

Greater Manchester Integrated Care Partnership: Big Conversation Survey Analysis

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1.0 Background

Greater Manchester's Integrated Care Partnership

Greater Manchester's Integrated Care Partnership is developing a 5-year strategic plan as part of the new arrangements across the country. Integrated care partnerships will bring organisations together to work better with the public to keep everyone healthier; plan and deliver health services more effectively; make sure everyone is treated equally and fairly; help the NHS become as efficient as possible itself and also help it contribute to the wider economy.

In Greater Manchester the new arrangements mark the latest stage in the city region's journey to more joined-up working, which has developed since our health and social care devolution deal in February 2015.

Members of the Partnership (which is an evolution of the longstanding Health and Social Care Partnership) come from all ten parts of GM, including all NHS organisations, councils, GM Combined Authority, organisations from across the voluntary, community, faith and social enterprise sectors and others all working together to help achieve our common vision.

5-Year Strategic Plan

Greater Manchester Health and Social Care Partnership's draft 5-year plan describes the agenda for improving the health and wellbeing of the citizens of Greater Manchester. The plan aims to reduce health inequalities, promote independent living, and develop person-centred, consistent, and joined-up care systems through community engagement and collaborative work.

The partnership wants to involve stakeholders, communities and people in shaping the 5-year plan to ensure it meets the needs of the population.

Key stakeholders came together to develop a proposed vision and shared commitments for the plan. Following which a survey was developed to elicit views on the proposed priorities, understand concerns and identify gaps.

2.0 Methodology

A survey was designed and developed based on the aims of the 5-year plan. To ensure that the sample was representative, demographic data was collected including age, sex, ethnicity, employment status, disability status, and religion.



The survey was distributed via existing networks and public social media posts. Non digital residents received survey information via the free weekly newspaper distributed across Greater Manchester. Accessible formats and support were available to enable respondents to complete the survey including BSL translation and over the phone telephone interviews.

The data was collected in Smart Survey and, upon close of survey, imported to Excel. Results were analysed using both descriptive and inferential statistics. Demographic data was compared to publicly available data via the Office of National Statistics (2011).

3.0 Results

3.1. Summary of findings

A summary of findings is contained below. More detailed findings are in section 3.2.

3.1.1. Demographics

1,334 people responded (including staff and citizens). The survey sample was somewhat representative of the population but under representative of sex (males) and age (younger and older people) and ethnicity.

3.1.2. Overall look/feel

There were many comments that suggested that the goals of the 5-year plan are not accessible to many groups of people, they are difficult to understand and do not give clear indicators of what will be done. Respondents want to see jargon-free language and plain English. There were concerns about the accessibility of the engagement with specific reference to the Deaf and Chinese community.

3.1.3. Shared Commitments

The statements which elicited the highest percentage of respondents either disagreeing or agreeing but with concerns were (in order from highest % to lowest):

- 'We will realise the opportunities from digital technology and our growth and innovation assets to enable health and care to adopt leading edge technologies and improve outcomes'. This appeared to be due to a lack of trust in technology and a concern that some services would not run effectively if face-to-face services were replaced. There was also a lot of concern about excluding those who do not readily access technology (26.4%



staff either disagreed or agreed but with concerns. 32.6% community members either disagreed or agreed but with concerns).

- ‘We will develop a paid and volunteer workforce fit for the future, with wellbeing at the core.’ There was concern that this meant replacing skilled paid workers or relying on family members to be responsible for the care and support of their loved ones (17.2% staff either disagreed or agreed but with concerns. 28.2% community members either disagreed or agreed but with concerns).
- ‘We will support and challenge each other to deliver our system priorities through allocation of resources.’ The main theme that emerged was the use of language. Respondents were not sure what this statement meant to them (14.9% staff either disagreed or agreed but with concerns. 20.4% community members either disagreed or agreed but with concerns).

The statements which elicited the highest number of respondents who agreed with them were (in order from highest % to lowest %) were:

- ‘We will reduce health inequalities experienced by people in Greater Manchester.’ While respondents were not asked their reasons for agreeing with the statement, they were asked if there was anything missing from the statements. Comments suggested that members of the community would like to see easier access to GP and primary healthcare services. There were suggestions that members of the public might be educated about those with additional needs and assisted to accommodate those needs (e.g., special education needs, autism friendly environments, etc.).
- ‘We will engage with people and communities to understand what they need to stay well, and act on this.’ It was apparent that members of the public were keen to be engaged in co-developing and working towards these actions in a collaborative manner. Some suggested that token engagement was not sufficient, but that there was a need to be involved in the co-development and co-design of new solutions.
- ‘We will enable people to access the right level of care where and when they need it.’ While this comment was largely agreed with it elicited comments suggesting that there was a need to define the right level of care. This will take a collaborative approach with members of the community to ensure that there is a shared understanding about what constitutes care. Comments were also suggestive of a need for clarity in the action statements.

