Greater Manchester
Integrated Care Partnership Board

Date: 28th March 2025

Subject: Primary Care and Live Well

Report of: Joint Report between NHS GM and Primary Care Board

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PURPOSE OF REPORT: To confirm the critical role of Primary Care in Live Well, and to set out an engagement exercise that will inform the design and strategy for Live Well implementation to enable the full contribution of all four Primary Care disciplines.

RECOMMENDATIONS:

The GM Integrated Care Partnership Board are requested to:

- Note the central role of Primary Care in Live Well, its track record of innovation in this area, and emerging issues/considerations
- Note that the PCB has been commissioned to undertake a detailed engagement across Primary Care to support the Live Well design and implementation
- Note the proposed timescales of this engagement and its application to other system work
- Advise any considerations or steers to be taken into account as this work commences

- Endorse that interim reports will be shared with the Live Well team and key stakeholder groups
- Endorse that a full report is presented to the ICP by July 2025.

Contact officer(s)

Name: **Zoe Porter**
Telephone: **0161 742 6023**
E-Mail: **zoe.porter1@nhs.net**

Name: **Helen Ibbott**
Telephone: **n/a**
E-Mail: **helen.ibbott@nhs.net**

GM Live Well is Greater Manchester's commitment to everyday support in every neighbourhood. Live Well will bring about a radical shift in how we deliver public services and collaborate with people and communities to reduce health, social and economic inequalities. Building on our existing neighbourhood prevention approaches, Live Well is about ensuring that there is a consistent offer across Greater Manchester so that 'everyday support' is available in every neighbourhood. Live Well support offered to an agreed standard across GM will help people to better manage the pressures of life, live as well as they can and find purpose through good work. In turn, this will also contribute to responding to the key pressures across the public service system by ensuring that best use is made of our collective resources and delivery is focused around the collective needs of our residents.

The model for Live Well consists of 4 key elements:

- **Live Well Centres, Spaces and Offers:** Public Services and community support working together to provide a consistent everyday support offer from recognisable places in the community.
- **The Optimum Neighbourhood Model:** Multi-agency teams working on common geographical footprints of 30-50k population towards shared outcomes & purposes alongside people and communities.

- **A resilient VCFSE Eco-system:** A resilient and connected local VCFSE (Voluntary, Community, Faith and Social Enterprise) offer from a sector resourced to respond to what matters to people, with community-led approaches at the heart.
- **A Culture of Prevention:** Workforce and organisational development geared towards prevention, with a strong emphasis on person-centred and relational ways of working.

Plans are progressing across Greater Manchester to invest in and support locality led leadership of Live Well implementation so that, over the next 5 years, these ambitions turn into reality.

Primary Care's central role in Live Well

Primary Care is a critical partner in this work, serving as the frontline of healthcare for most and the front door for public services for many, supporting prevention, integrated care and holistic well-being. We see this, for example, in our 621 community pharmacies where thousands of people are supported every day at times and places convenient to them with lifestyle changes, medicines, and clinical services. National policy directives towards Neighbourhood Health reinforce ways of working towards an integrated local approach in and with communities, that helps tackle health inequalities. The importance of the Neighbourhood Health model has further been emphasised through the recent publication of the NHSE Neighbourhood Health Guidelines as part of system planning for 2025/26. In Greater Manchester we have been at the forefront of developing neighbourhood working and embedding a person-centred offer for people who need 'more than medicine' as a national pioneer of social prescribing approaches, now embedded across all PCNs.

There are excellent examples across Greater Manchester of Primary Care models, programmes and partnerships that show what might be possible in the future. A selection of these is appended to this report. However, the majority of these have developed despite the immense pressure on everyday practice, and over and above

what is required and incentivised. Many are not sustainably funded or are reliant on individual leaders working ahead of the mainstream.

Primary Care colleagues across all four disciplines (general practice, community pharmacy, dental and optometry services) are highly supportive of the ambitions of Live Well and are keen to bring their learning and insights from innovative work so far in this space into its implementation, so that the best practice we see in pockets across GM becomes the default, fully contributing towards the Live Well ambition.

To ensure that Primary Care is able to play its full role in contributing to Live Well we need to understand what the key benefits and potential of it could be from their perspective, what will need to be considered to ensure that its design enables the full participation of Primary Care and realisation of these benefits, and key strategic changes/ enablers to make it easier for Primary Care to adopt Live Well models and approaches at scale.

