Greater Manchester: Devolution, Health and Social Care

9 November 2016
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Section one

Introduction

This report provides details of the ‘Greater Manchester: Devolution, Health and Social Care’ conference hosted by the TUC on 9 November 2016.

The event was set up to bring trade unions and staff from the NHS and social care sector in Greater Manchester together with representatives of the GM Health and Social Care Partnership to:

- increase awareness of the impact of devolution proposals in Greater Manchester, with particular reference to health and social care
- build members’ appetite and capacity to engage with initiatives and consultations related to health and social care in Greater Manchester
- work with members to help identify a collective trade union agenda for health and social care in Greater Manchester that informs subsequent engagement with GMCA structures such as the Workforce Engagement Forum.

This report provides notes from each of the thematic workshops, including comments made in the group discussions and other useful information.

The event held at the Mechanics Institute was attended by over 120 staff from a wide range of health, social care and related organisations across Greater Manchester, as well as reps and officers from the British Dental Association, BOSTU, CSP, GMB, British Dietetic Association, RCN, RCM, SCP, SoR, Unite and UNISON.
Savings, services and silver bullets - is integration all it’s cracked up to be?

Section two

This is an excerpt from an article that Frances O’Grady, General Secretary of the TUC wrote for the University of Manchester #OnDevo blog in March 2016

A new architecture

With the Cities and Local Government Devolution Act receiving royal assent at the beginning of the year, we may be a very big step closer to a new kind of architecture for local government and public services in many parts of the country.

With devolution deals working their way through the Treasury pipeline and local political tensions yet to be fully resolved, we are facing a paradoxical situation where things seem to be moving very quickly and yet very slowly at the same time.

In Greater Manchester, of course, it is full steam ahead, with Mayoral elections set for May 2017 and the Combined Authority taking direct control over a health and social care budget of £6 billion in April.

Northern powerhouse rhetoric

For trade unions devolution poses a number of risks and challenges but some real opportunities too. So what does this mean for unions and how do we intend to respond? Greater Manchester is a good place to start.

But first let us consider the bigger picture. The new devolution proposals for the English regions are a priority issue for the TUC, indeed ‘making devolution work’ has become one of the five key themes of our campaign plan this year.

Our members know from bitter experience that the highly centralised political economy of the UK has left too many parts of the country behind. In fact, recent reports suggest that regional economic imbalances are growing.

The TUC has long been a champion for a more dynamic approach to regional development – enhancing democracy and accountability through bringing decision-making closer to communities, designing and delivering public services more responsive to local needs, harnessing the voice of public service workers and the people they serve and stimulating economic growth through local control over infrastructure and an active industrial strategy.
Yet the Osborne model being driven through the new Act poses real concerns. The ‘northern powerhouse’ rhetoric clashes with the reality of massive cuts to public services, reform to local government funding that may exacerbate regional inequalities, disproportionate public sector job losses and a government washing its hands of strategic industries like steel.

**Devolution deals**

The devolution deals agreed seem light on both resources and democracy, characterised by backroom deals between council leaders and Treasury officials with few stopping to ask what local people want out of it, while imposing directly-elected Mayors on communities that had previously rejected the model.

Few of the deals so far have used the new powers to restructure public services and authorities have displayed understandable caution given the financial constraints they face. But we can assume bolder approaches will be taken in future. Public service unions are wrestling with the implications for the workforce, employment standards and collective bargaining.

What will it mean for jobs? What will it mean for national agreements and will we see new attempts to push through regional pay? And how will we achieve closer integration of workers on very different sets of pay and conditions? Nowhere is this more pressing than in health and social care. Which brings us back to Greater Manchester.

Health and social care integration remains the most eye catching and problematic component of Manchester’s deal. Achieving a coherent and deliverable plan that brings together two very different public services across a complex and fragmented commissioning and provider landscape is an enormous challenge. Not to mention the ambitious aim of achieving financial sustainability with a £2bn funding gap to plug. Then there is the existential question about how to maintain the ‘National’ in a devolved NHS.

Much of this will remain unresolved. Some of it necessarily. The TUC welcomed safeguards in the legislation that protect national standards and regulation in health but this will complicate lines of accountability in a devolved setting. Likewise, we will be adamant in our defence of national collective bargaining. Health unions successfully saw off previous attempts to break away from Agenda for Change by the South West cartel and will be vigilant against moves towards regional pay that emerge from any devolution deals.

