Locality: Salford

Urban Village Medical Centre.

Based in Manchester (Ancoats), this practice also operates as a homelessness inclusion health service, with strong connections to rough sleeping outreach and other support services.

Inclusion health group:

Homelessness

Locality: Manchester

The Wellspring GP drop-in, Stockport.

The Wellspring offers a regular GP drop-in service within a day center, providing open access support to anyone using the day center as well as referrals to other specialist services. It also offers broader services to people experiencing homelessness and disadvantage, including educational, computer, art classes and other activities such as gardening and football, giving people the skills and confidence to become independent.

Inclusion health group: Homelessness

Locality: Stockport

Case study



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St Ann's Hospice Homeless Palliative Care Service

This is a lottery funded palliative service for people experiencing homelessness with terminal illnesses. The service provides dignity in death within their hospices and has blazed a trail in understanding how people who would otherwise be excluded from hospice can be supported in their last days.

Inclusion health group: Homelessness

Locality: Salford

Rough Sleeping Outreach MDT

Through a variety of funding sources, Bolton Council have brought together a team of nurses, clinical psychologists, dual diagnosis practitioners and substance misuse specialists who are embedded in their rough sleeping outreach service ("Street Life")

Street Life works work with rough sleepers and other people with complex and enduring housing related needs. Advice and information is given particularly in relation to housing options, applications for housing, benefit queries and landlord concerns. Bolton's Drug and Alcohol Service attend to provide specialist support. NHS Homeless and Vulnerable Team Nurse Practitioners provide health screening and advice, wound dressings, flu jabs and prescribing.

Inclusion health group: Homelessness

Locality: Bolton

Case study



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Partnership

Rough Sleeping Social Work Team

Manchester have embedded social workers within their rough sleeping services, who work with people identified as experiencing long term and repeat street homelessness, to carry out Care Act assessments and link people up with specialist support. They have successfully supported people who have experienced long-term homelessness, and in the process, are enhancing system thinking about **learning disabilities, neurodivergence, acquired brain injuries and mental capacity.**

Inclusion health group: Homelessness

Locality: Manchester

GMMH Homeless Hub

GMMH have a well-established multi-disciplinary team supporting those who are homeless and with a mental health condition

The team consists of psychologists, psychiatrists, neuropsychologists, speech and language therapists and other professionals who support their wider work.

Inclusion health group: Homelessness

Locality: Greater Manchester



Best Practice Examples

GM Dual Diagnosis Support Service

Background

This service embeds psychologists and dual diagnosis practitioners in rough sleeping teams. The service has three strands:

- a) providing advice, support and reflective practice to the rough sleeping workforce
- b) providing direct case work and formulation with individuals experiencing the severest and most intractable mental health/substance misuse issues
- c) supporting wider reform of the system.

Results

- This operates in Bolton, Bury, Stockport and Trafford and has been extremely successful.
- The service will be expanding coverage to provide a consistent GM response to people experiencing co-occurring mental health, substance misuse and street homelessness.

Inclusion health group: Homelessness

Locality: Bolton, Bury, Stockport, Trafford



Best Practice Examples

Shared Health Foundation, Families experiencing homelessness

Background

[The Shared Health Foundation](#) combines expertise from health, education, and VCSE sector. They work across Greater Manchester, from the ground up, to identify the impacts of poverty on health. They develop initiatives, provide practical support or promote existing grassroots projects to reduce health inequalities. The team have led strategic work with families in temporary accommodation. The team are also connecting Local Authorities, Temporary Accommodation Providers, healthcare providers, schools etc. to provide a holistic service to improve the health outcomes and life chances of families experiencing homelessness

Results

Significant benefits have been seen in mental and physical health, and in stability to households. The team have worked with accommodation providers to deliver safeguarding and mental health training and identification of key health and social care pathways - this has improved service access for families, incorporating prevention not just crisis response. Their key recommendations for action are now being implemented at a local level which is anticipated to improve the health, wellbeing and safety of families experiencing homelessness.

Inclusion health group: Homelessness

Locality: Greater Manchester

Best Practice Examples

[Sale PCN-VCSE partnership](#)

Background

Since January 2023, the Sale Central PCN has worked with local VCSE organisations to run regular drop-in sessions with a community health advisor. These sessions recognise that some people face specific barriers when accessing traditional services and feel unsure what services are available to them and what time and where. The drop-in sessions for people living locally help tackle health inequalities by offering an alternative way for people to get help and support on health concerns.

