Our Strategy Missions

Mission 4

Recovering core NHS and care service

Continuing to improve access to high quality services and reducing long waits.

- **Improving urgent and emergency care and flow** including increased ambulance capacity, improved discharge and admission/attendance avoidance
- **Reducing elective long waits and cancer backlogs, and improving diagnostic performance** including reducing unwarranted variation in waiting times and access to diagnostics
- **Improving service provision and access** including making it easier for people to access primary care and core mental health services
- **Improving quality through reducing unwarranted variation in service provision** including development of virtual wards
- **Using digital and innovation** to drive transformation
- **System Resilience and Preparedness**

Mission 4 Case Study

Real-world examples of how a prioritised, person-centred, multimorbidity approach is applied to long-term condition management.

Our social model for health is enabling a shift away from only seeing the 'patient' and the condition towards working with people and communities. Our commitment to 'Names and not numbers' recognises intersectionality and the different experiences in access, experience and outcomes of care across our diverse communities.

Creating mechanisms to collate insight and data on health needs and access to care is essential, so that we can better understand how care can be proportionate and tailored to need.

Health and care providers are using a range of population health management approaches to reduce health inequalities by identifying people most at risk and prioritising access to care.

This includes making long-term condition dashboards available to GP practices to support data-led approaches to multimorbidity reviews, and enabling focused neighbourhood activity in collaboration with Local Authority and VCFSE partners.

In Manchester Locality, intelligence tools have been developed for GP practices so they can identify and provide targeted support to patients with diabetes and cardiovascular disease who are at highest risk of further or worsening CVD (for example, those with poor control of blood pressure or cholesterol). This has led to improvements in treatment targets across a range of CVD indicators. These tools are now included in the GM health and care intelligence hub for use by Primary Care Networks across GM.