**Financial straight jacket**

There is much to admire in the GMCA Plan. Bringing services and providers closer together will help address some of the dysfunction and fragmentation across health and social care. Arguably, the plans represent a positive move away from the chaotic dislocation of the government’s 2012 reforms – with the 37 different participant organisations in Greater Manchester talking more of co-ordination and collaboration and less about competition.
Savings, services and silver bullets - is integration all it’s cracked up to be?

But all of this is over-shadowed by the financial straight jacket imposed by the Treasury and the government’s obsession with arbitrary budgetary surplus targets and their on-going failure to seriously address the funding crisis in the NHS and our social care system – both absent from the Chancellor’s budget statement in March.

The much vaunted up-front funding given to the NHS in the Spending Review is already looking meagre, much of it disappearing into bailing out astronomical provider deficits and increased employer NICs payments. Elsewhere the budget for public health has been slashed, just the kind of investment into preventative measures that are integral to the success of the Manchester plan. The 2 per cent precept allowed to councils to raise money for social care will raise barely a third of the £6bn funding gap identified by the Health Foundation.

The government may be dismayed to hear calls for more funding so soon after delivering what the Chancellor described as the “biggest ever commitment to the NHS since its creation”. But this is a crisis of their own making. After all, contrary to George Osborne’s claims of largesse, average yearly increases in NHS spending amount to around 0.9 per cent across this spending review period, compared to an historical average of 3.7 per cent. Government spending as a proportion of GDP is falling.

Plugging the gap

Manchester will have its work cut out plugging the gap in this fiscal climate. Many agree the long-term solution lies in funding increases linked to productivity gains delivered through new ways of working, focusing on prevention and integration. But we should caution against glib assumptions that greater integration and prevention, with increased care in primary and community settings, will inevitably lead to significant savings, even though it might be the right thing to do for patients.

Few people have faith in the NHS finding the £22bn savings targeted in the Five Year Forward View and research shows that, while patient care improves, there is no evidence to support assumptions that integration between health and social care leads to significant cashable savings or reduced hospital admissions.

So while integration remains an essential, albeit often elusive, aspiration for improved health and care services, it may prove to be far from the financial silver bullet that many in NHS England, the Treasury or indeed Greater Manchester are hoping it is.

Making devolution work – partnership with the workforce

With the potential for significant changes to service provision, it is crucial that the health and social care workforce has a voice in this process. Unions will play an integral role in helping this happen – harnessing the views of members from the frontline, bringing experience and expertise in managing change and helping to negotiate around terms, conditions, transfers and other issues arising from complex reconfigurations, the nuts and bolts that will be fundamental to making a success of these plans.
We have worked hard with the leaders in Greater Manchester to agree structures to build dialogue and partnership with unions across the public sector.

The Joint Protocol signed by the leaders of GMCA and the North West TUC establishes a Workforce Engagement Board bringing unions together with leaders to discuss and manage the changes arising from redesign and integration. In addition, in agreement with the NHS Social Partnership Forum in the North West, we have also establish a Workforce Engagement Forum covering the health and social care sectors specifically.

We are under no illusions that change will be easy but this approach may help build the kind of robust relationships that will help mitigate some of the worst impacts.

And it is incumbent on us trade unions to work with our members to ensure that we are picking up what is happening at the frontline, in workplaces and in the community to ensure that where we have a voice, we are using it to reflect the genuine needs and interests of the workforce based on their experience of the changes that are taking place.

The TUC in the North West will continue to work with unions representing the health and social care workforce to ensure that we have the capacity to be effective partners in this process.
Section three

GM Health and Social Care: Workforce Engagement Forum

What is the Workforce Engagement Forum (WEF)?

Meeting for the first time in April 2016, the Workforce Engagement Forum (WEF) is a joint Greater Manchester wide forum for employers and trade unions to discuss at City Region level matters arising from the planning and implementation of devolution in health and social care across Greater Manchester.

The WEF seeks to ensure that the principles of meaningful partnership operate effectively throughout Greater Manchester and will promote good practice in all areas of staff engagement, development and management.

