Primary Care Inclusion Health Toolkit

For commissioners and providers of primary care services in GM

March 2024

Executive Summary

Individuals belonging to inclusion health groups experience extreme inequalities in healthcare, with **poorer access, experience and outcomes** compared to the rest of the population. 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. In order 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 ascertaining current best practice across the 10 localities in GM, and offering the opportunity to share the learning. The toolkit is based upon the following national toolkits, and has been developed to be specific to GM:-

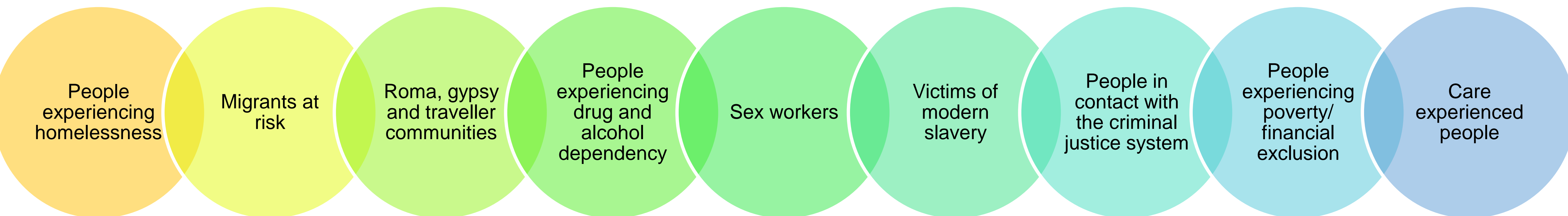
- **Core20PLUS5 HEAT toolkit,** which can help you to understand the data and how to adapt services to be flexible and inclusive
- **Core20PLUS5 Delivery Toolkit,** containing a range of national resources for planning and delivering healthcare improvement projects. Resources include tools and approaches aligning to Core20PLUS5, including an Evaluation Toolkit, Innovation, QI, PHM, Digital and Leadership tools
- **National NHSE Inclusion Health Framework,** containing key principles for action on inclusion alongside suggested practical actions

What is the inclusion health toolkit?

- 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 programmes 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***
- Based upon national CORE20PLUS5 and Health Equity toolkits which have been adapted for GM
- Supports commitments outline in the Primary Care Blueprint, Fairer Health for All and the ICP Strategy, as well as national strategic priorities for HI and CORE20PLUS5

What do we mean by inclusion health?

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.

GM is home to significant inequalities

Inequalities At a Glance in GM

Nearly 40% of the population in GM

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.

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.**

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 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.

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

1/3 of the GM population are children and young people (CYP)

around 1 in 4 live in poverty

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

A comprehensive, whole system approach to population health, prevention and early detection, consisting of a system-wide approach to health creation and delivery of a person-centred upstream social model of care

Shaping GM as a place conducive to good health by working together to address the root causes of ill health

Enabling people to live healthier lives by mobilising comprehensive approaches to tackling behavioural risk factors

Scaling up secondary prevention across all parts of the NHS to allow the early detection of risk and early diagnosis of illness

Supporting people to live well by optimising the treatment and management of health conditions

Leading to

Better outcomes

Healthy Life Expectancy and Life Expectancy

Inequalities and variation in health outcomes and experiences

Avoidable demand and cost

Increased economic & social productivity due to better health

Everybody has an opportunity to live a good life

Tackling inequalities and reducing unwarranted variation

GM Fairer Health for All Framework and CORE20PLUS5

Harnessing the following system characteristics

Person and community centred approaches	Strategic Intelligence / PH Management	Whole system partnerships/ collaboration	Public Service Reform / Integration	A highly skilled and prevention focused workforce	Clinical Excellence and Leadership	Finance, contracting and accountability rebalanced towards prevention and early detection	Evidence, research, technology and innovation

Strategic Context – our triple deficit

- The health of people in Greater Manchester is poor. On average, people who live in Greater Manchester become ill earlier, live in poor health for longer, and die earlier than the national average. This overarching picture also masks significant geographic and demographic health inequalities within the city-region.
- As well as this population health challenge, we face significant financial, performance and quality challenges across health and care in GM
- This is all holding back our ambition for *Good Lives for All* in GM
- We have the opportunity to mobilise our resources to scale up our efforts on population health and prevention and to re-prioritise a system wide, strengths-based approach to improving the health of our population

Strategic Financial Framework – Key Messages

- First time that we have drawn on the actual care record of every resident in GM to project the nature of future demand based on current trends. This is a unique asset for GM based on the **Advanced Data Science Platform** (ADSP)

- The framework shows that the **proportion of the population in 'good health' is set to decline by 10%** in the next five years under a 'do nothing' scenario – this leads to an additional £1.9bn of acute activity beyond our expected allocation

- It highlights **which groups of the population are likely to experience the worst deterioration in health**. It sets out the population health interventions that will make the most significant impact in improving the health of these groups.