Participants were asked if there were any gaps in relation to the shared commitments. Themes identified and strength of feeling were expressed in relation to;

Wider determinants of health (especially poverty and cost of living), primary care access (particularly GPs and dentists), mental health (with a focus on children and young people),

waiting lists, LD and autism, timely diagnostics and treatment, independent living, the potential impact on unpaid carers and the need for adequate care and support to achieve this. There were also concerns mentioned for specific localities.

3.1.4. Delivery

Responses highlighted a number of concerns/suggestions about delivery and evaluation of the strategy;

- Scepticism around ability to deliver in relation to health inequalities. Suggestions to set realistic goals and involve partners, government etc
- Unclear what some of the shared commitments mean. Need a shared understanding on definition of care for example.
- Concerns about adequate funding and resources to deliver
- The need to manage expectations of staff and public
- The need to ensure that communication is accessible to all
- Recognition that agenda is not just health and care responsibility. Some concerns that health and care should not be responsible for health inequalities
- More joined up working and integration needed across health and care
- Concerns about involvement of private sector
- Concerns about staff and public motivations
- The need to diversity the workforce, particularly leaders
- Concerns that tackling inequalities may mean discrimination for the majority
- Calls for more staff and community involvement
- Calls for more education and empowerment of public to take responsibility

3.2. Detailed analysis

3.2.1. Demographics

Against available population estimates, the survey sample was skewed towards female respondents, those aged 45-64, residents of Wigan or Trafford, those from White ethnic groups, and non-Christians. Chi square testing found differences between baseline estimates and survey samples to be statistically significant for sex and age distributions only.

3.2.2. Sex

Respondents were majority female (81%, N=993) compared to male (19%, N=238). Respondents who did not answer the question (N=40), preferred not to say (N=38) or self-described in another way (N=25) were in the minority.

		Total	Male	Female
Sample	N	1,231*	238	993
	%	100% ¹	19%	81%
Baseline	N	2,263,951	1,119,018	1,144,933
	%	100%	49%	51%
	% diff (S-B)		- 30%	30%

*excluding respondents who did not answer this question (N = 40), preferred not to say (N = 38) or self-described in another way (N = 25)

Table 1. Difference in frequencies by sex (N = 1,231)

Against baseline population estimates of distribution by sex in the Greater Manchester Metropolitan County (mid-2020, 16+), male respondents were under-represented in the sample, and the difference between estimate and survey sample was significant, $\chi^2(1) = 20.05$, $p < .001$.

3.2.3. Age

The majority of respondents were aged between 35-55-years (N=574). Younger (under 35-years) and older (over 65-years) populations were underrepresented in the sample:

		Total	16-24	25-34	35-44	45-54	55-64	65+
Sample	N	1,275*	22	171	260	314	309	199
	%	100%	2%	13%	20%	25%	24%	16%
Baseline	N	2,253,964	324,557	426,581	363,946	372,015	316,078	450,787
	%	100%	14%	19%	16%	17%	14%	20%
	% diff		- 13%	- 6%	4%	8%	10%	- 4%

*excluding respondents who did not answer this question (N = 59)

¹ % figures may not add up to 100% due to rounding.

Table 2. Difference in frequencies by Age group (N = 1,275)

Against baseline population estimates of distribution by age (2019, 16+), under-represented in the sample were respondents in the 16-24, 25-34 and 65+ age groups, and the difference between estimate and survey sample was significant, $\chi^2(5) = 15.17$, $p < .05$.

3.2.4. Area of residence

The majority of respondents lived in Wigan (N=165, 17%).