The WEF meets four times a year and is serviced by joint secretaries from the employers and trade union side.

What does the WEF do?

The aim of the WEF is to allow all partners to:

- Provide constructive comments to all partner organisations on the planning and implementation of devolution matters at a formative stage and during development phases.
- Contribute trade union and employer perspectives to the development and implementation of policy and practice.
- Ensure there is early discussion at City Region level on emerging issues and maintain a dialogue on policy and priorities.
- Contribute ideas on the workforce implications of service change.
- Promote effective communications between partners and a collective approach to supporting and developing staff affected by service changes.
- Avoid simply replicating or reporting on the work of other bodies.

Locality engagement

In addition to the Greater Manchester WEF, it has been proposed that each Locality should consider having their own WEF which will reflect these partnership structures to consider issues relevant to each of the localities – dependent on appropriate representation from local health and social care providers, trade unions and local elected members.
WEF Membership

Membership of the WEF is open to representatives of health and local government employers and unions with 16 seats reserved for both sides. Other individuals may be co-opted on to the WEF with the agreement of members.

Representing health and local government unions are:

**Health**
- Amy Barringer, UNISON
- Karen O’Dowd, CSP
- Marie Lloyd, SoR
- Gary Owen, Unite
- Chris Burns, SCP
- Michelle England, BAOT
- Corrado Valle, MiP
- Estephanie Dunn, RCN
- Lesley Wood, RCM
- Ursula Ross, BMA

**Local government**
- Pat McDonagh, UNISON
- Andrea Egen, UNISON
Section four

Workshop One – Population health and prevention

This session was led by Rachel Newton and Karen O’Dowd of the Chartered Society of Physiotherapy

Purpose of this session

One of the reasons for devolving the NHS budget to Greater Manchester, is that resources can be organised in a way to better meet the specific needs of the local population.

It seeks to do this through what policy makers have called a ‘radical upgrade in population health and prevention’ and a public health revolution – action to prevent conditions from getting worse unnecessarily, or from developing in the first place, through supporting lifestyle changes and prevention services.

The purpose of this workshop is to look at the priorities in the GM plan for prevention, and identify what the 100,000 strong health and care workforce in Greater Manchester needs to do to make this happen – because it won’t happen otherwise. Staff engagement is imperative.

Prevention and public health

We all know we have an ageing population - in GM there is predicted to be a 29% increase in the proportion of people over 65 by 2032 and proportion of over 85s expected to double.

There is also a higher than average number of children and younger adults, with under 19’s accounting for 24% of the GM population.

The CSP like probably all the unions and professional bodies represented here today, strongly argue for more funding for health and social care. But this isn’t about more money to do things as we have always done – the need to change how our health and care system is organised to do a better job of meeting modern population needs is irrefutable.

For example, there are brilliant improvements in reducing deaths from strokes, but after people have left hospital rehabilitative support drops off – people are needlessly more disabled by having had a stroke than they need to be and they are more likely to develop other health problems.
Greater Manchester has a high prevalence of many long term conditions, compared to the rest of England – including cardiovascular and respiratory disease, which means GM people have a shorter life expectancy and can expect to experience poor health at a younger age than in other parts of the country.

Linked to this are the higher levels of deprivation in Greater Manchester than in other areas of England, linked to unemployment and numbers of poorly paid jobs and the impact that this has on health, both physical and mental.

Prevention activity can include:

- **Primary prevention** – action that prevents health conditions from developing in the first place, e.g. reducing obesity to reduce levels of diabetes, reducing poor housing conditions that cause respiratory problems.

- **Secondary prevention** – action that prevents conditions from deteriorating, e.g. following a heart attack, coronary rehab, monitoring and life style changes to prevent another one.

- Also activity to stop one condition from contributing to the development of another (co-morbidities) e.g. depression resulting in lack of physical activity, resulting in musculoskeletal problems.

The nature of this means looking at how people access support, at an early enough stage. It also involves supporting people to look after their own health, supporting better the army of unpaid carers that already exist and utilising all the resources in communities e.g. leisure services, community activity.

