NHS Greater Manchester Integrated Care

Greater Manchester Children's and Young People's Health and Wellbeing Stakeholder Forum

Connecting Care for Children, Young People and Families

Wednesday 20 July 2022

Greater Manchester and Eastern Cheshire
Strategic Clinical Networks

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Executive Summary

The GM Child Health and Wellbeing Stakeholder event took place on 20 July 2022. These events were originally set up in 2017 to conduct a deep dive into an objective or theme related to the Greater Manchester Child Health and Wellbeing Framework.

There were 4 reasons why the subject of 'hub's' as a future model to enable integration and improving asthma outcomes were the focus of the event.

1. Implementation of NHS Greater Manchester as an integrated care system.
2. Development of family hubs led by the GMCA and 10 local authorities alongside the NW Office for Health Improvement and Disparities.
3. Improving asthma outcomes is a priority for the evolving Greater Manchester Children and Young People's Plan and also for the NW NHSE CYP Transformation plan as a key element of the NHS Long Term Plan.
4. Recovery from COVID within the context also of social determinants of life, with the long-term condition, asthma, being one of the priorities for children and young people within the Greater Manchester recovery plan.

76 people attended from a range of health and care organisations including the VCSE, parent and care and youth voice organisations, education and early years sectors. This was a virtual event with a mix of presentations, both national from NHSE giving up to date national perspectives on asthma and on the excellent tried and tested model of Connecting Care for Children now implemented across many parts of the UK, the GM regional position within the evolving Integrated Care System, the developing GM Children's Plan and specifically the work of the CYP asthma programme led by the Greater Manchester and Eastern Cheshire Strategic Clinical Network. Very importantly, the audience heard an inspiring lived experience story from a parent of a boy with asthma.

There were interactive sessions using questions posed by Mentimeter and a series of workshops – the responses are shared within the document and in the accompanying appendices.

These were the overall themes which came out of the event and which will be used to inform future planning to further integrate GM CYP services particularly building the pathways for asthma care. Co-production with children, young people and families will continue to be at the heart of further service developments and in setting outcome measures.

The responses to questions and those captured in the chat have been summarised and grouped into themes in the table below.

Theme	Issue	Actions/solutions
Children and young people's involvement to embed their lived experiences in improving services	• Need to consult on expressed needs for service delivery including how, where and when. • Need to understand how asthma impacts upon their lives- will help us to develop communications plans, service design, system-response to CYP with asthma. • Need to know what CYP and families understand about asthma to develop our educational programmes and inform conversations between CYP, parents, carers and professionals. • Need to understand what influences condition self-management/ care. • Need to develop CYP and family-friendly service provision, informed by outcomes of youth inspections (see page 23 of this document for further details).	• Work with Youth Focus North West (YFNW)and parents/ carers to develop means of consulting on pertinent issues for our CYP and families. • CYP and parent/ carer recommendations to inform service development/ standards for service provision- develop standards for service delivery. • Review education and training for all who come into contact with CYP and their families and ensure that key influencers of condition management are addressed. • Ensure the Youth Inspector programme includes asthma services. • Share recommendations from inspections back with providers and collate learning for sharing across GM. • Services to respond to CYP and families with 'you said, we did' messages.
Outcome measures	• Outcome measures are not consistently used across GM to determine if improvements are being made in asthma care.	• Review all outcome measures that are currently in use and align with requirements of Bundle of Care, GM Children's Plan, NHS Long Term Plan and Core20PLUS5 framework for Children and Young People (expected 2022). • Make recommendations for which outcome measures are key to measuring quality improvement in asthma care across GM.

Stakeholder engagement and ownership	• There are gaps in stakeholder engagement that will enable truly connected care for CYP with asthma. • Not all (potential) stakeholders understand their contribution to improved asthma outcomes for children. • Workforce capacity is stretched across the system and asthma may not be a priority for broader stakeholders.	• Stakeholder mapping against the priorities/ deliverables in the GM Children's Plan, GM Recovery Plan, CYP Transformation Programme, National Bundle of Care, NHS Long-term Plan etc. • Engagement with senior leaders using priorities as levers for improvement. • Communications plan to include wider social determinants and how inequality impacts adversely on asthma outcomes. • Potential Cost Benefit Analysis exercise for elements of Bundle of Care including Asthma Friendly Schools, diagnostic hubs.
Service design and delivery	• There is variation in provision and outcomes across GM. • Services may not necessarily need additional investment to improve, but resources could be used differently.	• Develop ideal service specification template for asthma across health and care boundaries and future community diagnostic hubs, including quality outcome measures. • Explore if Greater Manchester can apply the Connecting Care for Children model both locally and on a regional footprint. • Use data to provide evidence of variation and of impact e.g. assimilation of schools and health data in relation to asthma. • Develop GM clinical and referral pathways according to best practice for use with the specification. • Using the GM spatial planning framework, work collaboratively with Primary Care Networks, Local Authorities, CYP, parents/ carers, VCSE and Education sectors Identify CYP champions for CYP in primary care and in localities and neighbourhoods. • Develop standards for service provision incorporating CYP and family voice feedback and youth inspector recommendations. • Share areas of good practice that demonstrate connected care for CYP with asthma.

Next Steps

An action plan will be developed incorporating themes and suggestions from the event, which will be presented to the Greater Manchester Children's Health and Wellbeing Executive Board for endorsement. The plan will aim to contribute to improvement in asthma outcomes for Children and Young People and use the outputs of the event to progress integration and move to a preventative and early intervention model. The report from the event will be shared with other relevant Boards which have a responsibility for child health and wellbeing.

Presentations from the event will be used in conjunction with the Integrated Care System framework to support spatial planning for localities, with an ambition to develop a Greater Manchester **Connecting Care for Children (CC4C)** model, applying the CC4C logic model. This ambition will be realised by working in conjunction with Dr Mando Watson, Clinical Lead for CC4C and colleagues.