		Total	Bolton	Bury	Manchester	Oldham	Rochdale	Salford	Stockport	Tameside	Trafford	Wigan
Sample	N	984*	90	84	149	86	40	96	62	88	124	165
	%	100%	9%	9%	15%	9%	4%	10%	6%	9%	13%	17%
Baseline	N	2,263,951	226,233	152,011	443,210	184,361	175,100	209,515	236,811	181,136	186,884	268,690
	%	100%	10%	7%	20%	8%	8%	9%	10%	8%	8%	12%
	% diff		- 1%	2%	- 4%	1%	- 4%	1%	- 4%	1%	4%	5%

*excluding respondents who did not answer this question (N = 350)

Table 3. Difference in frequencies by area of residence (N = 984)

Against baseline population estimates of distribution by area (mid-2020, 16+), respondents living in Manchester, Rochdale and Stockport were under-represented in the sample, though the difference between estimate and survey sample was not significant, $\chi^2(9) = 5.57, p > .05$.

3.2.5. Ethnicity

The majority of respondents were White, including White Irish/European (89%, N=1128).

		Total	White	Mixed	Asian	Black	Other
Sample	N	1,264*	1,128**	25	70	14	27
	%	100%	89%	2%	6%	1%	2%
Baseline	N	2,253,964	1,891,178	47,735	228,094	63,503	23,454
	%	100%	84%	2%	10%	3%	1%
	% diff		5%	0%	-5%	-2%	1%

*excluding respondents who did not answer this question (N = 63) or preferred not to say (N = 7)

** including White Irish/European

Table 4. Difference in frequencies by broad ethnic group (N = 1,264)

Against baseline population estimates of distribution by ethnic group (2019, 16+), respondents from Asian or Black ethnic groups were under-represented in the sample. There were small frequencies (< 5) in multiple cells for chi square testing to be reliable in this case.

3.2.6. Religion

The majority of respondents were Christian (50.5%, N=601).

		Total	Christian	Non-Christian
Sample	N	1,191*	601	590
	%	100%	50.5%	49.5%
Baseline	N	2,782,363	1,481,325	1,301,038
	%	100%	53%	47%
	% diff		-3%	3%

*excluding respondents who did not answer this question (N = 53) or preferred not to say (N = 90)

Table 5. Difference in frequencies by Christian religion or belief (N = 1,191)

Against baseline population estimates of distribution by Christian religious affiliation (2018, all ages), Christians were under-represented in the sample, though the difference between estimate and survey sample was not significant, $\chi^2(1) = 0.13$, $p > .05$.

3.2.7. Staff and members of the public.

The majority of respondents were members of the public (N=1021) with N=349 responding as members of staff. Of those members of staff, there were N= 30 voluntary faith or community, N=49 local authority, N=228 NHS, N=25 social care, and N=10 Healthwatch.

3.3. Responses to Greater Manchester Health and Social Care Partnership's 5-year plan agenda statements.

Respondents were asked their agreement of the statements with options to select either 'I agree that this is the right thing to do', 'I do not agree that this is the right thing to do,' or 'I agree, but have some concerns.' Most people agreed with the action statements, but if they did not agree or agreed but with concerns, they were asked for a free-text response to explain their answer:

We will reduce health inequalities experienced by people in Greater Manchester



Of 349 **staff members**, 1 did not agree and 32 agreed but with concerns (**total 9.5%**)

Of 1020 **members of the community**, 13 did not agree and 131 agreed but with concerns (**total 16.1%**)

There were several themes identified in the free text responses:

- **There are many complex determinants to health inequalities:**

"I agree with your aims but your expectations are too optimistic. You must take into account that lots of people are disadvantaged by lack of education, lack of digital equipment and knowledge etc; Health inequality comes from a huge range of socio-economic factors, most of which are outside the scope of health services, and these inequalities will doubtless persist even if the health offer is excellent for everyone. Health services should focus on delivering health, not on reducing inequalities; Secondly peoples mental health is poor due to the cost of living which again is having a significant impact. The cost of living crisis needs to be addressed, so that health can improve."

- **Reducing health inequalities seems like an unattainable task:**

"I think there is already huge investment in addressing health inequalities. I'd really hope to understand the impact of the investment and whether it's making a significant difference. I appreciate the outcome being that 'looked after' people will stay well and invest in their own health putting less long term pressure on the NHS."

- **Respondents want to be told explicitly how health inequalities will be reduced:**

"We all want to reduce health inequalities but, how and who?; How exactly will this be done? Is this "more of the same"?"

- **There is concern that reducing health inequalities means discriminating against the majority:**

“Sadly, some parts of our community feel left out / excluded / alienated when they have the perception that other parts of the community get privileged treatment. Setting up services that exclude the majority is seen by some as discriminatory against the majority. Equality of all is good, positive discrimination creates division in society. It appears many decision makers do not recognise this fact.”