**GM strategy – objectives and priorities for prevention**

The Greater Manchester Combined Authority and the GM Health and Social Care Partnership produced a GM strategy – in this are a number of prevention targets, including:

- Reducing the number of people over 65 being admitted to hospital because of serious falls to the England average

- Reducing premature mortality from cardio-vascular disease, respiratory disease (e.g. COPD), cancer - with targets on reduction in deaths from these by 2021

- Reducing the number of low birth weight babies in GM to projected England rates so that 270 fewer very small babies (under 2500g) are being born by 2021

- Improving levels of school readiness to projected England rates so that in 2021 more children have a good level of development (cognitive, social, emotional)

- Increasing the number of parents in good work to England average to reduce children in GM living in poverty by 16,000 in 2021
Workforce voice

It’s been recognised by those leading the process of devolution of health and care in GM that they have been late in involving the workforce in working out how to use the devolved NHS and local authority budgets to address these issues.

This has now been partly addressed by the setting up last year of a Workforce Engagement Board, comprised of senior managers, political leaders and trade union representatives (Unison representing all the health unions), and wider Health and Social Care Engagement Forum, which feeds into this.

Most importantly we are there to represent the interests of the workforce – for example, agreeing a joint protocol on workforce matters that terms and conditions should not be detrimentally affected.

But it’s also important that the voice of the workforce is heard on how services can be improved – because this is the only way that they will be, and that the needs of the workforce are met so that they are able to do play its part in this, so they in turn can feedback to me at regional level for me to raise at the GM Partnership Forums if necessary.

Group discussion

Task:

Everyone to think of ideas for changes that would help prevent health conditions develop or get worse, based on experience – ideally on the priority areas in the plan, but other areas of health prevention if that works better for you.

Feedback:

• Screening for 50 year olds and over was piloted and successful in 2014 and should be followed up as a priority.

**Recommendation:** all women aged 50 and over and risk groups should have an assessment by GP annually. A suggestion is to produce evidence-base case study.

• Enable more direct access for deaf people.

**Recommendation:** to use technology and computer-based self-referral. Although here are problems with funding.

• More work could be done to prevent women smoking, with a specific focus on mothers.

**Recommendation:** some education around poor child development and non-judgemental engagement. Psychological therapy with women who smoke.

• Reducing admissions to hospitals from care homes and provide support in areas, such as dentistry, where complications can lead to other health issues.
**Recommendation:** multi-disciplinary teams and GPs to regularly visit care homes. Admissions should be seen as a last resort. In Oldham they are looking at model - but it needs financing.

- Further support for self-referral into physiotherapy.

**Recommendation:** enable patients to access advice at earliest opportunity. This will prevent long term conditions. The existing barriers are funding/technology and not the potential lack of fit with existing CCG plans.

**Recommendation:** use ideas already used in MSK physiotherapy teams. Gives people more responsibility for own health and reduces the burden. Train GP’s to be less gate keepers and more about taking ownership of health.

- Nursing students and AHP’s to be given the ‘tools’ to promote better health whilst studying. Currently, there are no best practice examples to show to students.

**Recommendation:** develop better educational resources for trainees and students, linked to best practice and library and other resources. Engage with qualified workforce on what tools/best service will change the health of the population.

- Community learning sessions (adult education) could be increased to reduce isolation and encourage community engagement.

**Recommendation:** link into university pilot studies done on introducing computers into residential homes/care homes. Health and social care staff being more aware of community programmes/support.

- Develop better and more accessible technology and on-line resources to help support self-management of conditions.

**Recommendation:** Develop apps with information, e.g. about osteoporosis. A useful app that people can access.
Section five

Workshop 2: Health and Social Care Integration - New Models of Care

This session was led by Janine Dyson of the Royal College of Nursing

Key points raised in discussion:

Challenges and opportunities

- There are significant issues arising from the integration of staff from local government and NHS on single sites and within integrated care organisations, these include:
  - Alignment of pay and other terms and conditions
  - Providing continuity of service for transferred staff
  - Access to relevant pension schemes
  - Job evaluation and banding
  - Status of new joiners
- These ‘industrial’ concerns are key enablers and should be addressed to provide the security that staff need in order to engage fully and productively in the process of change.
- The experience from the Salford vanguard suggests that addressing these issues through a collective agreement is a more effective and robust approach rather than relying on TUPE alone.
- The negative experience of public health workers transferred from NHS to local government has raised concerns about integration – emphasising the need to get the industrial nuts and bolts issues in place as an enabler for change. This negative experience is felt by Public Health staff who transferred in 2012 and is now starting to be felt by school nursing and health visiting in places following their recent transfer.
- Integration risks increased workloads through duplication of processes and reporting requirements on different KPIs, examples were given of two different processes for risk assessment as one example.
- Cultural barriers can persist long after structural integration is complete, examples from midwifery transfers between Salford and North Manchester suggest that silos and cultural barriers continue to persist five years later.