The role of primary care and the interface between primary and secondary care will be developed further in collaboration with Primary Care Networks, Local Authorities, neighbourhoods, VCSE and CYP parent carer voice. Consideration will be given to the opportunities for integrating care with emerging family hubs, and to input into the development of specifications for Community Diagnostic Centres.

Reflecting on Mando's presentation, existing enablers will be key to the development of this integrated approach and to determining if it is making a difference i.e. professional leadership, innovation, lived experience and data.

There is a strong emphasis on Improving wider collaboration and connections in our GM ICS and in particular working with transport and housing, also sharing good practice regionally and nationally 2 ways. Some of this work has already begun through the GM Asthma Network and will be strengthened by the inclusion of Asthma as a priority in the Greater Manchester Children's Plan.

Co-production with CYP and families is also a priority for healthy and care services and in the GM Children's plan, and it is important that this is embedded routinely into service developments and practice. We will continue to work with our partners Youth Focus North West, the North west Parent Carer forum, and other CYP, parent and carer groups throughout Greater Manchester to improve health outcomes through integrated care for Children and young People.

It is clear that this work will need sufficient resource including workforce capacity, leadership and sponsorship to progress, so it is recommended that this work becomes a priority for the GM Integrated Care Board (ICB) and Children and Young People's Transformation Programme in Greater Manchester, and that a working group is established to deliver it.

Recommendations

1. Children's Health and Wellbeing Executive Board should endorse the ambition to develop a Greater Manchester model for Connecting Care for Children and include in its Children and Young People's Transformation Programme.
2. This report should be socialised widely, and recommendations and actions incorporated into GM System wide, organisational, neighbourhood and locality plans for Children and Young People.

3. The development of family hubs led by Greater Manchester Combined Authority and in conjunction with the 10 Greater Manchester Local Authorities and the Office for Health Improvement and Disparities, should consider how they can contribute to improved outcomes for asthma for children and young people.
4. All areas should review the priorities in the Greater Manchester COVID Recovery Plan, with consideration given to how improvement in asthma outcomes can be included within locality recovery plans.
5. Enablers such as Parent/ Carer and Children and Young People's Voice, data, leadership and innovation should be incorporated into all plans for integrated care for children and young people.
6. In developing plans to improve asthma outcomes for Children and Young People, Greater Manchester's spatial framework model should be applied.

Aims of the Event

- To consider the different levels of commissioning, service development and delivery across Greater Manchester and illustrate this with live examples of connected care provision.
- To explore how the Greater Manchester asthma work programme can be developed further with support from the Greater Manchester system to enable improved prevention and care of asthma at all levels. Improving asthma outcomes is a priority for both the Greater Manchester CYP plan and the NHSE CYP transformation plan.
- To identify priorities and actions to enhance connecting care for children, young people and families particularly in the light of innovative ways of working and as part of recovery and restoration plans after COVID.
- To begin to develop priorities and actions for improvements in Greater Manchester.

Welcome and Introductions

Dr Carol Ewing, Greater Manchester and Eastern Cheshire Strategic Clinical Networks' (GMEC SCN) Children's Clinical Advisor, Royal College of Paediatrics and Child Health (RCPCH) Ambassador for Greater Manchester, Co-chair of the GM Children's Health and Wellbeing Executive Board and Chair of the GM Child Health and Wellbeing Stakeholder Forum

Dr Carol Ewing welcomed everyone to the event, with 76 people in attendance from across a range of organisations and disciplines, as well as parents, carers and young people representatives. She began by explaining that there has been quite a lot of system change in the architecture with the move to an integrated care system and that the event would be used with a collaborative focus so that attendees could contribute to discussions around children's integrated health provision. Narrative extracted from the chat funcion of this virtual event is included in the blue bubbles.

This event had a focus on asthma and improving asthma care, considering the use of hubs and integration. Integration of care was the theme for the January 2021 Stakeholder Event which began to look at what integration means for Greater Manchester.

Carol thanked the speakers and contributors in advance acknowledging the wide range of colleagues supporting with the event. Dr. Mando Watson, key-note speaker is an advocate for integrated care and has been at the forefront of Connecting Care for Children in North West London and across the UK.

Carol reminded everyone that a GM key principle is to co-produce with children, young people and families and we were pleased to have parent/ carer and children and young people's voice representation at this event.

Dr Kal Dixit, GMEC SCN Children's Asthma Clinical Advisor

Dr Dixit introduced himself and described his role as a clinical advisor with the Children's SCN. He stated the importance of gaining consensus and standardising the way that asthma is managed, with consideration for the multiple factors that affect asthma, including environment, obesity, housing, and smoking. Kal described his role as working with colleagues to ensure we protect our children, young people and families and help them to deal with their asthma, which is a life-long condition.

Responding to an audience question about whole-system working, Kal described the membership of the asthma working group in Greater Manchester which has members from a range of sectors, and also talked about the work that GM would like to progress with, and the connections that have been made at regional and national level, and most importantly, with parents, carers and young people.

Concluding, Kal stated, "We also need to remember that this is not a two-year plan, this is a ten-year plan."

Katie Puplett, Children and Young People's Senior Policy Manager, Children and Young People's Transformation Programme and Vimal Bedia, Policy Officer, Children and Young People's Transformation Programme, NHS England

Katie is Senior policy manager within the NHSE Children and Young People's Transformation team, leading on asthma, workforce and transition. Vimal is a policy officer with the NHSE CYP Transformation team and works alongside Katie on asthma.