Summary:

Responses suggested that both staff members and members of the public were sceptical about the likelihood of health inequalities being reduced. Many responses suggest an awareness of the complex interaction of socio-economic, environmental and inter- and intra-personal factors that lead to health inequalities, and they stressed that there are many variables to consider. There is a risk that this lack of confidence in the ability to elicit change will lead to poor motivation in the workforces where it is needed. When asked what was missing from the statements, responses suggested that there was a need to explore and understand the determinants of such health inequalities (e.g., environmental, social, inter- and intra-personal factors).

We will enable people to live as well and independently as possible.



Of 349 **staff members**, 0 did not agree and 41 agreed but with concerns (**total 11.8%**)

Of 1020 **members of the community**, 10 did not agree and 172 agreed but with concerns (**total 17.8%**)

There were several themes identified in the free text responses:

- **Concerns that this means vulnerable people will be left to fend for themselves.**

“I'm concerned about people who may need more support, such as a bed in hospital/hospice. Yet, may find themselves back at home with only health professionals attending daily at certain times. I'm thinking of people who are quite poorly or end of life care. I am aware of this happening more and more.”

- **Staff concerns were often that members of the public would not take ownership of their own health and wellbeing:**

“People need to be willing to engage for the requested treatment and not just use the services for a means to access benefits or achieve compensation, too many people making multiple referrals for the same thing and don't engage, this wastes everyone's time.”

- **Members of the public were concerned that the care and wellbeing of their vulnerable population would be their responsibility rather than that of the NHS or healthcare systems:**

“Independence currently means exploiting family connections often inappropriately e.g. “we will not provide this care because you have a relative who could do x”. This is massively inappropriate and disconnected from the reality of the lives of many relatives.”

- **Further, members of the public felt that already stretched unpaid carers would be further burdened with their loved one's health care needs:**

“We will enable people to live as well and independently as possible - is this another way of rationing health and social care and/or shifting it onto unpaid carers?”

- **Enabling people to live as independently as possible takes planning and the right support and infrastructure in place:**

“People can't be pushed towards independence when they are not ready or able purely to reduce care costs or meet targets. Too often independence isn't pushed so heavily that people aren't given support they desperately need. Independence isn't a good thing if it comes at the cost of those individuals; Patients must be involved in the planning of both their own medical and social care. Independence is VERY important but this must be set against ensuring adequate support is provided. Assumptions and frameworks are all well and good but there must be options for personalisation and flexibility; Independence is very important but we need to make sure that the support is there and not just leave people struggling. Support needs to be in place to allow this to happen.”

Summary:

Responses suggested that, from healthcare professionals (staff) point of view, there were doubts that members of the public would actively engage with independent living. They felt that people would be reluctant to take responsibility. Members of the public's concerns centred on feelings of abandonment. They wanted to know what this would look like logistically and there were concerns that care would be reduced and issues with accessing healthcare would be worsened. Responses were often defensive, with people expressing feelings of frustration that they would be further responsible for an aging and vulnerable population without



support. When asked what was missing from the statement comments suggested that there needed to be a focus on people with mental health and learning disabilities. These potentially vulnerable groups experience health disparities to a greater degree than their peers and there is a need to understand the variables that contribute to this.

We will engage with people and communities to understand what they need to stay well, and act on this.

Of 349 **staff members**, 0 did not agree and 33 agreed but with concerns (**total 9.5%**)

Of 1020 **members of the community**, 9 did not agree and 146 agreed but with concerns (**total 15.2%**)

There were several themes identified in the free text responses:

- **Not all voices are being heard, particularly those people who do not engage with healthcare services often:**

"I believe that engaging with people and communities is the correct thing to do but my concerns are that is the same people and community groups that are repeatedly engaged as these are the ones actively accessing services already and so we don't get a true representation of many communities; Its important to get communities views but previous

engagement has shown the people who tend to engage represent a small subset of the population. Greater emphasis should be placed on reputable research on what actually works. Stop reinventing the wheel and rearranging the deck chairs on the titanic."

- **Concern amongst staff centred on the notion that the needs of the community are likely to exceed what is achievable:**

"Managing community expectations of what health and social care deliver is critical. Clearly defining what social care's role is in supporting people is key. We need the public to understand the very limited resources and legal duties which are working within."

