



Key Facts about the future of the NHS in Manchester



Event Report

Wednesday 11th July 2012

GMCVO St Thomas Centre, Ardwick Green, Manchester



Clinical Commissioning Groups (CCGs) and Wards in Manchester



Map based on OS mapping with the permission of the controller of HMSO. Crown copyright. Unauthorised reproduction infringes Crown Copyright and may lead to prosecution or civil proceedings. Licence number 100019568.

Manchester Health Intelligence Team (August 2011)

Event Aim

In co-production with [Macc](#) and [Manchester Local Involvement Network](#), the event was an opportunity for people to:

- Find out more information about the three [Manchester Clinical Commissioning Groups](#) and their visions and plans
- Find out how as individuals or community groups/organisations they can engage with the Clinical Commissioning Groups and their Patient and Public Advisory Groups
- Find out more about the Voluntary and Community Sector services in Manchester, how they are ready for the challenge of clinical commissioning and development work taking place
- Find out how [Manchester City Council](#) is developing HealthWatch Manchester
- Find out how they can respond to the [HealthWatch Manchester consultation](#) and get involved



The event enabled the three [Manchester Clinical Commissioning Groups](#) to engage with a range of voluntary and community sector groups and individuals.

Event Structure

Evelyn Asante-Mensah, current Chair of [NHS Manchester](#) and a non-executive Director on the board of [NHS Greater Manchester](#) chaired the event.

Presentations were given by:

- Dr Bill Tamkin Chair South Manchester Clinical Commissioning Group
- Dr Mike Eeckelaers Chair Central Manchester Clinical Commissioning Group
- Dr Martin Whiting Chair North Manchester Clinical Commissioning Group
- John Butler Development Worker, Macc (Manchester Alliance for Community Care)
- Nathan Atkinson Head of Supplier Management, Manchester City Council

A question and answer session took place following the presentations.

Event Co-Production

By working with [Macc](#) and the [Manchester Local Involvement Network](#), event details were widely distributed across Manchester to stakeholders through a range of networks and methods.

Attendees were also given the option to send in a question before the event.

Event Attendees

The event flyer was distributed widely across Manchester and members of the newly formed Manchester Clinical Commissioning Groups Patient and Public Advisory Groups were also invited.

There are three Patient and Public Advisory Groups, Central, North and South Manchester. The groups are made up of 12 local people and their role is to provide a patient and public view on proposals going before the three Clinical Commissioning Group boards.

On the day over 75 people attended and included representatives from the following organisations:

Manchester Local Involvement Network	Manchester Race & Health Forum	GMB Coalition of People Living with HIV
Macmillan Cancer Information Centre	African and Caribbean Mental Health Services	Manchester Disabled People's Access Group
Black Health Agency	Rethink Mental Illness	Macc
42 nd Street	Manchester Carers Forum	Migrants Supporting Migrants
Socialist Health Association	NEPHRA Residents Association	The Stroke Association
Lesbian and Gay Foundation	George House Trust	Royal National Institute for Blind
Chorlton Good Neighbours	The Mustard Tree	Riverside ECHG
TB Alert	Talbot House	Manchester Equalities Hub
Expert Patients Programme CIC	British Heart Foundation	Common Purpose
African Caribbean Care Group	Wai Yin Chinese Women Society	Making Space
Alzheimer's Society	The Federation	National Family Carer Network
Crossroads Care CEMT	ZEST	Just Psychology CIC
Tree Tops Counselling Service	AWARM	LMCP Care Link
Manchester Care & Repair	Big Life Centres	British Red Cross
Remploy	Indian Senior Citizens	Richmond Fellowship
C-I-C Volunteering	Action for Blind People	Manchester City Council

Event Presentations

Each of the Clinical Commissioning Chairs explained why they were involved in this new way forward for the NHS and the impact their group would have for local people in Manchester.

Facts and figures were shared about each of the Clinical Commissioning Groups (CCG):

- Central Manchester CCG
 - 40 GP practices
 - £265m budget
 - 211,000 people
 - 56% under 30
 - >30% from BME communities
- North Manchester CCG
 - Population 186000
 - 36 GP practices
 - 3 'patches'
 - 12% over 65
 - Diverse population
- South Manchester CCG
 - 166,000 +registered patients
 - Refer to 2 Foundation Trust's University Hospitals
 - 25 GP practices
 - Budget approximately £250m

The Challenge

- What does it mean to be a good doctor & clinician in this new world?
- How do we improve the care all our patients receive?
- How do we do the most good with the resources we have?