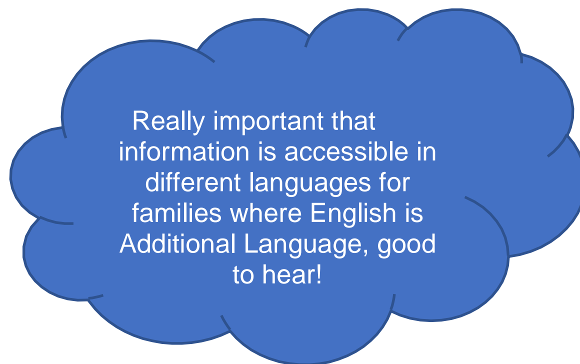
Katie described the national work programme which has developed from the Long-term Plan for at least two years. It was stalled with COVID, but the ultimate aim was to produce a national bundle of care for children and young people with asthma, and that was born largely off the back of the success of the *Saving Babies' Lives* care bundle. Phase one of the Bundle of Care for asthma was produced in September 2021 and there's likely to be a final iteration published in autumn 2022. This will not be a set of new standards but will include more resources to support delivery of the current standards, for example a referral pathway and some different templates.

The training and education working group have produced a five-tiered set of training capabilities, and these are now available on Health Education England's (HEE) *eLearning for healthcare* site. HEE has a strict governance process about updating the capabilities and they will be reviewed every couple of years. There is also training on the site with tiers 1, 2 and 4 there currently, and tier 3 likely to be available mid-August.

Sites for Integrated Care System (ICS) asthma practitioner pilots have been finalised with eight sites identified across the country: one in each of the regions and two in the Midlands due to the number of ICSs in the Midlands. None of these are in Greater Manchester, with Lancashire and

> Absolutely critical that we have whole system buy in and support to achieve our desired improvements. We have our Greater Manchester Combined Authority supporting us and asthma is in their priorities, housing are engaged actively and developing standards for landlords and we have a pilot of asthma friendly schools commencing. we can always do more but we are off to a good start

South Cumbria ICS being successful for the North West. Development of a risk stratification tool will be commissioned to run alongside these pilots. The model for the pilots is to have a Band 8a who will work strategically with education and arms-length bodies and local authorities. They will consider which Primary Care Networks (PCNs) have poorest outcomes and work with those to start with, and also consider how these can link with CDCs and establish diagnostic pathways. A Band 7 will lead on the identification of children and young people most at risk of exacerbation, using the risk stratification tool to link primary and secondary care data. Those children and young people will be risk stratified and signposted either back into secondary or primary care, or to tertiary care as required. An evaluation has been commissioned.



The national data dashboard for asthma is continually being updated with plans to make it more interactive than it currently is. There are plans to include ethnicity, Indices of Multiple Deprivation (IMD) and air quality. Currently secondary care data is available to view but there are also plans to ultimately include prescribing data with links to school absence due to asthma admissions, and the information about training. This will provide a very comprehensive landscape of what is happening in local areas for those using the dashboard, enabling reflection and exploration into reasons why.

Next steps include developing the supporting documentation: assessment around an exacerbation, whole system care pathway, personalised asthma action plan template and discharge plan. Some of the key documents from BEAT Asthma CYP resources https://www.beatasthma.co.uk/ will be translated into the top six non-English-speaking foreign languages in the UK. This will support children and young people who have been marginalised because of language difficulties.

Additionally, there will be updates to the NHS UK websites to include children and young people, as it currently has an adult focus and is not reflective of children's asthma symptoms.

The training and education working group has produced the national Capabilities Framework for Professionals who care for CYP with Asthma, which will be hosted on the e-learning for health website alongside the training modules, due to be launched in the summer of 2022. More than 2000 people have already accessed the training. Once tier 3 is up and running there will be more strategic and targeted communications with materials that can be shared across networks to encourage uptake.

Links to the training are included in the slides.

Kelly Taylor, Head of CYP Transformation Programme North West, NHSE/I

Kelly provided an overview of the North West Children and Young People's Transformation Programme for asthma.

Dr Ian Sinha and Vicky Webster, Nurse lead for Lancashire South Cumbria are Co-Clinical leads for the North West.

Kelly shared the emerging governance and what it means for the people of the North West and Greater Manchester and how both are working together. There is a North West

Children's Board which discusses and takes forward a whole range of priorities areas which are in the NHS Long-Term Plan. Asthma is a large and complex work programme, with a North West children's asthma group that supports delivery. There are many cross-cutting issues with some children having other disabilities as well as asthma for example obesity, special educational needs and disability and one or more long-term condition.

The Integrated Care Board (ICB) asthma clinical leads in the North West region are:

- Dr Dennis Corbett (East Lancashire Hospital Trust) and Vicky Webster for Lancashire and South Cumbria
- Dr Margaret O'Connor (Alderhey) and Dr Ravi Jayaram for Cheshire and Merseyside
- Dr Kalpesh Dixit (Northern Care Alliance) for Greater Manchester

As a Region the aim is to get information from the National team to the Integrated Care Systems (ICS) to deliver the National Care Bundle. The North West asthma groups link to each ICS area.

The North West asthma programme has held two North West group meetings in which they have held an away day to formalise clinical governance and links to ICS plans, shared national information e.g. Health Education England (HEE) courses, Expressions of Interest for a Transition pilot with Band 8a and Band 7 roles sited in ICSs, held workshops sharing good practice including Leicester diagnostic hubs and a clean air workshop, and also the Tiny Asthma Medical App.

The successful ICS areas for the transition pilots with Band 7 and 8a roles are:

Region	ICS
London	North East London
East of England	Cambridgeshire & Peterborough
Midlands	1) Shropshire, Telford, Wrekin
	2) Black Country
South East	Surry Heartlands
North East & Yorkshire	North Yorkshire & Humber
North West	Lancashire & South Cumbria
South West	Devon

Kelly briefly described the themes within the asthma care bundle:

Organisation of Care
Environmental Impacts
Early and Accurate Diagnosis
Effective Preventative Medicine
Managing Exacerbations
Severe Asthma

With cross-cutting themes of:

Data and Digital
Asthma Competencies & Education & Training Needs

Within each of these specific areas there are lots of tasks that sit underneath, and each ICS area must report progress against each of the various tasks. Each area grades where they are up to with each task as red, amber or green in terms of deliverables, and these are shared with the national team which provides an overall picture of where each region is up to. This is a long-term programme to 2024/2025 and the teams are in the process of agreeing governance.