- **Groups of people feel that they are excluded from this statement:**

"Why, as a sizable community of people in the China Towns, in London, and Manchester, is there a dearth of our presence/mention on your leaflets, booklets, advice materials etc? According to statistics, it has been stated that the total Chinese population, within the Chinese communities of London, and Manchester, total the number on Grant Avenue, San Francisco, yet on the popular materials we are excluded, and absent? Additionally, there are no articles that relate to us, or our health problems? Even LGBT matters have excluded us! As

tax payers, and responsible individuals, I feel ignored.”

“Problem with GP can’t access for Deaf People.”

- **The statement needs to be reframed to ensure that it is clear that the design of healthcare in the future is co-designed and co-produced with members of the community:**

“Coproduct not just engage; I don't like the phrase 'act on this', I think it assumes that it is a transactional and paternal relationship. I think it would be better phrased as 'coproduce solutions' or 'we will engage with people and communities to understand what matters most and coproduce solutions'.”

Summary:

Respondents were keen to see practical ways that the community would be engaged with and how this would translate practically. They were keen to see that healthcare was designed cooperatively with them. Conversely, staff members seemed to raise concerns about managing public expectations because of limited budgets and resources.

At the end of the block of three statements, people were asked if there was anything missing from the list, if there was anything that could help them to be achieved, and if there was anything that might prevent them from being achieved. The following common themes were identified:

- **EDUCATION** - education needs to start in schools to ensure that young people grow up knowing what it means to live a healthy and well life.
- **ENGAGEMENT**- particularly with hard-to-reach populations and those whose voices are not ordinarily heard.
- **LACK OF KNOWLEDGE**- people do not understand what they need to do to stay healthy and well.
- **LACK OF OPPORTUNITY**- there is not the infrastructure or the right environment for people to support themselves to stay well. It was also highlighted that more insight work is needed with potentially vulnerable groups (e.g., those experiencing mental illness and people with learning and developmental disabilities, elderly populations, and unpaid carers, etc.) to ensure that the determinants of health are better understood.
- **LACK OF FUNDING** - services being stretched was a common theme.
- **LACK OF MOTIVATION**- staff feel that the community are not motivated to take action. Additionally, staff are despondent and lack motivation because they are resigned to being under-resourced and under-funded.



We will enable people to access the right level of care where and when they need it.



Of 349 **staff members**, 1 did not agree and 36 agreed but with concerns (**total 10.6%**)

Of 1020 **members of the community**, 12 did not agree and 129 agreed but with concerns (**total 13.8%**)

There were several themes identified in the free text responses:

- **There is a need to see tangible action, not just promises. Certain services have already shown that they cannot cope with demand:**

“They are the right things to do but, no substance behind the statements!; I agree the right level of care at the right time is very important, however I’m concerned whether this is actually achievable. Mental health care particularly for children is very difficult to access due to long waits & a lack of knowledgeable GP’s which causes further issues for the individual. Surely to resolve this, in just this one area, will need significant investment?”

- **People want to understand how funding will be allocated to enable this:**

“I think people need to see how you will achieve this and how it will be funded; Again how you gna (sic.) do most of them..when these community's (sic.) can't afford to get to a hospital to get that right care..or when they get out..rules in place now are not being followed for people who leave hospital.”

- **The ‘right level of care’ needs to be defined:**

“It is very difficult to state what the 'right level of care is' - as that is open to different interpretations by the 10 GM adult social care authorities. The 'right level of care' may be information and advice/signposting, or it may be a complex, MDT assessment. We need to provide greater definitions about care standards (aligned to the care act of course) to reduce the variations in assessment practice and local policies; A patient's definition of 'need' is very different from that of the service, so I feel it will lead to disappointment and anger if this is what we promise people. Unfortunately, our services are too busy and underfunded to provide the immediate care that people rightly feel entitled to.”

Summary:

Responses suggested that community members felt that this was an empty promise based on their current experiences. They want to see practical steps being taken towards this goal, and they want to know how this will be funded. Further, staff felt that ‘right

level of care' needs to be clearly defined to ensure that people are in receipt of what they need at a level that can be maintained.