- It was strongly felt that staff engagement should begin at the outset with staff perspectives informing the design of new services – both in terms of achieving staff buy-in and motivation but also being more cost-efficient than dealing with problems retrospectively.

- Unions had a key role to play in supporting staff engagement, representing the views of workers involved in service change, bringing expertise and experience to discussions and sharing good practice from different settings.

- Structural engagement through the Workforce Engagement Forum (WEF) had a key role in supporting and promoting staff voice in the process. The benefits of which would be maximised through more effective harnessing of experiences and perspectives from members on the frontline and through a focus on professional/service issues as well as industrial and HR concerns.

- A major problem identified was the implementation of change without adequate resources, staff shortages and lack of training. The perception was that staff were being called on to fill gaps without consultation.

- While engagement with management was seen as problematic at times, relationships with commissioners were more so. There was a feeling that commissioning decisions were remote from the workforce and there was little explanation provided, particularly when effective services were decommissioned. This has left staff feeling that the most vulnerable in society who they cared for have been left even more vulnerable.

- There were also issues around how effectively commissioners were being held to account by councillors and through local health and wellbeing boards.

- There were also considerations that CCGs continue to put services out to tender which acts as a barrier to greater collaboration and integration in local areas.

- Commissioning decisions and service re-design as part of the devolution plans (and STPs in other parts of the country) were seen as primarily focussed on costs savings rather than service quality – decision makers needed to be more honest about the tensions that exist between quality and savings.

- More engagement between unions and the 10 x locality plans in Greater Manchester would be beneficial and it was noted that this was an aim of the WEF, albeit with challenges related to unions’ capacity to engage at that level.

**How can we promote better service integration and new models of care?**

- Staff should be included at the outset in the service design – this should be informed by a focus on core business and managing risk.
• There should be a clear roadmap to change, with implementation staged according to a transparent timeline agreed with unions.

• There needs to be more structural engagement at ‘locality’ level.

• Gathering more evidence of good and bad practice from the frontline will enable unions to effectively bring issues to the attention of management and commissioners through the WEF and other engagement structures.

• Unions could provide more events of this kind to share information and provide updates – there was a perception that union organising models based on workplace reps were struggling to engage with challenge of communicating complex, structural changes of this nature to members. This was particularly the case when unions are engaged in defensive battles on a range of issues resulting from funding cuts, staff shortages, pay and pensions issues etc. The TUC can play a role in supporting unions with this.

• There would be merit in more bite-sized briefings and capacity building for reps to deal with the “elevator moment” - how do you use 30 seconds to pitch key issues to a Chief Executive you meet in a lift?

Key issues for unions:

• Capacity – how do we enable members/reps to engage?

• Communication – how do we inform members/reps about what’s happening and the impact on their workplace?

• Engagement - the members are often aware of the changes at the frontline, how do we gather this intelligence.
Workshop 3: Acute and Specialist Care in Hospitals

This session was led by Mellanie Patterson of the GM Health and Social Care Partnership.

Acute and specialist care is one of the four key themes of the GM plan, the aim of which is to support quality, safety and efficiency by developing new models of care and achieving greater consistency through adopting standard ways of working.

The changes must be seen in their wider context, with localities delivering more joined up primary, community and social care and a greater focus on population health and prevention reducing hospital admissions.

Clinicians, providers and commissioners have developed 7 clinical priorities:

- Cardiology and respiratory
- Healthier together – acute medicine and A&E
- Healthier together – general surgery
- OG and urology cancer
- Breast services
- Paediatric services
- Maternity services

These seven priority areas cover two-thirds of spending and activity in Manchester hospital. Service transformation will be achieved through the consolidation and centralisation of some services – with clinical staff encouraged to work collaboratively and share best practice, e.g. through the provision of four providers of high risk general surgery and the creation of a single centre of excellence for OG surgery.