CCGs and VCS bodies

- Two relationships
 - Provider of services
 - Advocate for communities
- A lot to learn from the sector
- Ideas
 - Ongoing dialogue
 - Work with the voluntary sector through MACC
 - CCGs will provide a single point of contact for MACC
 - Helping to promote healthy living
 - Mapping VCS organisations by CCG/localities

John Butler, Macc presented the key facts and information about the Voluntary and Community Sector services in Manchester and what they can offer the new health and social care structures moving forward.

Rough profile of the VCS in Manchester

- 3000 highly diverse organisations:
 - Large organisations with turnover of £1m+
 - Small community groups with a turnover of less than £1K
 - Contracts with NHS & Social Care
 - Grants from public sector & grant trusts
 - Donations
- Total budget over £300million
- 93% of budget within medium / large organisations
- 35,000 volunteers
- Over 8,000 FTE paid staff (around 2% of local workforce)
- A third of voluntary sector organisations have less than 10 staff
- A quarter have no paid staff

Nathan Atkinson, Manchester City Council presented key facts and information on the development of HealthWatch Manchester.

What is HealthWatch?



HealthWatch is to be the new independent consumer voice for the public across health and social care issues.

Is it completely new? No, it builds on previous work, led by the government, aiming to give the public a voice in making services accountable and in developing local services which are right for the area

- PALS – Public Advisory Liaison Service (which dealt with Health issues, complaints)
- LINK – Local Involvement Network (which bridged Health and Social Care Issues), a virtual network of interested bodies, groups and individuals supported by a commissioned organisation, independent of either health or social care

Event Social Media #McrCCGs

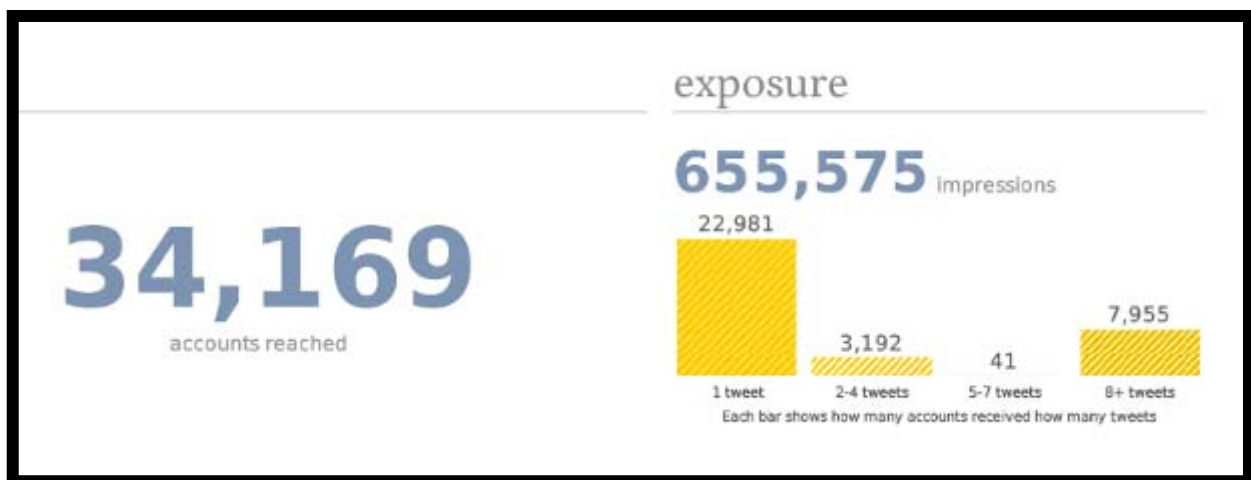
There was live tweeting from the event with the opportunity for people on Twitter to ask questions.

These were either answered during the sessions or responded to after the event if the information was not available or needed a longer response than 140 characters.

Using a software package called [Tweetreach](#) which measures the impact of a hashtag used for an event/project, we looked at the 123 tweets we sent out during the event. The specific hashtag used was #McrCCGs.

The front page of the [Tweetreach](#) website explains in more detail about the software and the information it measures.

The Tweetreach report indicated that our tweets had reached **34,169** twitter accounts and they had been exposed to **655,575** impressions.



Throughout the event 23 contributors had re-tweeted our tweets or joined us in a conversation online.