Results

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

Further health issues and concerns can be discussed e.g. around smoking, weight management and diabetes. People are also supported to book cancer screening and vaccination appointments.

Success factors:

- Partnership working helps people to get the advice needed to improve their health and wellbeing, and helps to link people to wider services including cost-of-living advice, help as a carer, befriending and befriending services to combat loneliness.
- Partnering with local VCSE organisations to deliver these sessions has helped community health advisors broaden their knowledge of the community services available in the area and build long-term relationships.
- The more informal setting removes barriers and help residents feel more comfortable sharing concerns

Inclusion health group: All

Locality: Trafford



Best Practice Examples

Including Everyone Manchester

Background

As part of Digital Inclusion in Primary Care, a brochure was produced to understand barriers to access and how primary care services may be delivered to reduce these and improve equity of access.

Results

Case study example: Ibrahim's story, containing advice and information to support **vulnerable migrants** including:

- Have a list of languages that non-English speakers can use to show you which language they speak
- Have a welcome letter in different languages that can be printed and handed to the individual, including information such as
 - GP practice details and services
 - When and how to use NHS 111, pharmacies and A&E
 - How to ask for an interpreter
 - Details of other local healthcare services
 - Help that is available online
- Ensure website has a translation function and explains how to access both in-person and online services

Refer to the [Safe Surgeries Toolkit - Doctors of the World](#)

Inclusion health group: Asylum seekers and Migrants

Locality: Greater Manchester



Key Actions

1. Take **learning from existing best practice** examples and challenges identified to **inform local planning of services**
2. Engage with communities to understand barriers of access for different inclusion groups
3. **Consult with community** as part of planning process
4. **Implement good accessible information standards in all your communications**
5. **Address barriers to care** that you have identified from locality insight

Prioritise workforce development opportunities and training to enable services to be **culturally competent**, and **improve representation** of inclusion health groups within our workforce



Training opportunities may help staff in:

- ✓ Developing skilled approaches to having conversations
- ✓ Designing care with people that responds to their individual circumstances and strengths
- ✓ Developing better approaches to working with people to support them to self-manage and adopt health improving behaviours

Relevant **types of training** may include:

- ❖ health coaching
- ❖ patient activation
- ❖ motivational interviewing
- ❖ person centred care
- ❖ support planning

Prioritise workforce development opportunities and training to enable services to be **culturally competent**, and **improve representation** of inclusion health groups within our workforce



There are a range of existing learning **resources** to support workforce development and training:

- [FHFA Academy Training and Development](#), e.g. HEE e-learning sessions and webinars, Apprenticeship training courses, and a Making Every Contact Count (MECC) toolkit.
- GMPA resources, including [The Role of the NHS in GM in Tackling Poverty](#) to understand the risk faced by the population of GM in relation to poverty and financial exclusion.
- A GM Tackling Poverty toolkit [currently in development]
- A report from the [King's Fund on the relationship between poverty and NHS services](#), containing tools and examples of good practice
- Training opportunities with the [Personalised Care Institute](#)



Best Practice Examples

Poverty Awareness Training, NHS GM

Background

- GMPA recently evaluated online and in-person poverty awareness training delivered by Resolve Poverty which was delivered to over 500 staff
- The training equips NHS GM staff with knowledge of how **poverty** impacts people's lives and their health, and consequently how this affects the NHS GM system
- Staff are helped to understand how they can best support people in poverty and tackle poverty in their specific job roles
- The training includes
 - how to successfully design strategic and programmatic responses to tackle poverty (such as service design and policy)
 - how those in frontline roles can practically support those in poverty, including practical resources staff can use in their work.

Results

- Data from the most recent stage of training demonstrate a positive impact on staff, increasing knowledge of poverty and how to tackle poverty, as well as supporting those in poverty through their work

Inclusion health group: People experiencing poverty

Locality: Greater Manchester

Case study



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Money Advice Referral Tool

[Resolve Poverty](#) believes that responses to poverty should focus on getting more money into people's pockets. That's why one of their strategic priorities is to support local efforts to boost household income and financial resilience. For many frontline organisations helping people dealing with poverty, information on where to refer people for appropriate support and advice is not always easy to find. The [Money Advice Referral Tools \(MARTs\)](#) aim to help these organisations and professionals by simplifying the process and putting the key information at their fingertips.