Early conversations around this have identified the following design questions:

- What **key metrics and cohort priorities** would we agree that would drive the right outcomes for our population – beyond overall impact on demand?
- How would we use opportunities available to us to **shift resource** towards integrated, preventative work that reaches people who don't always access our support and helps address inequalities?
- How could we develop **genuinely integrated practice** and networks in neighbourhoods, so that all four disciplines are aligned to best support prevention and make use of contact points in the wider community?
- How can we co-design a clear and agreed understanding of the **model and impact on frontline delivery** and how together we transact this model I.e. detail of practice between different partners or offers so that people get what they need, and key workforce groups are integrated, rather than creating more hand-offs between specialisms?
- How we could help **shift the whole culture** towards a person-centred holistic approach, so that, for example, GPs don't feel complicit when working in partnership with what is currently experienced as a punitive system (such as

welfare benefits); building from what is already taking place and looking to scale up?

- What opportunities for co-location in Live Well Centres might be, and what this would mean for **Estates**?
- What would the **information and digital requirements** be to enable this work?
- How will this integrate into the **Prevention Demonstrator** – how does all our strategic intent knit together and help providers understand roles and responsibilities?
- What are the bottom lines of a **consistent offer**, versus locally led development, responsive to different communities?

Many of these questions will be common across all sectors, but we have an opportunity to incorporate the insight and perspectives of our Primary Care colleagues at this crucial stage and ensure that Live Well implementation is fully inclusive of Primary Care. The next section sets out our plan to start this process.

Live Well: Primary Care engagement

The NHS GM Population Health team in partnership with the GMCA have commissioned the GM Primary Care Board (PCB) to undertake a deeper engagement across all 4 professions of Primary Care to inform the design and strategy for Live Well implementation.

The engagement will ensure Primary Care is a key partner to co-design the model and shape the strategy for Live Well implementation.

The PCB will ensure the full involvement of the Primary Care sector and undertake a structured programme of engagement and co-design across General Practice, and wider Primary Care, to help inform the contribution of the sector into Live Well and develop strategies for successful implementation.

All of this will inform the design principles for the GM Live Well model and ensure that GPs and all of our Primary Care colleagues tangibly feel part of the Live Well ‘ecosystem’.

It will build on the good work that is already taking place in all the GM localities (as outlined in the appendix) and it is proposed that a series of detailed engagements will take place across the 4 Primary Care professions during April, May and June to ensure all are clear on the Live Well model and the role of Primary Care within this and to draw out specifically:

- What Live Well means for them, what is in place / working already
- What enabled that
- Barriers and risks

The work will be undertaken by Primary Care Board (Helen Ibbott) in partnership with Zoe Porter (Assistant Director, Person and Community Centred Approaches, NHS GM) and Dr Jaweeda Idoo (Clinical Lead, Person and Community Centred Approaches, NHS GM) with regular check-in points during the work.

It is also envisaged that the work will connect into and support design and delivery in other key GM Groups, such as Primary Care Blueprint Implementation Group, Population Health Committee and the development of Neighbourhood working in the City Region. It will play into emerging cross-system Live Well governance to ensure that the insights from the work are considered as the design and decision making around the implementation of Live Well iterate.

The output will be a clear report detailing the insights for the GM System to bear in mind as Live Well develops, along with other work streams in the system.

It is proposed that a report will be presented to the ICP in early Summer 2025.

Appendix – Examples of Live Well in Practice in Primary Care

Gorton Hub is an all-in-one space dedicated to learning, health, and community services. It has been designed to make life easier by bringing various support services together under one roof. The Hub includes a library and learning space, Gorton Medical Centre GP, NHS community health teams, Manchester Adult Education Service, Jobcentre Plus and One Manchester's housing office.

Healthy Hyde is a Tameside PCN (Primary Care Network) improving the health and wellbeing of the most deprived 10% of its local population through a front door to advice and support and early prevention. They support the homeless population, refugees, asylum seekers, food bank users, children struggling in schools, and parents with young children. They bring together the PCN with housing organisations, domestic violence organisations, voluntary and community groups, the local council, housing shelters and statutory services. Over time they have adapted their offer to fit their communities' needs. They currently offer English lessons, wellbeing checks and health drop-in sessions, pre and post-natal courses, mum and toddler groups, a memory café supporting carers and support with employment, housing and nutrition. They create easy access through advice sessions at local food banks.