We will all play our part in achieving the best possible person centred experience and outcomes of care



Of 349 **staff members**, 0 did not agree and 40 agreed but with concerns (**total 11.5%**)

Of 1020 **members of the community**, 11 did not agree and 136 agreed but with concerns (**total 14.4%**)

There were several themes identified in the free text responses:

- **Defining person centred care is important:**

“In principle these sound great - but reconciling person-centered care with shared standards means a lot of complexity and is perhaps a contradiction in terms; It sounds great in theory but the practice of integration is flawed; I worry that a lot of places/people use the term 'Person Centred' but truly dont see what this looks like for an individual and how to put it into practice. Person centred comes in many different forms that puts the person at the centre of their care.”

- **Expectations need to be managed:**

“Sometimes person centred care can cause people to make unreasonable demands and complaints. Clear expectations for the care receiver can help with this; Not really sure what's meant by best person centred care - need to balance cost and benefits of individualisation vs standard offer - won't always be possible so we need to be honest to manage people's expectations.”

Summary:

There is some concern that care being person-centred contradicts shared standards, and it must be clear what this will look like in practical terms. Again, staff members expressed concerns that putting the individual at the cornerstone of care planning might lead to high expectations that cannot be met.

We will progress shared standards to reduce unwarranted variation in the provision of care



Of 349 **staff members**, 0 did not agree and 43 agreed but with concerns (**total 12.3%**)

Of 1020 **members of the community**, 3 did not agree and 129 agreed but with concerns (**total 12.9%**)

There was one main theme identified in the free text responses:

- **Shared standards need to be co-developed with members of the community and staff:**

“Shared standards are only good to strive for if they are genuinely developed in partnership with the population.”

At the end of the block of three statements, people were asked if there was anything missing from the list, if there was anything that could help them to be achieved, and if there was anything that might prevent them from being achieved. The following common themes were identified:

- **WAITING TIMES-** people are concerned that waiting times are not being addressed and people are not receiving support while they are on waiting lists.
- **DEFINITION OF CARE-** respondents felt that there was not a clear definition of care or consistent approaches to care. Certain services, such as mental health services, are more at risk than others.
- **ACCESSIBILITY OF SERVICES-** respondents suggested that often people do not know where to go for the care and support they need, including engaging in proactive behaviours that are protective of health (exercise, mental wellbeing, etc.)
- **DIFFCULTY UNDERSTANDING THESE AIMS-** There were many comments that suggested that the goals of the 5-year plan are not accessible to many groups of people, they are difficult to understand and do not give clear

indicators of what will be done.

Respondents want to see jargon-free language and plain English.

- **COMMUNITY INSIGHT-** many responses suggested that community insight needs to be gained in order to know what is best for the local community, but there are challenges with reaching certain populations who do not readily engage with health and social care services; these are often the groups most at risk of experiencing health disparities.

We will ensure that health and care organisations play their part in the wider economy and environment to positively impact on our communities now and in the future.



Of 349 **staff members**, 0 did not agree and 40 agreed but with concerns (**total 11.5%**)

Of 1020 **members of the community**, 33 did not agree and 145 agreed but with concerns (**total 17.4%**)

There was one main theme identified in the free text responses:

- **This is too ambitious and there is no place for health and social care in the environmental and economic domains:**

“Before start playing part in the wider economy and environment need to get the health care right; In relation to 'the wider economy and environment', whilst agreeing in principle, these must not distract them from their primary health and care objectives.”

We will realise the opportunities from digital technology and our growth and innovation assets to enable health and care to adopt leading edge technologies and improve outcomes.



Of 349 **staff members**, 1 did not agree and 91 agreed but with concerns (**total 26.4%**)

Of 1020 **members of the community**, 30 did not agree and 300 agreed but with concerns (**total 32.6%**)

There were three main themes identified in the free text responses:

- **There is a risk that this approach will exclude the digitally excluded and these groups are often already experiencing health disparities (e.g.,**

elderly, non-English speakers, those with cognitive impairments etc.):

“Digital technology has limitations for vulnerable people particularly cognitive impairment. Digital is cold and vulnerable people need friendship and involvement as well as care solutions. They need people they can connect with; Need to embrace digital opportunities while ensuring communities and individuals facing digital exclusion aren't negatively impacted. This needs to be accessible for all.”

- **Technology cannot, in many cases, replace face-to-face services:**

“Digital health assessments are limited. You cannot do a full assessment via facetime (sic.) etc. You need to feel rashes, listen to chests etc. There is huge scope for error and will inevitably lead to more emergency dept referrals. Slightly an increase in staff, you will not be able to achieve wider access in community.”