It was suggested that it is not always clear population health and prevention and GM’s mental health strategy interacts with the transformation of acute services.

More information would be welcome regarding the rationale for choosing the seven clinical priority areas.

Data suggested that Healthier Together had delivered some improved outcomes for patients but there were some concerns about the engagement of staff in the process.
It was recognised that implementation of these changes will be complex and occur at different speeds in different areas and across the different priorities. Workforce engagement and the involvement of unions was crucial so that staff understood their role in the transformation and what this meant in terms of locations, skills and development.

**Key points**

We need to think carefully about engagement and its purpose – GM needs to give unions the information to discuss and reassure union members about their jobs, as well as the rationale for clinical reconfiguration.

This is a great opportunity for unions to mobilise and get recruiting! Unions need to be up to speed, have the relevant information and voice and influence in this GM programme.
Workshop 4: Clinical Support and Corporate Functions

This session was led by Jeff Niel of the GM Health and Social Care Partnership.

The GM Plan is looking to build on the recommendations of the Carter Review, looking at how standardisation and shared practice can achieve efficiency savings, focusing on five key areas:

- Hospital Pharmacy
- Procurement
- Radiology
- Pathology
- Corporate Functions

Each of the five areas will constitute a separate project led by an individual trust Finance Director, with an initial focus on trusts.

Potential outcomes will be determined following data gathering and analysis, with clinicians and practitioners responsible for developing the strategy.

Some potential savings were identified, for example through ‘patients own drugs’ initiatives where patients are encouraged to self-medicate and bring their own stocks from home or through the aggregation of procurement across Greater Manchester, including the purchasing of items such as prosthetics, surgical gloves and other equipment. This may entail buying from a smaller range of suppliers and there may be issues to consider regarding reconciling purchasing efficiency with the interests of consultant choice on the use of certain items, e.g. prosthetics.

A strategy is also being developed on pathology and radiology, looking at a range of improvement themes, with a business case presented early next year.

Some concerns were raised in the discussion about the lack of wider staff engagement in the design of these strategies, with staff calling for more discussion at the outset in order to help formulate the proposal and achieve better buy-in from staff.

Corporate functions are being looked at with a view to achieving greater efficiency across all 37 providers and commissioners, although there was no plan for a single shared service across Greater Manchester. This would entail greater collaboration...
across organisations with an initial focus on finance, HR, IT and payroll. It was suggested in discussion that in-sourcing those functions that had been contracted out would support greater collaboration and efficiency.
Section eight

**Workshop 5: Supporting Staff with Improved Technology**

*This session was led by Naomi McVey, CSP and North West AHP Network.*

**Key points**

- Staff feel quite comfortable with using technology in work – until something goes wrong.
- Technology moves so quickly and can sometimes surpass us at work.
- There should be an appreciation of different accessibility needs, and technology should be diverse, e.g. an IT telephone helpline being the only source of support cannot help people with hearing impairments / hearing loss.
- There needs to be time and resource invested in staff to be more comfortable with using different types of technology so they can be resilient / continue working when problems arise.
- Staff need to be as ‘tech savvy’ as service users – if not this may limit the best care being delivered.
- There are ongoing issue of technology vs data protection: could organisations empower service users to take more responsibility over their data e.g. ‘opt-out’ options?

**Facilitator’s presentation**

Attendees were asked to rank themselves 1-10 on how confident they feel about using technology in work.

There was an agreement that everyone felt fairly comfortable – until something went wrong, then they would have to call a helpdesk.

The group noted the difference between using technology in work their personal time every day – we use apps with ease every day to manage our lives, so why is there less provision in the NHS?
Technology is used in a wide range of settings including:

- Operating Theatres
- Medical devices and rehabilitation equipment
- High intensive cancer care
- Personalised medicine
- Informatics, geomatics
- Staff learning and development (e.g. podcasts, CPD)

**Improvements in the rate and speed of take up for technology across health and social care**

- Used to understand patient / service user needs
- Increase and secure better safety of patients / service users
- Supports self-management (both staff and patients)
- Efficiency – quicker and cheaper in the long term for support to be delivered in this way

**Task:**
The session was run as an interactive workshop focusing on the following areas:
What do you love about technology? What do you hate? What are the challenges and opportunities?