Some of the feedback received online included:

CCG chair using a powerful + moving real person's story to make case for better integration + collaboration #McrCCGs

[MancBMENetwork](#): #McrCCGs Surely we must concentrate limited resources on the most deprived communities... Integrated services but these must be targeted

[Marie21M](#): Asking GPs not just to advocate for the person in front of them but for the whole community #McrCCGs

Event Video

Recognising that not everyone would be able to attend the event, the Communications and Engagement team from NHS Manchester on behalf of the Clinical Commissioning Groups recorded it all on video.

The video will be uploaded along with this report and presentations to the [Talking Health website](#).

Event Question and Answer Panel Session

This part of the report has been taken from the recorded video film of the event.



Question:

How will you ensure that the providing roles and the commissioning roles of GPs across the city do not lead to conflicts of interest? (Manchester Local Involvement Network)

Answer:

Dr Martin Whiting

Well, I'll make a start on that and others may want to chip in. I mean there are a few basic principles; first of all as I said Clinical Commissioning Groups are not responsible for commissioning general practice so we are not responsible for paying the general practice's bills. We are not responsible for deciding whether a practice can carry on working or whether the practice should merge, or whether a new practice must be created. So in that way we are distinct in terms of our roles as GPs from commissioners. However there are always conflict of interests and I personally provide a very small eye clinic service in North Manchester, that's a sort of halfway house between primary care and hospital services – clearly a conflict of interest because we are paying the bill for my service.

So there has to be an external view on this, and the Clinical Commissioning Group because they are responsible for tax payer's money, will have a structure similar in a way to the Primary Care Trust, we will have an audit committee. We have two lay chairs on the board of every Clinical Commissioning Group, one of who is charged with dealing with these conflicts of interest, so for example in the case of my board, my Chair who is a lay member, would exclude me from any discussions about the service I provide, which is right and proper. There is central government guidance about the appropriate use of office and you can be found in breach of that especially if you are the Accountable Officer.

So there is safe guarding in terms of the Chair, senior lay member of the Clinical Commissioning Group, there is also an audit committee structure and a remuneration committee structure and that will deal with conflict of interest as well. Now that can't be entirely convincing structure but it is fairly tried and tested structure. We also have our duties as a doctor and duties to the General Medical Council. So if you were party to significant problems with conflict of interest and that borders on fraud, then you are standing in risk of losing your registration as a doctor and hence your career, so it can be quite serious if we are found in breach of that particular clause in our contract. Is that a sufficient answer?

Dr Mike Eckelaers

I think this week we had contact from the National Commissioning Board, who are the governing body of all the Clinical Commissioning Groups, and really made it very clear this is a central issue, its not just one for Manchester and it's at the heart of the matter as GPs are as you say in the driving seat, but I believe the Government's arrangements are in there, remember our meetings are held in public now, the information is out there in the public domain and especially the decisions we make at those public meetings. As Martin just said on the issues where we may be contracting with our practices or suggesting that way forward, the chairing of those discussions will be with the lay chair/member. A lot of those things are in place but it's something a lot of people will be watching very carefully so we don't step out of line.

Evelyn Asante-Mensah

Just to add to that, each Clinical Commissioning Group will have two lay people; one of who will be responsible for governance and so there will be external perspectives from the lay people on the CCGs as well. But I think conflict of interest has been something of a challenge for us for a long time and it's

about being open and accountable. And the public having access to attend board meetings and read the minutes and decisions being made – thank you.

Question:

Many Voluntary Sector providers in Manchester have a crucial role to play in addressing health and social care needs and delivering health related outcomes. Many of them are concerned to ensure that the value of the services they provide are recognised in future commissioning arrangements, given that this is a new role for GPs. How can we work together to develop practical communication routes for you to engage with a diverse range of providers? (Voluntary Sector Forum)



Answer:

Dr Bill Tamkin

Thank you. I think a few things as I think about the long question - it covers quite a lot really. Firstly I would like to understand what is actually out there and how you can help us. Secondly the route into us in south Manchester is through our Patient and Public Advisory Group, so we have a vocal group linked to our board and who are very keen to tell what is going on. I think around getting some messages out around pathway redesign, around good self-care would be very useful. For me I'd like to hear about your "Hilda's", when you tell Hilda's story so can see the problems in the system and if you have Hilda's I could understand better where you are coming from, that would be very useful.