- **Technology has been unreliable in the past and there is lack of trust in its reliability now:**

“Reliance on technological "solutions" should proceed only after rigorous testing and investigation to ensure that nobody will be excluded by their implementation, that they offer genuine value for money and that they offer clear and demonstrable advantages over "analogue" alternatives (pen and paper, TALKING etc); I'm

concerned money will be wasted on new computer systems that don't work rather than clients."

Summary:

There was concern among many respondents that technology is unreliable, has the potential to lead to error and greater strain on the workforce, and is likely to exclude people who are unable to easily access services through technology.

At the end of the block of two statements, people were asked if there was anything missing from the list, if there was anything that could help them to be achieved, and if there was anything that might prevent them from being achieved. The following common themes were identified:

- **CLEAR OBJECTIVES-** there is a need for clear objectives and actions that the general public can understand. Respondents felt they needed, 'an explanation of what you're talking about,' suggesting that the goals are not clear.
- **UNWILLINGNESS TO CHANGE-** Respondents suggested that there was resistance to change in both dejected health and social care staff, and members of the public. Some descriptions included, 'entrenched and inflexible, fear of technology, people's reluctance, stubborn mindset,' etc.
- **RELIABILITY OF SERVICES-** this theme arose particularly in response to the statement relating to technology.

- **COMMUNICATION-** This theme arose in response to both statements and centred around making communication accessible for all.

We will build trust and collaboration between partners to ensure joined up delivery of services.



Of 349 **staff members**, 0 did not agree and 24 agreed but with concerns (**total 6.9%**)

Of 1020 **members of the community**, 4 did not agree and 93 agreed but with concerns (**total 9.5%**)

There were several themes identified in the free text responses:

- **There is doubt that this can be achieved as it has been a goal for several years and the system is fragmented, with many systems working in silo:**

"Been trying to work joined up for decades! How will this be different?; Great but the budget has been devolved since 2015, why hasn't joined up delivery of services already happened?; Joining a system that has been allowed to fragment

will take 30 years. Exiting contracts that are made with private companies will be costly and take massive investment if an overdue single system is achieved. Why not turn volunteer roles into paid roles?"

- **There is the risk that a 'joined-up' model of care means stretching already thin resources:**

"Joined up services do not always make the best model, it just means less staff seeing a wider client base."

- **Definition of joined up care and what this means, who it benefits, and how it is being funded needs to be made accessible to all. Currently, there is a lack of understanding amongst members of the public:**

"Again I don't understand some of these points. Whose well being at what core - the public?; These are all excellent aims but after experiencing the lack of "joined up" care between the NHS and social care at the moment I have no idea how you're going to fix it."

Summary:

Joined up care needs to be defined for the general populations so that they know what this will look like, particularly given that it has the potential to impact how they receive care or which services they need to go to for support in the future. Staff also need reassurance that joined up care does not mean that they will be further stretched.

We will develop a paid and volunteer workforce fit for the future, with wellbeing at the core.

Of 349 **staff members**, 4 did not agree and 56 agreed but with concerns (**total 17.2%**)
Of 1020 **members of the community**, 48 did not agree and 240 agreed but with concerns (**total 28.2%**)

There were two main themes identified in the free text responses:

- **There were concerns that mobilising a volunteer workforce means that there will be fewer skilled paid workers:**

"I have concern about an excessive volunteer workforce. Likely I will not be the only person to raise this. Health and Care has lots of vulnerable customers in it. It will be odd if other sectors have less volunteering than health and social care. Put more volunteers into lovely roles at the airport such as arrivals desks, shops, food and drink but people won't as that's about making a profit."

- **There were concerns that a volunteer workforce means more work for families of people who need care and support:**

"You say volunteer, do you mean family members taking on the care of a loved one because it's easier for the health and care services for them to do it?; volunteer

workforce? That honestly sounds like a pathetic excuse for we didn't fund adequately so needed a bunch of slaves to fill some gaps."

Summary:

This statement elicited responses that suggest people are wary of a volunteer workforce that might outnumber a skilled paid workforce, and they need reassuring that this does not mean cutting corners or cutting costs for services. People highlighted the role of unpaid carers in their responses, and it is worth noting that unpaid carers are already at high risk of negative outcomes due to stress and burnout. These are likely to be a population within the community who might make use of a volunteer workforce but also need reassurance that this will support them rather than add to their load.

We will support and challenge each other to deliver our system priorities through allocation of resources.