The national picture is showing that most ICSs are at the Amber stage with most of their CYP asthma deliverables and the majority of ICSs are on track. The deliverables that are proving most challenging to achieve are:

- Environmental Impacts – agreeing criteria with housing associations for CYP with severe asthma.
- Early and Accurate Diagnosis – Diagnostic Coding.
- Severe Asthma – Implementation of a severe asthma registry.
- Capabilities, Training and Education – Training of professionals caring for Children and Young People with asthma.

Progress is normally discussed at the team's weekly catch up. There is a 'Future NHS' platform where there is regional and national information and which is good for sharing good practice.

Asthma Awareness Week, #AskAboutAsthma 2022s was rescheduled to the 3rd – 9th October 2022. Webinars were as follows:

- Ask the Expert webinar
- Nursing webinar
- Pharmacy webinar
- Virtual one-day conference
- Primary care webinar

All events were recorded and are available on the #AskAboutAsthma webpage after the event.

If you would like to be included on a wider North West Distribution list for information about CYP asthma - please request to be added to this via this email england.nwcyp@nhs.net.

Gill Gibson, Director of Nursing, Quality and Safety, NHS Greater Manchester Integrated Care (Tameside)

Gill is the chief nurse for NHS Greater Manchester and it has been agreed at Board level that the role that supports children, young people and families (Senior Responsible Officer) will sit in the chief nurse's portfolio, which puts children young people and families right at the centre of an Integrated care system.

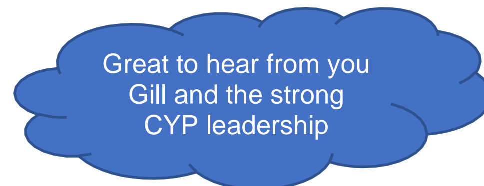
Gill went on to talk further about Primary Care Networks (PCNs) and Primary Care in relation to provision for Children and Young People.

Children and young people are big users of primary care services, children are citizens of neighbourhoods and there are thirty to fifty thousand people in a neighbourhood with a big proportion of these numbers being children. Previously a lot of work in neighbourhoods has focussed on adults. Gill stated there now needs to be a focus on getting things right for children; there are too many children in the care system and too many children not getting the

outcomes that they need. The foundation of integrated care and prevention sits in the neighbourhood model. The work of primary care colleagues and wider community services such as health visitors and school nurses, and the work of local authorities such as the early help offer, social work or sharing information around schools and colleges in sight of children contributes to this.

Children have spoken out about their main concerns, one of which is that health services expect children to come to them whereas children want health services to go to them. Developing services involves listening to the voices of children and young people to make sure that we deliver what they need and to reach as many children as possible which will then improve outcomes.

Gill expressed that she would like to be part of the Greater Manchester Children's and Young People's Health and Wellbeing Stakeholder Forum going forward.



Keynote speaker- Dr Mando Watson, Consultant Paediatrician at St. Mary's Hospital and Imperial College, London – Connecting Care for Children (CC4C): A partnership between hospital & community health providers, GP federation & networks, local authority, charity, patients, citizens and more

Mando's work is significant for Greater Manchester as it is a forerunner to and inspiration behind the GM ambition to have a truly integrated health and care system for Children and Young People.

Mando explained that she would be talking through the logic behind and the design of the CC4C model and discussing whether it works. She would then talk about continuous improvement, the impact of COVID, and asthma within the context of the model.

Mando presented a driver diagram (below) and explained that the middle column contains the things that are being addressed to bring about change.

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THE LOGIC BEHIND THE MODEL:

Action Effect Diagram - Adapted June 2018 from CC4C/CLAHRC 2014
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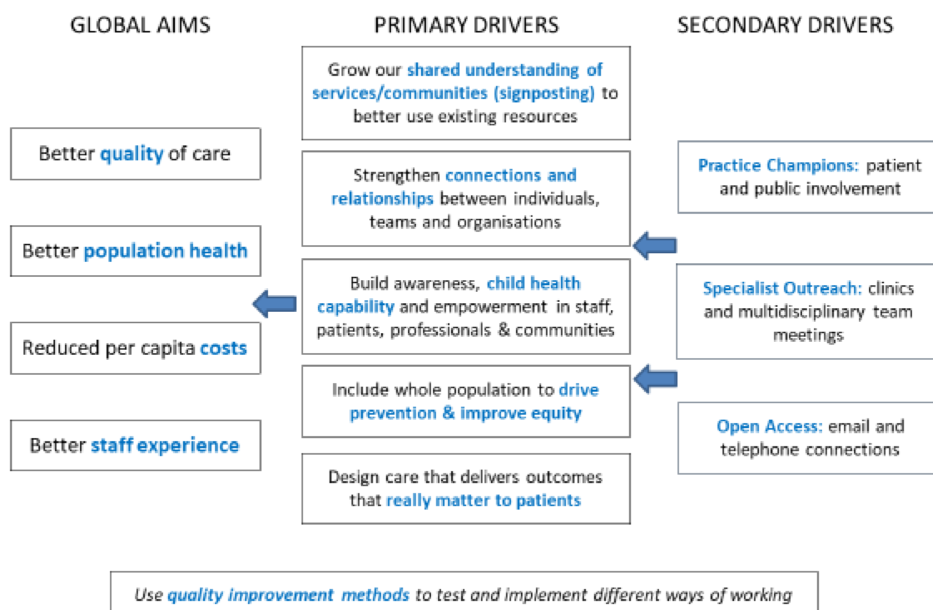

The CC4C programme has led to the development of Child Health GP hubs as part of an integrated child health model of care. The outcomes from implementing these hubs include:

- Improved experience of care; there has been outstanding feedback from patient and family experience as a result of being seen in the child health GP hub. Feedback from parents indicates a change in parental perceptions that GP practices are where child health is delivered as opposed to hospitals.
- Improved staff experience and learning.
- Improved population health with reference to specific preventative interventions.
- Reduced per-capita cost, an observed reduction in hospital activity.