IMPACT

Money Advice Referral Tools have now been developed for seven boroughs and can download the latest version of these [here](#). The MARTs have been created via local working groups, typically involving local authorities, housing associations, foodbanks, other voluntary groups and people with lived experience of poverty.

Inclusion health group: People experiencing poverty

Locality: Greater Manchester

Case study



Fairer Health
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GMCA Pension Top Up toolkit

Thousands of older people across Greater Manchester are missing out on money they are entitled to. This winter we are encouraging and helping residents of State Pension age to access the millions of pounds that go unclaimed every year.

IMPACT

Using UK-level estimates, research team found that in Greater Manchester

- There are around 38,000 eligible households not claiming Pension Credit, 30,000 not claiming Attendance Allowance, and 33,000 not claiming Carer's Allowance
- This equates to £367m per year across the city region.
- 1 in 4 people of State Pension age can claim Pension Credit which is worth on average £3,400 a year.

That's why the Greater Manchester Ageing Hub is launching the next phase of the Pension Top Up campaign to encourage older people – or their loved ones – to check they are getting all that they are entitled

Inclusion health group: People experiencing poverty/ financial exclusion

Locality: Manchester

Case study



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Greater Manchester's priorities for health and care workforce

Getting it right for GM's health and care workforce. The People and Culture Strategy for 2022-25 sets out Greater Manchester's ambitions, aims and priorities for its health and care workforce.

IMPACT

This strategy creates a shared vision for what we want to achieve together for our Greater Manchester workforce as an integrated care partnership. It provides a blueprint for why, where and how we work together to deliver maximum impact. It does not seek to replace or override local or organisation plans.

Inclusion health group: All

Locality: Greater Manchester



Multiple Disadvantage Framework

Multiple disadvantage refers to experience of a combination of intersecting problems including, but not limited to, homelessness, substance misuse, contact with the criminal justice system, mental ill health, domestic abuse. For many, their current circumstances are shaped by long-term experience of poverty, deprivation, trauma, abuse and neglect. There are frequently interconnected inequalities i.e. gender, race, disability which further compound the disadvantage experienced. A combination of factors mean this cohort are often the most vulnerable within our communities and experience the harshest health inequalities. Supporting people with Multiple Disadvantage is a national and local priority which is rapidly gaining momentum and crosses into various connected workstreams including equality, diversity & inclusion.

IMPACT

The aim of this framework is to explore how the health and care sector might improve the way they recruit and retain individuals with experience of multiple disadvantage, and might they be better served when accessing services.

Here is Adam's story: <https://youtu.be/tjJeSCnlvEg>

Inclusion health group: Mental health, poverty, alcohol misuse, domestic violence

Locality: Greater Manchester

Case study



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Manchester Foundation Trust (MFT) & Citizens Advice

MFT has been working with Citizens Advice on the trauma unit at MRI for several years, supporting patients with benefit, debt and other advice linked to their condition. This offer is now being expanded to include North Manchester General Hospital and will be available for all patients and staff. Funding applications are underway to develop this at other sites too, offering patients financial, housing, and other advice and support at the point of care

IMPACT

The impact will be evaluated. Previous work has shown significant benefits to patients in terms of claiming the correct benefits and helping manage debts. Feedback from other Hospital Trusts suggests having advice workers on site may benefit patient flow and support discharge too.

Inclusion health group: People experiencing poverty

Locality: Manchester

Prioritise workforce development opportunities and training to enable services to be **culturally competent**, and **improve representation** of inclusion health groups within our workforce



Best Practice Examples

Role of NHS in tackling Poverty

Manchester Foundation Trust (MFT) & Citizens Advice

Background

MFT has been working with Citizens Advice on the trauma unit at MRI for a number of years, supporting patients with benefit, debt and other advice linked to their condition. This offer is now being expanded to include North Manchester General Hospital and will be available for all patients and staff. Funding applications are underway to develop this at other sites too, offering patients financial, housing, and other advice and support at the point of care.