Of 349 **staff members**, 4 did not agree and 56 agreed but with concerns (**total 17.2%**). Of 1020 **members of the community**, 48 did not agree and 240 agreed but with concerns (**total 28.2%**)

There was one main theme identified in the free text responses:

- **Use of language. This theme has arisen consistently throughout the**

survey but was prevalent within this context. Respondents do not feel fully informed of what these goals mean and, in particular, what they mean to them:

"We will support and challenge each other to deliver our system priorities through allocation of resources - not entirely clear what this means. Shouldn't mean that money flows away from more preventative care towards reactive acute care but this is a risk; You're using woolly language rather than terms people understand. "Challenge each other?" "Wellbeing at the core?" I would hope wellbeing has always been at the core of the NHS. Use plain terminology and don't try to flannel people; I don't understand the bureaucrat word soup that is the third bullet here?"

Whose responsibility is it to make these things happen?

Respondents were asked to comment on who they felt was responsible for ensuring that the promise statements were put into action and how this can be best supported, by whom, and through what channels:

- The majority (N=1260) felt it the responsibility of health and care organisations to ensure 'A Greater Manchester fit for the future, where all our people have good lives, with better health and inequalities reduced in all aspects of life.'
- The majority (N=1268) felt it the responsibility of health and care organisations to ensure 'A Greater



Manchester where health and care works in partnership to support economic development sustainability and innovation.’

- The majority (N=1258) felt it the responsibility of health and care organisations to ensure ‘A Greater Manchester where health and care is an effective system fit for the future.’

Who else can help us achieve these aims?

- Central government
- Educational establishments through educating young people.
- All members of the public

What should we do to make these things happen?

- Communicate
- Listen to the needs of the community through patient and public involvement
- Educate the community on available services and how to access them
- Encourage individuals to take ownership of their own health and wellbeing
- Work collaboratively to ensure joined up care
- Diversify the workforce, particularly workforce leaders

Who do we need to engage to understand what helps them and what stops them from staying well?

- People who are already in receipt of care and service users.

- People experiencing health inequalities such as those from lower socioeconomic backgrounds.
- Groups with protected characteristics who are more likely to experience health disparities.
- A representative from all demographics.
- Hard-to-reach populations such as those who are digitally excluded and unpaid carers.
- The healthcare workforce.
- Local authorities and council members.
- Many respondents said “everyone.”

How can we engage them?

- Through patient and participant involvement such as focus groups and workshops.
- Involve people with complex needs to develop and design their own care pathways.
- Social media for young audiences and traditional media for older generations.
- Integrate within the community- drop in services and sessions where people can make their voices heard.
- Engage with advocates (e.g., for people with learning disabilities and neurodevelopmental disorders).
- Use public locations such as supermarkets and community centres to engage with people who are not already engaging with services.
- Patient surveys

Respondents were asked how they would prefer to be kept up to date with information about the integrated care package. The following responded (in order of preference):

- Official website (N=868, 63.5%)
- Facebook (N=431, 32.3%)
- TV (N=320, 23.9%)
- Printed materials (N=303, 22.6%)
- Twitter (N=289, 21.6%)
- Radio (N=216, 16.6%)
- Instagram (N=153, 11.4%)

4.0. Recommendations

1. There is strength of feeling and desire to continuously engage with citizens and staff and it is recommended that the results of this survey are shared more widely and stakeholders are engaged in deciding next steps. Other recommendations to consider;

2. The results of the survey suggest that further work is required to ensure that the objectives are clear and understandable to stakeholders (including staff) and communities. There is a lack of understanding and confidence in the ability to deliver on the commitments. Clear communication is needed to engage partners, staff and the public in the first instance; in order for them to get behind the messages.

3. There is strength of feeling that some priorities for stakeholders and the public are not defined in the commitments and may be

missing from the strategy e.g. mental health, access to GPs and waiting lists for treatment. The strategy should seek to address these issues and provide clarity as to how this will be achieved.

4. Respondents had concerns that some of the commitments may widen inequalities e.g. digital health and care access and enabling people to live independently. It is recommended that this is explored more deeply to understand current issues and solutions.

5. The responsibility for citizens to take care of their wellbeing and use services appropriately is a key theme throughout responses. It is recommended that partners explore opportunities for behaviour change.

6. There are specific themes in relation to some of the workstreams of the plan and for some localities e.g. mental health, health inequalities and primary care access. It is recommended that these be disaggregated and shared with the leads for each workstream and locality leaders.