- We need to address both the immediate financial challenge in the system and the **drivers of future demand** signalled in the population health analysis to secure a sustainable health and care system in GM

Quantified opportunities map to primary, secondary, and Social Determinant focussed interventions

For the purposes of initial investment quantification – opportunities one has been aligned with primary intervention, opportunity two with secondary interventions, and opportunity three with Social Determinants of Health interventions

Opportunity 1: Reducing the growth in prevalence and progression of ill health

Opportunities to reduce prevalence and progression of ill health relative to baseline trend based on targeted prevention and early detection activities

Primary Prevention intervention across five key areas:

- Smoking
- Obesity
- Diet
- Exercise
- Alcohol Dependency

Opportunity 2: Optimising models of care

Opportunities to change models of care to deliver more consistent proactive care to support effective population health management

Secondary intervention, targeting 5 specific patient cohorts:

- Cardiovascular Disease
- Diabetes
- Respiratory Conditions
- Frailty
- Serious Mental Illness

Opportunity 3: Improving care for the most disadvantaged communities

Opportunities to improve health and address and reduce disparities in care for people in deprived socioeconomic groups

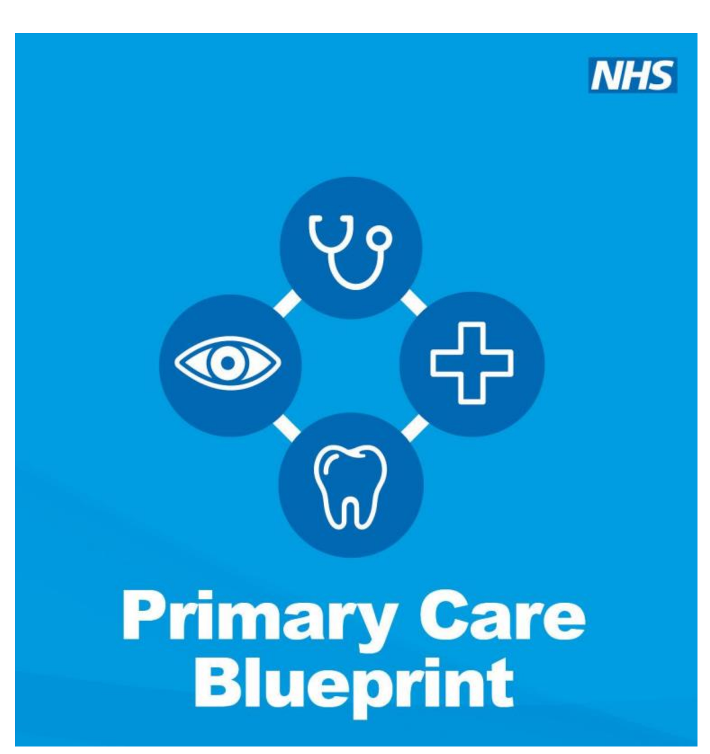
Interventions targeting 4 social determinants of health areas:

- Housing
- Food Insecurity
- Transport
- Substance Misuse

What are the challenges facing primary care in GM?

As highlighted in the Primary Care blueprint, there are strategic risks to delivery including:-

- Financial challenges
- Estate capacity
- Workforce
- Information governance / data sharing
- Changed management capacity and capability
- Issues relating to national contracts and incentives schemes where review and reform is anticipated e.g. GP and Dental contracts, GP Quality and Outcomes Framework
- Engagement of the population
- Digital exclusion



Further information on GM's Primary Care Blueprint is available here

National Commitments

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

Classification: Official

Publication approval reference: PR00157

Tackling Neighbourhood Health Inequalities

Supplementary guidance

Version 2.0 1 April 2023

NHSE: Tackling Neighbourhood Inequalities DES

NHS Constitution for England

Department of Health & Social Care

Guidance

The NHS Constitution for England

Updated 17 August 2023

The Public Sector Equality Duty

GOV.UK

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

Leadership and Accountability

It is recognised that in order 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.