Dr Martin Whiting

Can I just add to that a bit of challenge to the voluntary sector, there are as we heard maybe a thousand different organisations and NHS Manchester contracts with about 400 of them. That is a very complicated system and not something that CCG's who are a lot leaner than previous Primary Care Trusts and maybe a third of the number of staff were going to have access to than PCT's did and we can't contract with 400 organisations. I want to be able to contract with a system that provides a homogenous service across a third of the city of Manchester.

Now my challenge to you is to organise yourselves such that so we can have access to the right people and that you can begin to provide an homogenous service, I don't say it has to be from one organisation, it can be from a variety of organisations working together but you need to work together so that you are potentially good providers for us. I don't want to change the structure of what you are, as I think that's vital you remain distinct and individual in your way, but you do need to present yourselves as able to be contractible, so that's a challenge to you.

We are quite happy to discuss that in North Manchester, each CCG has its own public engagement and sort of point man for this, in North Manchester its Jules but the others have got their own point men so if you make contact with them and we can discuss the best way to organise ourselves.

John Butler

Just to say in terms of what's out there and what the sector are doing, there is a "state of the sector", survey going on at the moment which will provide a more detailed and up to date picture of the range of voluntary and Community sector organisations and what services are being delivered. There has been some learning from previous attempts, with varying degrees of success, to establish VCS consortia for the purposes of contracting; I understand that GMCVO are currently supporting the development of a health and wellbeing consortium. Perhaps one of the better examples is the BIG Manchester partnership facilitated by Macc and led by Manchester Mind where the lottery have made it a requirement for funding that there is an integrated approach with a lead provider. With the Big lottery fund fulfilling



lives programme this has been extended to include statutory partners. In terms of the sectors other role as a source of intelligence about needs and as an advocate for communities we already have mechanisms such as the VSMHF and the VCS assembly.

Evelyn Asante-Mensah

I think it's really important to say in terms of voluntary and community sector that this has been a challenge for us for many, many years and I think as we go forward particularly in a time when finances are incredibly lean, as Martin says it becomes more difficult, particularly around government to contract with so many different organisations. I think if we are going to meet the needs of the diverse population its about finding a way within the sector that actually there are lead organisational arrangements that then maybe subcontract with smaller ones who have one worker or no workers and therefore there is an opportunity I think to support smaller organisations who don't necessarily want to contract but who could do with having the support for to enable them to continue providing their service in an effective way.

Question:

Tackling inequalities is a theme that runs throughout the Health and Social Care Act. Within Black and other Minority groups there is evidence of the prevalence of particular conditions e.g. diabetes, particular cancers, strokes. How will the CCGs and the Public Health team work together to tackle these disparities? (Black Health Agency)

Answer:

Dr Mike Eckelaers

I will start with this, but I have to apologise as I have to leave shortly to go to a meeting about public health transformation. People don't realize that is has gone from within the Primary Care Trust to the Local Authority and there is piece of work going on to ensure this done effectively. Yesterday I met with the Public Health Specialist that support the CCG and one of the things we were talking about, was really just like your question, was how are we going to make a difference because as I described earlier Central Manchester is very diverse and we have pockets of challenging areas, so for example in Longsight and Levenshulme we've got a large Asian population, we have a lot of diabetes and all the conditions that go with that and we have been thinking about this recently and one of the questions I asked of the Public Health people did they see a role in supporting us down to the local community level and in actually tackling issues particular to that patch. I described earlier we have broken down our area into four localities and so we have GPs from each practices represented at those meetings and what we have agreed is that Public Health Specialist will help supply the data so that the localities and GPs can understand the problems but also help us to develop the strategies and with a phrase we have used in the past, is to move some of the resources upstream to prevent some of those problems coming about. I think the Public Health Specialists have a key role in this and also in the very nature of their work probably connect with some of the voluntary sector that can actually do some of this work. But I actually think Public Health is key and our job is to connect them with those communities and more importantly with the GPs in the practices there so they can start to own some of the solutions.

Dr Martin Whiting

I would just add that my general attitude to inequalities is that it is not just black and ethnic minorities that suffer inequalities in Manchester, the whole population has a degree of inequality in terms of its healthiness and longevity and risk of disease compared to the slightly leafy suburbs of Manchester let alone the rest of the country. I think first of all GPs who have day to day contact with their patients and



we all have slightly different ethnic and minority make up of in our practice populations, I think we are a significant advocate for particular and disadvantaged groups. But I also think therefore we are going to be more likely to commission more accessible services. I also think its down to our information systems as well and I think it comes back to the Hilda's of this world to tell the stories of difficulties in accessing the services we might provide, for not only black and ethnic minorities but also the disabled and other particular groups. Patient stories are the most powerful tool to change systems and the general desire to improve the lot of the whole of Manchester residents.