Some challenges to implementing the hubs were also described:

- There needs to be really clear governance as integration can blur boundaries.
- Personalities and hierarchy may inhibit participation in Multi-disciplinary Teams (MDTs).
- Safeguarding of confidentiality breaches; the broader the MDT, the easier to cross the information governance line.
- How best to share learning; each hub has its own flavour, strengths and weaknesses.
- How to make it the GP practice's hub; careful design and creation is required, pull not push.
- Doctors may dominate MDT meetings, so it is important to ensure other professionals are able to step forward either with their questions or with their information.

Since the outbreak of COVID, many meetings have moved to virtual ones which has meant an increase in the numbers of GPs able to attend meetings. The MDTs established good relationships with parents, the community and with GPs and so when a crisis arose, for example immunisation rates plummeted as parents were concerned about taking their children to a healthcare setting to be immunised, within 48 hours, many parents were able to explain their concerns and GPs responded with solutions via a WhatsApp group for parents and professionals. This was a clear demonstration of trust and relationships, and that solutions to challenges can be developed by the community.

Welcome this approach, having secondary care colleagues coming into the community and improving relationships between primary and secondary care - improving outcomes for CYP and parents

Mando went on to summarise their work around asthma. MDT hubs were given the opportunity to appoint an asthma nurse or an asthma doctor to do some focused work on asthma and to look at the children most in need. A data dashboard was developed, similar to the national team's dashboard. Children with most need could be reviewed by the MDT discussion to determine if they would benefit from a face-to-face discussion in the GP practice. This enables the GP and the paediatrician to be involved in the same discussion. Discussions involve not only GPs but also practice nurses, school nurses etc. who are involved with children with asthma.

For those practices that are not part of a hub, data was used to identify those practices that have many children with difficult asthma or with high asthma activity such as visits to hospital etc. The hubs offer to support them so there are many practices that have this support without being part of a hub. This is an opportunity to engage with those who have benefited from training and to ask if there are other topics for paediatric health that would benefit from hub support.

Design principles for integrated care

Mando emphasised the need to start with families and to focus on the connections and relationships, considering assets available. The GP practice is the most extraordinary asset in the system which takes a population-based approach and has peer to peer influences – parents talking to parents, GPs talking to GPs that support growth and spread of the model.

Mando followed her presentation with questions which linked to existing service provision and to opportunities for better connected care. In summary the most popular themes coming out of the questions were as follows and a full list of responses is given in Appendix 1:

The merging themes and individual comments will assist the development of the asthma programme and enhance integrating our services on a health and wider sector footprint.

The number of people who responded to each theme for each of the questions were also recorded below.

Q1. The logic behind the model (primary drivers) – what are you doing well?	
Grow our shared understanding of services/ communities (signposting) to better use existing resources	**3**
Strengthen connections and relationships between individuals, teams, and organisations	**12**
Build awareness, child health capability and empowerment in staff, patients, professionals & communities	**0**
Include whole population to drive prevention & improve equity	**0**
Design care that delivers outcomes that really matter to patients	**2**

Q2. Name a local professional role who might embrace this opportunity (free text response/ word cloud)
Top 4 in order: Paediatric, nurse, teachers, CCNT

Q3. Have you a relevant outcome measure for 'better quality of care'? (free text response)	
Friends and family test	5
Patient experience: feedback/ patient journey case studies/ Improved patient journey	4
PROMs (Patient Reported Outcome Measures)	1
Hospital activity: Reduced hospital admissions/ attendances to A&E/ hospital readmissions	5
Whole family approach	1
Focus groups	1
Improved school attendance	1
Q4. Have you a relevant outcome measure for 'better population health'? (free text response)	
Smoking: Smoking prevalence. Reduction in YP smoking, SATOD, Reduction in parental smoking	4
School: attainment, absence, days missed (due to illness)	5
Hospital Activity: Hospital readmissions, unplanned hospital admissions/ attendance, shorter hospital stays, reduced attendance at unscheduled care with respiratory illness, number of bed days per admission	7
Pharmaceutical: better understanding of prescribed medication, reduction in prescription	2
Self-care/ management: Better LTC (Long Term Condition) management, improved inhaler technique/ education	2
Physical wellbeing: increase in physical activity, reduction in obesity	2
Better housing/ environment	1
Asthma rates	1
CYP surveys	1
Q5. Have you a relevant outcome measure for 'reduced per capita costs'? (free text response)	
Workforce: Sickness absence rates, retention, staff survey, NHS staff survey	4
Activity: Reduce GP referrals, improved access to advice and guidance, reduce medicines cost	3
Q6. Have you a relevant outcome measure for 'better staff experiences'? (free text response)	
Recruitment/ retention: Improved retention of staff, improved recruitment figures.	5
Staff feedback: (NHS) staff survey, staff satisfaction survey	4
Sickness absence: reduced sickness absence, improved sickness levels, reduction in sickness and absence due to work-related stress.	4
Organisational: Management supervision, access to education and training, relationships with colleagues	3

Staff wellbeing: Improved wellbeing, improved mental health, improved physical activity.	**3**
Services: work with and empower families to be confident in managing asthma, diagnostic hubs to include services for CYP, improved diagnosis	**3**
System: Collaborative approach across the system	**1**

Q7. Is there anything else to add with respect to improving asthma outcomes? (free text response)
We need to do now
Wider determinants measures
Better educated primary care staff
Need more capacity at operational level to deliver
Standardised templates, leaflets etc.
Let's think creatively working with our CYP and families e.g. filming CYP telling their lived experience
MDT involved
Patients and public involvement
Improve access to primary care appointments
What are the touchpoints for CYP with asthma?
Work with and empower families to be confident in managing asthma
Improved awareness in schools and settings
Diagnostic Hubs to include investigations for CYP
Collaborative approach.