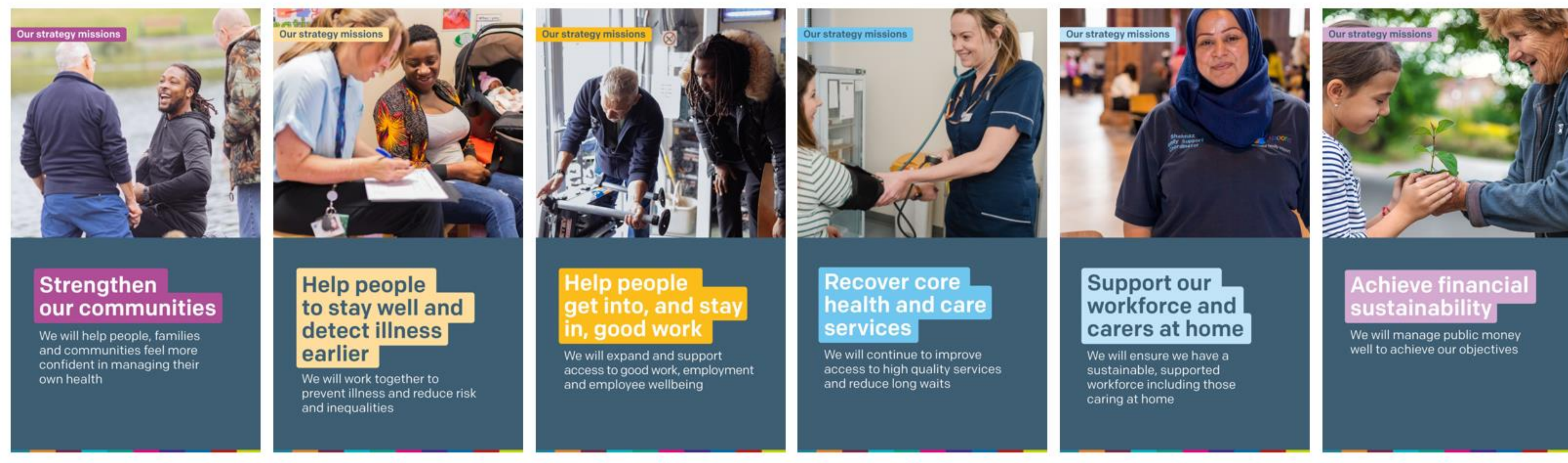
There is an opportunity for colleagues across primary care to **innovate** and **drive improvement** through **trialling** the toolkit. Contributions through **sharing case study examples** of **best practice** will enable us to **share learning** and to **showcase** best practice in relation to commissioning 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, recommissioning or evaluation of primary care services
- Commitment to **sharing examples of best practice** to facilitate shared learning across the system

GM Commitments: GM Integrated Care Partnership Strategy

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



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

This toolkit supports commitments outline 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**

GM Commitments

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.

People power

We will work with people and communities, and listen to all voices – including people who often get left out.

We will ask 'what matters to you' and 'what has happened to you' as well as 'what is the matter with you'.

We will build trust and collaboration and recognise that not all people have had equal life opportunities.

Proportionate universalism

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).

We will **change how we spend resources** – so more resource is available to keep people healthy and for those with greatest need.

Fairer Health for All is everyone's business

We will think about **inclusion and equality** of outcome in everything we do and how we do it.

We will make sure how we work makes things better, and makes our environment better, for the future.

We will tackle structural racism and systemic prejudice and discrimination.

Representation

The mix of people who work in our **organisations will be similar to the people we provide services for.**

For example, the different races, religions, ages, gender, sexuality, disabled people and people with multiple severe disadvantages.

We will create the space for people to share their unique voice and be involved in decision making.

Health creating places

As anchor institutions we will build on the strengths of our communities and leverage collective power – to support communities and local economies.

We will focus on place and **work collaboratively** to tackle social, commercial, economic and environmental determinants of health.