Dr Bill Tamkin

Just wanted to add to that, I am quite optimistic that we can do this. I had little contact with public health until the CCGs got going to be honest, we now have a public health specialist on our board, we meet with the health and well-being board, so we are asking GPs not just to be the advocate for the person in front of them but also for the wider community. And picking up on Martin's point we are now getting practices in small patches/demographic areas to comparing their data, comparing their performance with their peers they are working with, and there is nothing like benchmarked data to make people think they should be improving.

Question:

What is the process and how do we get access to the budgets which you have to spend on local populations to raise awareness and develop referral pathways? (TB Alert)

Answer:

Dr Mike Eckelaers

I will make a start on that, being in Central Manchester this is obviously a big worry for us, we know that TB is very pertinent and I suppose it links back to the previous question the public health people will certainly make us aware not only of the data in terms of what is happening at the moment but are also as part of their role they have will also have comparative data about how well we are or how well we are not doing.

I have made a couple of references earlier to the relevance of breaking down our responsibilities into localities and one of the things we did with our localities this year was to give them a sum of money to invest as they seem to fit, according to what they felt was their greatest need, and interestingly enough the Hulme and Moss Side locality identified TB as one of their key areas. This is an example of how the changes in the structures are allowing us to focus in on what really is important. The general question I think public health will be telling all three of us is what are the areas of need, but at the heart of all our questions is money, competing priorities but as I say we have managed to address this in central by devolving some of the spend.



Dr Bill Tamkin

From an education point of view, what we are doing is linking our pathway redesign with education, so working with University Hospital of South Manchester around designing education for our GPs and healthcare workers around pathways and understanding we should treat people better, so we are trying to improve that.

Dr Martin Whiting

It's difficult dealing with single diseases because sadly we have to take a holistic view of commissioning as a whole but the case in Birmingham and other near misses have been solitary reminders that TB is not a forgotten disease. I did not see much of it in the first ten years of my career but I have seen a lot in the last ten years and certainly in the last five years, and I think we just need to chip away and work with our public health colleagues in terms of looking at diseases across Manchester, certainly on the agenda and a rising concern.

Question:

Do the panel envisage a greater oversight and knowledge of community care of vulnerable adults and disabled people? (The Stroke Association)

Answer:

Dr Martin Whiting

Let's hope so, because after all we are community workers too, all three of us and our GP colleagues on our boards all have the day job, about fifty per cent of my time is spent with patient contact and my board members more than fifty per cent and when you get them together, they will know about antidotes and about the Hilda's of this world. This means we are solidly grounded in what is happening in reality in our communities and GPs are heavily involved in trying to advocate for patients as well. So if this reform does not deliver more awareness of community based problems then I struggle to see the purpose, I guess we have to prove we are up to the task.

Dr Bill Tamkin

The short answer is "yes" – one of our big challenges financially is the patients who are constantly in and out of hospital all the time so you are always doing crisis management rather than anticipatory care. So my slide about Hilda and Mike's about Jack means we can co-ordinate those people in a preventative way to stop crisis happening, so they can remain in the community.

Dr Mike Eckelaers

I support that and the purpose of those integrated teams, I did talk about the most vulnerable patients but I think as we heard earlier HealthWatch have a role here as we do need to know where things go wrong, where the gaps are because there will be problems ahead as well and there has to be a way of feeding that into the system so we can wake up to those needs as well.

Nathan Atkinson

One of the key roles of HealthWatch will be to signpost members of the community and to feedback on communications. Its always a challenge for us in the local authority and I think across our health partners, to get out the right level of communications, so everyone in the community knows exactly what is available and where and how to access it. I see the HealthWatch playing a key role in challenging us and supporting us in developing and improving our communications.



Question:

Do the Commissioners have plans to undertake co-production when commissioning services for people with severe mental illness? How will commissioners ensure that people with severe mental illness and their families are consulted meaningfully about changes to their services?

In 2010 Rethink conducted a poll of 251 GPs. Only 30% of those GPs said they felt confident in commissioning mental health services. How are the Manchester commissioners planning to address the lack of expertise in mental health?