Getting in Touch - Contact details

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Website: https://www.cc4c.imperial.nhs.uk/
Next webinar: Thursday 15 December 2022, 3:00 - 4:30 PM on Microsoft Teams

Andrea Greenwood – Development Manager for Oldham Parent Carer Forum Family Experience of Asthma Diagnosis in a Child

Andrea shared her own very personal experience of having a son with asthma and their 14-year journey.

Andrea described how her son's birth was not straight forward and soon after the birth, she realised he could not tolerate milk, and always seemed to have coughs and colds and skin rashes. Andrea's family has a history of asthma. She has asthma herself and her father was diagnosed as an adult.

Following the birth of her son, the family struggled to get support and her GP said the family was being overprotective. Eventually after his lack of weight gain and persistent weight loss the family was told that his lack of growth was significant, and his baby formula milk was changed to *Neocate*.

My question is really in relation to what we have going on locally in Rochdale as part of the Local Care Organisation mandates. There are two that impact on children's services. One of the mandates is moving services into co-terminous neighbourhood constructs around the PCN's and localities, which brings in health social care etc and led by health. The other mandate is in relation to Family Hubs which is being led by local authority and tends towards a more early help/social care agenda. Both appear to have the same vision as CC4C in as much as wrapping services around the community but both are led via differing drivers. Does GM have a view on how our children's community (CCNT/Public Health? therapies and paediatricians) collaborate and engage with both agendas?

By the time her son was two, Andrea and her family had been asking for support for two years. They had taken him to clinics for regular weigh-ins but the fact that he was not thriving or gaining weight was ignored. The skin rashes cleared somewhat with the change of baby formula, and he started to gain some weight however he remained very nasally.

At 4 years of age, Andrea's son was being treated by an allergy specialist and an endocrine specialist who were looking at his growth and allergies because he was constantly picking up infections and coming out in rashes. He was hospitalised 3 times and given nebulisers and asthma inhalers before he was given a diagnosis of asthma.

The worst asthma episode happened when he was 5 years old at which point the consultants had not actually given him a diagnosis of asthma. This attack emphasised the need for family education about asthma. Andrea's son developed a continuous cough which would make him sick. The family had just returned from holiday and at around 7.30 pm Andrea contacted the NHS helpline. She was asked if it was him coughing in the background and if he had asthma. Their advice was to take him to A&E to be seen, by which time the cough had gone. He was very sleepy, clammy and sweaty and really pale. The A&E doctor advised that he had probably just picked up a virus whilst on holiday and could be sent home.

Andrea's felt that this was not right and asked for a second opinion which was something that she had never done before and felt really brave for asking. The doctor agreed that his oxygen levels were very low, however was adamant it was a virus. Andrea insisted that she was not going to take him home.

The doctor spoke to other staff and upon return, said they would nebulise him and admit him to the paediatric unit. By this time, he was struggling to breath. The nebuliser started to work, and you could then hear a faint wheeze again. The family was told that asthma can present itself in different ways in children. He was taken to a ward where the staff were waiting. He was very poorly and was given a lot of treatment through the night including nebulisers and drips, the team started to see an improvement at lunch time the following day.

A nurse provided a leaflet on how to complain. Andrea stated: "I did not want to do that. I hadn't even thought about it." The Nurse asked if Andrea had ever heard about a silent chest. She couldn't remember and Googled "what is a silent chest?". It was at this admission her son was given his asthma diagnosis and community nurses began to support at home, providing a management plan.

Over the next few years Andrea's son's asthma did bother him at times and sometimes and it was difficult to control, especially during hay fever season where he would need hospital treatment. Normally this would be a one-night stay, and other times after he was nebulised, he was able to return home.

Different fragrances and smells could all be a trigger, and he had skin prick tests and blood test for allergies. Return to school in September was also a time that his asthma could exacerbate, and he would be quite poorly. He has seen the endocrine team regarding his growth, and the allergy team and *Grazax* was prescribed to help with his hay fever.

Previously he had been tested three times for cystic fibrosis because he had previously presented as a very small child as nasally and with breathing difficulty. A consultant at the time was sure that he has cystic fibrosis, however the tests repeatedly came back negative. There was a wait for an appointment with an asthma specialist, and the consultant was described by Andrea as 'amazing'.

Transition to secondary school was a struggle and caused more asthma symptoms. By this time biological medication had started to be discussed. Andrea asked if he could try *Symbicort* which is the medication she had used for 14 years, never needing emergency treatment. Prior to being prescribed *Symbicort* she was admitted to hospital 3 or 4 times a year requiring A&E support.

Andrea's son was using a brown inhaler which was changed to a purple inhaler as despite using a spacer, it wasn't controlling his cough or his asthma. The decision was made to try him on *Symbicort* before the COVID pandemic. His asthma improved during a period of shielding although he still has episodes now, and if he starts to cough the family are on high alert, however he has not been admitted to A&E since being prescribed *Symbicort*, In addition to his daily medication which includes daily hay fever medication even outside of hay fever season, he is on *Montelukast* tablets and anti gastro -oesophageal reflux medication, and he needs his asthma medication before doing PE or physical activities during hay fever season, or when he seems to be starting with a cold.

"This chap has now graduated from our services".

Grazax, which is a treatment for severe grass allergy, has had a great influence on him as it makes his symptoms less severe. His asthma is now really well-managed, and he was recently discharged from the team in Manchester back to the care of the paediatrician.

The consultant stated:

Love the 'graduate from the service' this needs to be our new mantra for transition....

The paediatrician that the family worked with always spoke directly to Andrea's son, who was the important person in the room, and would acknowledge Andrea. Andrea felt the child was always the important person and that meetings centred around her son. His asthma plan has been reviewed over the last 3 years; he has an Education Health and Care (EHC) plan because he has additional needs, and there is reference to asthma in this plan, and he also has an individual health care plan in school which is separate to EHC plan.