See table below:

### LOVE
- Instant access
- Speed of communication
- Variety
- Exciting / progressive
- Video and email are good for people with hearing impairments / loss
- Always changing
- Future possibilities
- Life changing
- International
- Communicative

### HATE
- What to do if it goes wrong? Lack of help, or understanding
- Dependence
- Discrimination e.g. voice-only announcements at train stations
- Dependence on sound technology
- Always changing
- Too much choice
### CHALLENGES

- Security concerns
- Forced use
- Red tape
- Lack of technical support
- Equipment is quickly dated
- Sometimes not accessible e.g. doesn’t take into account sometimes low level of literacy rate in some deaf communities – assumption written English is fine rather than BSL interpreted
- Lose the nuance in communication

### OPPORTUNITIES

- Connect widely
- Learning / e-learning
- Integration and science
- Health monitoring
- Speed and efficiency
- Reaching more people across different geographical areas
- Breaking down discriminatory barriers e.g. iPads in pharmacies allows people with hearing impairments / loss to use online interpreter with staff

### What would help?

- More diverse range of IT service support i.e. not solely phone / hearing based
- Institutional support so all levels of management understand the needs to adapt to technological progress
- Knowledge of how to use the technology in the first place
- Time (investment in training as well as getting used to using it)
- Breaking it down so the concept of ‘technology’ isn’t scary / allowing people to ignore it – some people seem intimidated by integrating new technology into working practices
- This could be solved through training

### Group feedback

- Very few younger people use NHS choices website – usually using Google, but advice can be incorrect and so they get mixed messages.
- Older people are in fact less adverse to accessing information online – younger people aren’t necessarily looking at where the info is. Is this a website design or awareness issue? Or wider society?
- Sometimes an organisation’s policy on accessibility isn’t even accessible itself, let alone being implemented across all levels of an organisation.
- There is usually funding issues linked to this – e.g. if an online interpreter was used in a pharmacy, who pays for this? The pharmacy, or the NHS who may require it?
- But this is an easy piece of technology to implement and use, that has real benefits for orgs and patients.
- It fits into the ‘streamlining’ agenda on the GM plan – pharmacies and NHS will need to arrange who pays for the service at the beginning.

- Real problem of getting comprehensive coverage of good training – or good technology – without funding and time resources.

**How best can staff articulate their needs to their organisation?**

- Data security: clinicians in particular can be very protective of patient data (for good reason) – could orgs be broader on patient consent?

- We save honest conversations with patients about how sharing their data could improve their care and support offer – precise on who and what, but also precise about how it meets their needs.

- Remaining question of who owns the data—organisation, or patient?

**Closing comments**

Request for information on the mechanism of how this information is fed back to the relevant people who are developing the Plan.

What will this look like? How will it get to them? Will attendees get feedback on this process, and get to input again in the future? What is our baseline?
Section nine

Further information

For more information about the plans for devolution in Greater Manchester and health and social care integration, the following links might prove useful:

A full set of presentations given at the TUC’s ‘Greater Manchester: Devolution, Health and Social Care’ conference can be found at: www.tuc.org.uk/xxxx

The Protocol for Joint Working and Workforce Matters signed by the North West TUC and Greater Manchester Combined Authority sets out the relationship that has been developed between unions and the leadership in Greater Manchester here: https://www.tuc.org.uk/industrial-issues/public-sector/protocol-signed-between-trade-unions-and-greater-manchester-devo

The Greater Manchester Health and Social Care Partnership website has a host of useful resources: www.gmhsc.org.uk

The strategy for health and social care transformation are set out in ‘Taking Charge of Health and Social Care in Greater Manchester – The Plan’ which can be downloaded from here: http://www.gmhsc.org.uk/assets/GM-Strategic-Plan-Final.pdf

The all-important delivery and implementation plans can be found here: http://www.gmhsc.org.uk/assets/GM-STP-3-Implementation-Delivery-Narrative-FINAL-251116.pdf


The University of Manchester has produced a useful series of blogs and articles which have been put together in the following OnDevo briefing paper, it includes a number of articles specifically on health and social care: http://documents.manchester.ac.uk/display.aspx?DocID=24416