Mental illness costs the country £33.75 billion a year. Inadequate mental health services mean greater costs for the benefited system, A & E Departments, police and the courts. How are local commissioners

planning to ensure they count the long term costs of cutting mental health services, as well as the short term savings? (Rethink)

Answer:

Dr Martin Whiting

What we do in Manchester is jointly delegate responsibility for commissioning to our joint commissioning board, which I chair, so I have had to come up to speed in mental health commissioning. Some of us have expertise, some of us work have worked in secondary care, we also have some other GPs from across Manchester who have specific expertise who can advise us and we are not shy in bringing people in from outside. That said I think although Manchester spends what appears to be the about the right amount of money on mental health compared to other city populations I still think there is a lot of work to be done to improve mental health services in Manchester.



If you ask GPs what is the most difficult part of your job they will say getting access to the mental health services when a patient is particularly ill and getting bounced around the system. I know there is a big job of work to be done, there are some major changes coming for the Mental Health Trust in Manchester as its going its foundation trust status and it will have to step up to the mark in terms of improving its services.

We are going to retain for Manchester CCGs the team that commission mental health services but we are beginning to be far more directive with the Mental Health Trust about the services they supply. They only supply about £90 million of the £150 million of our total spend so there is a big job of work to be done. I am feeling more confident about commissioning but not totally confident about commissioning but I think we have now some of the levers to achieve some changes and we are going to try improve the way services work in the community, and we are going to improve accessibility to services in terms of timeliness and try and get the patients to the right service on the first try, rather than have them bounce around the system. We have lots of plans for that but they have not been delivered yet. Bear with us, we have only been running the joint commissioning board for nine months and I have yet to prove that we have actually made a difference on the ground but I am optimistic.

In terms of mental health being a very significant cost both in terms of social and health terms for the country as a large, we have significant plans in terms of what types of service we want to commission and we also have plans to improve access to psychological therapies, that is a national process, we have some plans to streamline the community mental health teams work so they are practising more, the jargon is evidence based, well that means they are doing the right thing, and they are providing brief interventions and there are appropriate plans for patients so we can get them into the system. The whole idea is to try and free up the referral and discharge process so we can more ready access when things go wrong. We know there is a problem with access to beds to mental health beds for people who are severely mentally ill and we know there is a problem about delays in A&E and the police have difficulty getting access to rapid mental health assessments prior to taking people to places of safety. This is high on my agenda and I have spent a lot of meetings over the last month or two trying to resolve some problems in the system. Again, I'm slightly more optimistic than I have been for a long time, it's a difficult one to promise that we are going to get it absolutely right.

Dr Mike Eckelaers

Can I just say that actually Martin is doing a brilliant job, we are fairly new to the role of commissioning and we are starting to a grip on it. The point about the money is really relevant because it costs us a lot of money mental health and I just wanted to say that we know that comes about because of the problems going on currently – we are going through a recession, people are losing their jobs, lots of support and benefits that people were relying on before are no longer there and I suppose if we step back from that, many of those solutions are at our behest and I think as part of our, all three of us sit on

the Health and Well-being Board that we heard about earlier, some of those changes that will be needed to prevent and reduce the burden of mental illness will come from other areas of the city, and some of those under the control of the local authority so as well as the Health and Well-being board keeping an eye on what we are doing, we can also try and influence on what else is happening in terms of the local authority, we are going through some difficult times.

Dr Bill Tamkin

Just on the second part of that question, I also sit on the Manchester Investment Board which is based at the City Council where health, police and legal system are represented and one of the things we are trying to unpack is the funding streams, if we can get into joint commissioning across the city and make sure the money flows in a more effective way we might start to unpack this particular issue.

John Butler

I sense one of the most important areas for development, it's about co-production really, its about people helping themselves and each other, recognising the expertise and understanding within individuals and communities and families.

Co-production is perhaps one of the most important areas for development. In essence it's about a more equal and reciprocal relationship between people who use services and mental health professionals based on recognition of the expertise and understanding within individuals and communities and families.