Andrea described herself as a mum with asthma. However, when speaking to families as a forum, she feels there is a need for more education and support for families with young

children and for all children in our communities and those services supporting them, including schools to help them understand that there are different ways in which asthma can present itself. There is more to asthma than just a wheeze. Asthma plans need to be regularly reviewed and updated and co-produced with families.

Andrea was pleased to participate in this Stakeholder event and hear the progress of the asthma work in Greater Manchester, that asthma is talked about and there is co-production. Information does need to be easy to understand and done in a language to make accessible for hard to reach families, and families who speak in different languages.

Andrea finished by sharing some good news. Her son completed his Bronze Duke of Edinburgh expedition award the previous week, and inside his map bag were all his asthma sprays. He is now really confident in taking his medications because he knows what each medication does and why he has to take it.

She reflected on the journey with her son stating that if she hadn't been brave and asked for a second opinion on that night and taken him home, perhaps nothing would have changed, and the family would be in a very different situation.

"I Hope the story that I have shared with you will help- it is about receiving the right support how it can change lives."

Andrea - such a clear story with loads of points which you identified - I will make sure the points from your story are part of our developing plans - thank you!!

Stuart Dunne CEO, Youth Focus North West (YFNW) – The Children & Young Persons Voice

Stuart thanked Andrea Greenwood for her frank insight into her family's experience of the battle they had to get the diagnosis of asthma and the correct treatment for her son.

Stuart also picked out two insights that Andrea had shared that he felt were particularly pertinent:

Honestly he was so proud "Graduating" from our Service it was certainly a defining moment for him!

The Paediatrician working with the family always spoke directly to her son and her son had 'graduated from the service'

Stating that he would like to share information about the architecture of the young person's voice across Greater Manchester and wider, Stuart alluded to the fact that much work in this area had already been done, of which the Youth Focus North West (YFNW) team is very proud, and that there is still much to do.

Youth Focus North West is a small voluntary sector organisation that works across the North West and beyond. One area of work and a theme within the mission statement is around children and young people's voice, and that he would like to explore how the young people's voice can be embedded in governance across the North West. He described how it would be useful to utilise existing mechanisms that attract diverse groups of young people and to understand how health and wellbeing can be woven into the existing themes.

Greater Manchester already has much activity around Children and Young people's voice. Youth Focus North West is pleased and proud to support the Greater Manchester Youth Combined Authority which is a group of 52 young people representing 26 organisations. They meet once a month and try to hold the Greater Manchester Combined Authority to account as well as Andy Burnham, Mayor of Greater Manchester.

Last year the team was supported by Greater Manchester Health and Social Care Partnership (now known as NHS Greater Manchester), to develop a Young Inspectors' scheme. This pilot scheme saw a group of young people trained to be young inspectors and access healthcare providers to explore how young-person-friendly the health provision was. Youth Focus North West is working with the young inspectors to present all their findings in a report to the Greater Manchester Children's Health and Wellbeing Executive, after which time the young people will make recommendations for the second year's pilot. The team are thankful that there is financial support secured for the young inspectors' scheme going forward.

Regarding the wider health agenda Youth Focus North West is now the lead for Children and Young People's Voice for mental health and is currently working with the GM Mental Health Board to consider how young people's voice can influence mental health provision.

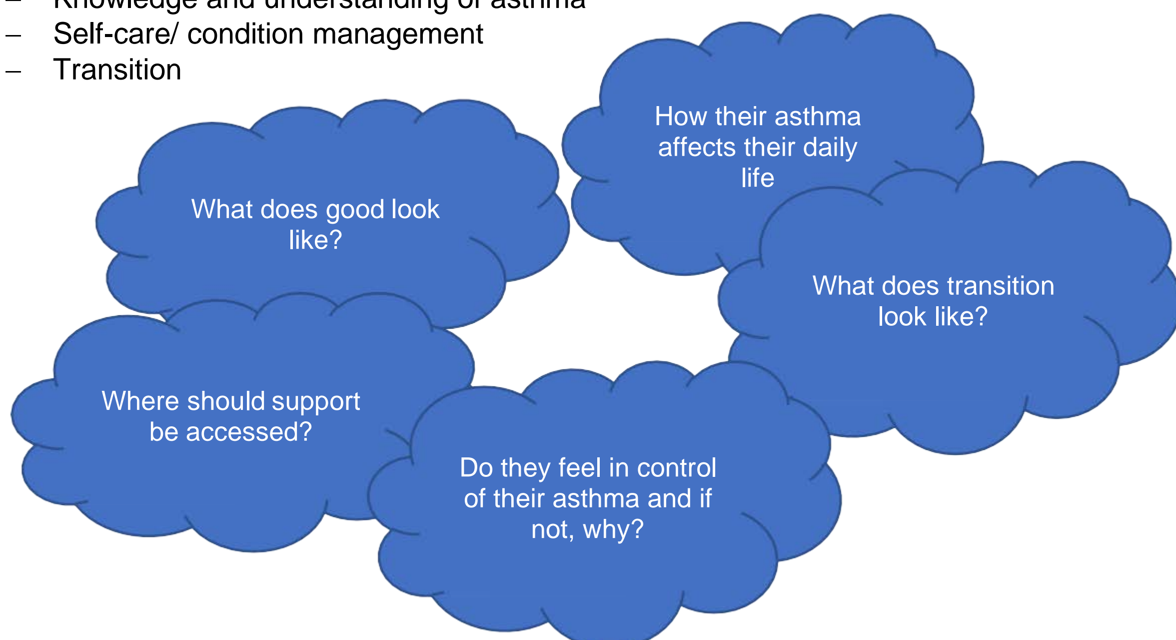
Stuart stated that to ensure that young people have a meaningful voice in service design and development it is always best to start on a footing of co-production, and part of that co-production is that the team understand what the priorities are in health to align with the priorities for young people. It is unhelpful asking young people what they want to change in a service because some suggestions are not always a reality and can't always happen.

Three questions were posed to attendees using Menti.com:

Q1. With regards to asthma, what do you need to know from children young people and why?