Results

The impact will be evaluated. Previous work has shown significant benefits to patients in terms of claiming the correct benefits and helping manage debts. Feedback from other Hospital Trusts suggests having advice workers on site may benefit patient flow and support discharge too.

Locality: Manchester

Sale Central PCN

Background

Since January 2023, the Sale Central Primary Care Network (PCN) has worked with local voluntary, community, and social enterprise (VCSE) organisations to run regular drop-in sessions with a community health advisor aimed at people who face specific barriers when accessing traditional services, including those experiencing severe financial hardship.

Results

Working in partnership helps people get the advice needed to improve their health and wellbeing and to be linked to services that can support further including cost-of-living advice.

Locality: Trafford

Bolton Locality:

Bolton has at least one Social Prescribing Link Worker (SPLW) based in each of its nine Primary Care Networks working with people from financially disadvantaged backgrounds – linking them to services such as financial and debt advice, housing services and skills training.

Locality: Bolton



Best Practice Examples

Role of NHS in tackling Poverty

Resident Advice and Support (RAS)

- Stockport's Resident Advice and Support Team's (RAS) Cost of Living Helpline, which uses a "tell us once" approach to accessing advice, benefit checks, help with applications for benefits and warm referrals to relevant support services, is routinely used by NHS staff. A team of experts offering specialist casework to assist the most vulnerable residents with income maximisation, complex debt and benefit problems is also available. RAS Benefit Advisers also deliver outreach approach to support patients from their hospital ward, or their local community mental health outreach centre to ensure they get the best advice, quickly. This enables patients to leave hospital after long stays with the correct benefits in place.
- The Council and NHS have jointly delivered a benefit uptake campaign building on successful Pension Credit uptake campaign, and the council is working on a pilot with the Heaton's GP Practice to promote Attendance Allowance to a target cohort of patients i.e., those with long-term limiting health conditions will be encouraged to contact the Cost-of-Living Advice Line for access to a full benefit assessments and support to apply.
- Benefit advisers are supporting patients with mental health needs from their hospital ward, or their local community mental health outreach centre to ensure they get the best advice, quickly and helping patients to leave hospital after long stays with the correct benefits in place.

Locality: Stockport

Tyldesley, Astley, Boothstown and Atherton PCN

TABA PCN (Tyldesley, Astley, Boothstown and Atherton), which has eleven practices in its network, has implemented several initiatives to tackle health inequalities. One initiative involved working with the charity Mind to increase the uptake of Severe Mental Illness (SMI) health checks. A more holistic approach was adopted to tackle underlying problems affecting a patient, such as financial concerns.

Locality: Wigan

Anti Poverty Summit

3 anti-poverty summits have been delivered locally with all partners including Health, social care, housing, DWP, food banks, vol sector orgs and people with lived experience, across which we have collectively agreed our anti-poverty strategy and the use of our Household Support Fund (along with listening to lived experience).

Results

- Bury have implemented the Money Advice Referral tool in collaboration with GM Poverty Action and local VCSE partners.
- Targeted support enabling provision of £306,600 of HSF beyond those receiving direct payments or direct provision from voluntary/community groups.
- 36 voluntary groups applications supported through Cost-of-Living resilience payments with a total allocation of £80,414.
- Increased the uptake of healthy start vouchers in Bury to 66% through working with Bury Market to provide more venues to use the vouchers (GM uptake is 61%) (<https://www.burymarket.com/bury-market-news/nhs-healthy-start-success>)
- Supported the coordination of over 40 warm spaces in Bury.
- Invested in a new software (ascendant) which helps to identify cohorts who are financially vulnerable.

Locality: Bury



Best Practice Examples

More support for international GPs to stay in practice, GM

Background

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

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

Results

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

Inclusion health group: People experiencing poverty

Locality: Manchester

Prioritise workforce development opportunities and training to enable services to be **culturally competent**, and **improve representation** of inclusion health groups within our workforce

Key Actions



1. Consider the **training needs** for your staff, teams, organisation or partnerships and **signpost colleagues** to resources
2. **Work with the FHfA team** to develop **tailored training** resources for your team
3. Understanding and awareness of existing health inequalities amongst workforce



It is important to foster a culture of sharing learning and best practice. Forming a **Community of Practice** can help to share expertise. There are a number of existing Communities of Practice and Networks in GM:-