The culture of clinical practice needs to evolve to enable a different approach to service delivery and resources need to be used differently to develop, new peer support approaches. The recovery movement, the hearing voices network and the expert patient programmes are good examples

I was in here the other day with about nineteen carers and we were looking at the experience of voice hearing, not from a clinical view, but the actual experience what is that like and what does it do to people, what are the alternative ways that we can make sense of that, reduce symptoms without accessing services, there may be some clinical input, but clearly the way that we address mental health problems is very wrong, it is very top heavy, it is very clinical and we do no need to develop in those other areas, otherwise we will make no impact on any of this. The health inequalities that cause mental health problems is growing exponentially and mental health need is growing, we can't keep doing the same, we do need to develop another approach.

Nathan Atkinson

I would agree with John and to build upon that and from a City Council perspective we are going to be looking at investing a lot in preventative services because clearly as John alluded to peer to peer support is really effective and also I think the voluntary and community sector play a big part in that. The other key thing we are looking at in mental health is to promote the recovery model, which is known as IMROC. The IMROC model is essentially looking at instead of people being kept in long-stay residential placements, moving people back into the community and basically using our resources better and getting better outcomes for individuals.

Question:

Identifying local priorities: how will services of grassroots specialist organisations be maintained? For example, Sexual Health & HIV, Mental Health Services and support for people with Learning Disabilities? (42ND Street, Alzheimer's Society, GMB Coalition of PLW HIV and Talbot House)

Answer:

Dr Martin Whiting

HIV is one of things that is regarded as specialist commissioning and will be dealt with not be the CCGs but by a national body called the National Commissioning Boards, although I guess we would like to think we would have a voice in that. There are many developments in HIV care, HIV is becoming systemised such that it is almost becoming a bit like Diabetes. It is a life long condition that people live with and it is controlled by medication.

Support for people with learning disabilities again is jointly commissioned through the joint commissioning board and I would like to see some sort of patient feedback about those services and mental health services. I know we have patient information about mental health services but perhaps that is work we need to get a grip on.

Dr Mike Eckelaers

Commissioning is a cycle which starts with a need and looks at what is currently provided and having to improve on it. No doubt we will have our own way of doing that in our own CCGS, we will be using the Patient and Public Advisory Group, listening to our practices and we will be surveying/listening to patient experiences and feeding that into the cycle and coming up with what is our absolute priorities and that is something we have done year on year. I think it is fair to say that because a lot of services are provided by the voluntary sector we had a system in the last year of trying to rationalise how we can continue to afford that and we will have to go through a similar process in our own organisation in moving that forward and that will be formed by our own priorities and local priorities when it comes down to our various communities.

Question:

My name is Deena Murphy and I chair one of the largest resident associations in Manchester. Mine is not so much a question but a suggestion, when our health forum had to fold because of lack of funding two years ago, we couldn't just let it go. So what we have done in our area is identified two or three people in every street, they are all CRB checked and they are all first aid trained. And anyone who is at all vulnerable or who needs help is identified to one or other of us on the committee, and we instigate help, treatment, support or whatever – do you think this could roll out across the city?

Answer:

Dr Mike Eckelaers

It sounds absolutely fantastic what you are doing. Quite often I hope for the glue that is going to hold all this together and I am not politically inclined this but I think there is a Big Society message in terms of what society can do for itself and you certainly have a model there and I would like to see that model rolled out across the city.



Event Next Steps

A copy of this report, the presentations and the video of the event will be made available on the [Talking Health website](#).

If you would like paper copies of this report and the presentations, please email talkinghealth@manchester.nhs.uk or call 0161 765 4168.

If you would like to make contact with one/or all of the Patient and Public Advisory Groups, please call:

- Central Manchester: Sandra Stronach 0161 765 4177 CM-PPAG
- North Manchester : Jules Palfreyman 0161 765 4176 NM-PPAG
- South Manchester : Val Bayliss-Brideaux 0161 765 4168 SM-PPAG

Or email talkinghealth@manchester.nhs.uk quoting the relevant PPAG you would like to contact or share patient experiences with in the subject heading line.

Manchester has a vibrant voluntary and community sector with a range of organisations providing valuable services and acting as a voice for particular communities. We view this sector as a key partner in supporting the health and well being agenda in the city and welcome their place on the Health and Well Being Board, contributing to planning and strategy development. During 2012, a Voluntary and Community Sector Assembly will be developed. This will provide a single contact point for the sector, enabling the Manchester Clinical Commissioning Groups to draw on their expertise, support and insight when required.

If you have comments about the Voluntary and Community Sector involvement with the three Manchester Clinical Commissioning Groups (CCGs) and what as a sector are the next steps, please email Macc on mary@macc.org.uk.