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 Inclusion Health Toolkit

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

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

Utilising the data can help you to **define** and **identify** population groups who are experiencing inequity. There are a number of 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
- **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**

(Links to follow)

**if you have a local JSNA or HEA that you would be able to share, please upload it for sharing on the FHfA website here [pending – will be collated in GM database and hosted on FHfA academy]*

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

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 services and making 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), Manchester

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

For further information on case studies, please click here

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,
Gypsy, Roma and Traveller communities
and Armed Forces Community

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

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)
4. Identify **local VCSE organisations** and explore methods of **engagement**

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

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.

Source:GM's people and communities participation strategy

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

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***

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.

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

For further information on case studies, please click here

Best Practice Examples

High Intensity use of A&E Services, MFT Pilot Manchester

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

2

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

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

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.

3

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

Further information on planning care flexibly is included the **Core20PLUS5 GM Plans:-**

Core20PLUS5 Clinical Areas	Further details
Maternity	GM Maternity Equity and Equality Action Plan 2022-2027
SMI	GM Mental and Wellbeing Strategy
Chronic respiratory disease – COVID and flu uptake	tbc
Early cancer diagnosis	GM CVD Prevention Plan
Hypertension / lipids	GM CVD Prevention Plan
Asthma	tbc
Diabetes	GM Diabetes Strategy
Epilepsy	tbc
Oral health	tbc
Mental health	GM Mental and Wellbeing Strategy

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.

For further information on case studies, please click here

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

For further information on case studies, please click here

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

Best Practice Examples

- **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.
  - **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.
  - **Wellspring GP drop-in, Stockport.** Regular GP drop-in service within a day centre, providing open access support to anyone using the day centre.
  - **St Ann's Hospice Homelessness Palliative Care project.** 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.
  - **Bolton Rough Sleeping Outreach MDT.** Through a variety of funding sources, Bolton Council have brought together a really effective team of nurses, clinical psychologists, dual diagnosis practitioners and substance misuse specialists who are embedded in their rough sleeping outreach service.
  - **Manchester City Council 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, in order 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.
  - **GMMH Homeless Hub**: GMMH have a well-established multi-disciplinary team, consisting of psychologists, psychiatrists, neuropsychologists, speech and language therapists and other professionals who support their wider work.

For further information on case studies, please click here

Best Practice Examples

GM Dual Diagnosis Support Service (Bolton, Bury, Stockport, Trafford)

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.

For further information on case studies, please click here

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.

For further information on case studies, please click here

Best Practice Examples

Sale PCN-VCSE partnership (PCN-VCSE T&L site) Trafford

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

For further information on case studies, please click here

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

For further information on case studies, please click here

Key Actions

1. Take **learning from existing best practice** examples and challenges identified **to inform local planning of services**
2. Understand the **drivers for community engagement**
3. **Consult with community** as part of planning process
4. **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 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 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

For further information on case studies, please click here

Fairer Health For All

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.

Trafford Locality

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.

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.

For further information on case studies, please click here

Best Practice Examples

Role of NHS in tackling Poverty

Stockport Locality

- 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.

Wigan Locality:

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.

Bury Locality:

Background

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 HSF (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.

For further information on case studies, please click here

4

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

Greater Manchester Integrated Care Partnership

Fairer Health For All

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..

For further information on case studies, please click here

4

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

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

GM Inclusion Health Toolkit

5

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

Fairer Health For All

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

It is important to foster a culture of sharing learning and best practice. Forming a **Community of Practice** can help to share expertise.

In order to drive continuous quality improvement, there must be a robust **evaluation** process. The **national evaluation toolkit** provides an approach to:

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

The **NHS evaluation toolkit** may also be used.

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

For further information on case studies, please click here

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

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

Using the Toolkit

- Are you delivering a service and you want to work with communities and people with lived experience to improve access, experience or outcomes of care? We would like to work with you to see how these tools can help you improve care for different Inclusion Health groups.

- Do you want to find out what intelligence and leadership tools are available to help your staff think differently about why different Inclusion Health groups have poorer health outcomes?
- Do you want to understand what VCSE data is available, and how you can access your local VCSE organisations….etc
- And get inspired by case studies..
- Do you want to improve staff training?

- Are you working with different primary care partners to review how quality and performance schedules can better monitor impacts and outcomes for different Inclusion Health groups?

- Do you want to think about how your resource is allocated according to need for different Inclusion Health groups?

Get involved

Do you want to be part of testing the toolkit?

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: Bhupendra Mistry, bhupendra.mistry@nhs.net

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.

Greater
Manchester
Integrated Care
Partnership

Fairer Health
For All