Equality Panel	Facilitator	Email
LGBTQ+ Panel - https://www.greatermanchester-ca.gov.uk/what-we-do/equalities/lgbtqplus-adviser-and-panel/	Emily Wilkins LGBT Foundation	emily.wilkins@lgbt.foundation
Women and Girls Panel - https://www.greatermanchester-ca.gov.uk/what-we-do/equalities/women-and-girls-equality-panel/	Anabel Butler Pankhurst Trust	a.butler@manchesterwomensaid.org
Disabled People’s Panel - https://gmdisabledpeoplespanel.com/	Jane Bevan Rick Burgess Greater Manchester Coalition for Disabled People	Jane@gmcdp.com Rick@gmcdp.com
Youth Combined Authority - https://www.greatermanchester-ca.gov.uk/what-we-do/children-and-young-people/youth-combined-authority/	Hannah McMullen Youth Focus North West	h.mcmullen@youthfocusnw.org.uk
Older Peoples Panel (Age-Friendly) - https://www.greatermanchester-ca.gov.uk/what-we-do/ageing/	John Mulvenna Macc	john.mulvenna@macc.org.uk
Race Equality Panel – https://www.greatermanchester-ca.gov.uk/what-we-do/equalities/race-equality-panel/	Charles Kwaku-Odoi Caribbean and African Health Network	gmracepanel@cahn.org.uk
Faith and Belief Advisory Panel - https://www.greatermanchester-ca.gov.uk/what-we-do/equalities/faith-advisory-panel/	Chris Hart Pulse Regeneration	chris@pulseregeneration.co.uk
GM Equality Alliance - https://www.gmcvo.org.uk/GMEqualityAlliance	Rory Campbell Greater Manchester Centre for Voluntary Organisation	rory.campbell@gmcvo.org.uk



To drive continuous quality improvement, there must be a robust **evaluation** process, proving an approach to:

- Identify and understand
- Assess
- Plan
- Collect and analyse data
- Review and act on changes.

The [NHS evaluation toolkit](#) will help you improve services and outcomes, determine value and effectiveness, and make informed decisions. It's primarily for those involved in health and care services, but will be useful to anyone hoping to conduct an evaluation.

The [GM Evaluation Framework](#) outlines 4 stages to evaluation along with supporting documentation for each stage



Best Practice Examples

Salford Primary Care Together Inclusion Service

Background

- Following a trauma-informed audit in 2020/21, a list of actions were developed including encouraging and developing ways for patients and professionals to leave feedback regarding the Inclusion service, and how to improve engagement activities
- Further staff training was sought through
 - GMMG
 - Connecting Communities - supporting people experiencing homelessness with advanced ill health
 - A trauma-informed toolkit from the Scottish Government to facilitate trauma-informed training
 - A Groundswell “Clarissa” video for teaching with students ('Clarissa' the film | Groundswell)

Results

- Staff are given 0.5 days per month protected CPD time for training
- Pathways masterclasses are shared with staff, supporting trauma-informed practices
- Feedback and success stories are more consistently collected, as well as increasing engagement with social media
- A trauma-informed communication plan has been developed to inform a service communication plan, including an inclusive language policy enabling opportunities for patients to disclose trauma
- A number of new SOPs have been developed to enable trauma-informed practices

Inclusion health group: All

Locality: Salford



Key Actions

1. Join a **Community of Practice** for Inclusion Health groups
2. Utilise **evaluation toolkits** to ensure areas for improvement are identified and acted upon
3. **Access and engage with FHfA** to share learning, experiences and showcase best practice

- **Do you want to be part of testing the toolkit?**
- **Do you have a best practice example to share?**

We are collating “stories of change” – and would love to hear your ideas about how we can create regular mechanisms to showcase best practice in relation to commissioning for inclusion.

- We are looking for **volunteers** to help us to test the toolkit.

If you or a colleague are able to help us, or would like more information, please contact: Khalada Abdullah, Khalada.abdullah@nhs.net

Thank you

Greater
Manchester
Integrated Care
Partnership

The logo for Greater Manchester Integrated Care Partnership features the text stacked vertically. Below the text is a horizontal bar composed of several colored segments: orange, teal, dark blue, light blue, and yellow.

Please Check out the [Fairer Health For All Academy](#) site for further resources