All **Community Pharmacies** are accredited as **Healthy Living Pharmacies (HLP).** At least one member of the team undertakes training and assessment to complete the Royal Society for Public Health (RSPH) Level 2 Award in Understanding Health Improvement and is therefore a Health champion promoting healthy lifestyles through public health campaigns and localised health promotion events tailored to the needs of local communities. The HLP framework aims to achieve a consistent provision of health promotion interventions to meet local needs to improve the health and wellbeing of the local population and helping to reduce health inequalities providing a range of walk-in commissioned and non commissioned services such as Stop smoking, weight management, sexual health, vaccinations, lifestyle advice and the provision of drug and alcohol services. This is an opportunity to build offers to

support Live Well through Community Pharmacy to support patients already accessing our services in the heart of local communities.

The five PCNs in **Salford** have been collaborating locally through 'neighbourhood wrap arounds' where they meet with partners to focus on tackling inequalities and support each other. This has resulted in a range of initiatives, such as work with the Polish Community centre and the local Mosque to increase childhood immunisation uptake. Their events provide food, entertainment, warmth, vaccinations, and other screening and early detection information. They are seeing the partners involved in the wraparounds increasing, including Adult Social Care and NHS Trust community teams.

Health in Communities in Trafford involves VCFSE partners, Sale Central PCN, and Trafford Local Care Organisation and is led by Sale West and **Trafford** Community Collective. It provides inclusive person-centred support to those with the greatest health inequalities in a community setting and is home to a foodbank and Citizen's Advice. They provide health advice and signposting to housing, finance, debt, emergency food, training and employment support. Their partnership has extended into Active Practices, Smoking Cessation, Cancer Awareness, ONE Workforce and more.

Healthier Wigan sees services wrapped around schools and GPs. Primary Care additional roles are employed as part of the wider health improvement team, targeting those likely to experience health inequalities. This includes new community link workers and care co-ordinators. They have integrated Community Response Teams and Community Therapy, preventing hospital admission.

Oldham Family Practice are working to support their 4,500 patients with a focus on prevention and promoting a person-centred approach to care. They want to address the social factors, like poverty, that impact their patient's health outcomes. They have moved some of their general practice team into the community with their Action Together (VCFSE) colleagues. They have started introducing longer appointments with their healthcare assistants and community connectors called enhanced health

and lifestyle checks where they agree with the individual the options available to better manage their care. This provides patients with a happier lived experience, improves patient outcomes, reduces the demand on their practice, and helps them to provide a targeted approach to the cohorts that need it the most.

The **Optometry Easy Eye Care service** provides an enhanced sight testing service for people with learning disabilities or autism. This pathway uses supplementary to enable these patients to access this specialist offer from optometry practices, working in partnership with the charity SeeAbility. This service is commissioned across all 10 Greater Manchester places, and has supported more than 400 people in it's first five years of operation, a significant proportion of whom had never had an eye examination. The SeeAbility charity supporting the pathway are encouraging more providers to offer this service through their *Eyecare Champions* model featuring people with lived experience. As an example, Bury locality have seen a recent increase in providers signing up to deliver the service following focused work in partnership between the lead provider organisation and a local Eyecare Champion.

Following a successful pilot in November 2020, **Child Friendly Dental Practices** (CFDPs) are being rolled out across all areas in Greater Manchester. The CFDP network was created to reduce the number of children being referred into hospital dental services for specialist treatment, including those provided under general anaesthetic. CFDPs provide quick access to additional and complementary services in primary care from dental teams with enhanced skills to minimise the referral of children and young people (aged 0-18 years) with dental decay to specialist services. Where possible, patients are seen, treated, and discharged back to their regular dental practice. This approach also recognises the processes CFDPs have in place to improve oral health in children and young people, by improving attendance at dental appointments and supporting preventative care.

575 out of 623 community pharmacies across Greater Manchester offer blood pressure checks as part of the national **community pharmacy hypertension case-finding service**. This can help to educate people about the risks of high blood

pressure, improve hypertension diagnosis rates through referral to general practice and offer a more personalised approach to support where it is needed. Data about the service are published in the 'Strategic Health Asset Planning and Evaluation (SHAPE)' Atlas, which is used to target users of community pharmacies that are located within the top 20% most-deprived areas, to identify gaps in hypertension case finding or blood pressure optimisation. This is one way in which community pharmacy teams in England are already helping reduce health inequalities. Learning from the successful implementation and establishment of this service across Greater Manchester community pharmacies is also being used in the Greater Manchester's participation in a national pilot programme focusing on hypertension case finding at **optometry practices**, further showcasing the role of these disciplines in prevention of ill health.

More and more people are using the new **Pharmacy First** scheme for consultations of minor illness, urgent repeat medicine supply and blood pressure checks. The GM ICB has the highest number of "completed" Pharmacy First consultations among the 42 ICBs in England as per NHSE data with over 95% Pharmacies in GM providing the service.