Summary themes for responses:

- Children and young people's expressed needs about how/ where asthma care should be delivered
- Impact of asthma on life
- Knowledge and understanding of asthma
- Self-care/ condition management
- Transition



Q2. Do we need to differentiate age groups or target other groups of children and young people? Yes – No – Don't know

A. All 20 respondents answered 'yes'

Q2a. If the answer is 'yes', which is the priority age group you would like to find out the information from? E.g. 0 – 5 years, 5 – 8 years, 8 – 10 years or teenagers, children and young people with SEND, children in care.

Sample of answers

Under 6 years	0-5	Early years
Minority groups	0-5, transition age,	Teenagers
Pre schoolTeenagers	Early years - early identification and intervention	Early years
Under5s	SEND	SEND
Early Years, Primary, Secondary	Tenagers	Differentiate dependant on age and then and additional group of send/lac
5-10	Frequent flyers	0-5yrs 5-10yr 10-16yrs 16-18yrs 18-25yrs
adapt the service in relation to the CYP needs	SENDLAC / Care Leavers	Those with specific LTC

Q3 Stuart also asked people to consider how meaningful engagement with young people impacts on change in relation to their practice stating the reason for these questions is that Youth Focus North West will be recruiting to the Bee Counted group who will be starting their inspections in Autumn 2022, and there will be a focus on asthma.

Shape our service's - lived experience	Improve engagement and outcomes	Location of engagement
inform improvement	Design of services	Can shape service development
Informs the decision They are the service users … their views count Child / young person focus service helps to improve outcomes		

For further information please contact Stuart Dunne at S.Dunne@youthfocusnw.org.uk
Youth Combined Authority https://www.greatermanchester-ca.gov.uk/media/6199/yca-vision-2022-2024.pdf

Alison McGovern GMEC Strategic Clinical Networks Maternity & Children Programme Lead – Greater Manchester Integrated Care System (NHS Greater Manchester Integrated Care): Children's Health Priorities

Alison provided an overview of the Greater Manchester Integrated Care System priorities and explained where asthma was positioned with those.

To explain what constitutes an Integrated Care System, Alison shared a slide from the Kings Fund which provided an outline. Integrated care systems are statutory in England, bringing together three different system levels: **neighbourhoods** which are aggregated up to a place level (previously Clinical Commissioning Groups [CCGs]) and then brought together as a whole **Greater Manchester** system. The Greater Manchester Integrated Care System has an overview of each level, all of which constitute the Integrated Care System (ICS). All ICS areas must have an Integrated Care Board (ICB) and an Integrated Care Partnership (ICP) as of 1st July 2022.

In Greater Manchester, the Integrated Care Partnership operates on three different levels, with 66 neighbourhoods and 10 local Integrated care partnership boards, all of which feed into one integrated care partnership system.

The Integrated Care Partnership brings together our wider partners and our wider commitments for all the population in Greater Manchester including health, social care, public health and education. It is a wide partnership that will set the strategic direction for Greater Manchester. There will be interplay between the Integrated Care Board who will look at the health commitments, and the wider Integrated Care Partnership plan with a view to operationalising it.

Because of devolution, Greater Manchester had already started working in an integrated way back in 2016 and is quite far ahead into the journey of working with partners. There is already governance, networks and connections and relationships established to help support the work of the Integrated Care Board. Currently Greater Manchester has a Health and Wellbeing Executive Board which brings together multiple partners and was originally established to produce a Children's Health and Wellbeing Framework to improve children's health outcomes. Supporting this work are different groups e.g. Children's Community Nursing Teams (CCNTs), and Paediatric Clinical Directors and Heads of Nursing (CDs & HoNs) who all come together to share their learning, challenges and solutions. Through these mechanisms the teams link into the wider GM programmes such as family hubs and the Community Diagnostic Centres. As the ICS evolves there is a need to strengthen relationships across all the different spatial levels in the system and to make sure that there are strong connections between system, place, and neighbourhood so that all are working towards the same priorities and that there is a flow of information in both directions ensuring that all are doing what needs to be done at all the different levels.

In 2018/2019 the GM Health and Social Care Partnership developed the Children's Health and Wellbeing Framework which had 10 objectives that the Partnership wanted to deliver. The following year Greater Manchester Combined Authority developed its own children's plan which had touch points with the Framework - however there was not one integrated plan. Over the past few months the ICS and the GMCA have come together to refresh both documents into one to see where they can be harmonised and also to look at where we are now in terms of the opportunities that GM has as the devolved system has matured. These cover the impact that COVID has had on services and the population, and in also listening on what our young people and families want from a GM health offer. This work has identified 6 priority areas for the GM Children and Young People's Plan:

1. Early Help: with a focus on family help, family hubs, speech and language, obesity/ healthy eating, asthma and transition from year 6 to year 7.
2. Mental health and wellbeing
3. Looked After Children (LAC) sufficiency
4. Educational attainment and attendance
5. Recruitment and retention of staff
6. Adolescents

Asthma sits within early help but also within educational attainment. If there are well managed healthy children, they will have a higher school attendance because they are not absent from school with ill health.

The GM Children's Plan priorities feed down into the health priorities which have been influenced by what children, young people and families have expressed as important to them but also what data tells us about inequalities in health outcomes, which have been exacerbated by the COVID pandemic.

Alison stated that the Children's Health Priorities for 2022/23 echoed what is in the GM Children's Plan, highlighting the inclusion of Long-term Conditions management and the prevention of avoidable hospital admissions (asthma, epilepsy and diabetes). Stating: "This is a work in progress." Alison concluded by acknowledging the distance travelled in terms of devolution which is very much attributed to the relationships and networks that have been developed.

> I'd be really keen to see what you have developed with housing Alison as I know this is something that ICS are finding challenging. I know Ian Sinha is developing a policy, is that the one you're referring to?

Afia Ali, Children's Project Manager, GMEC SCN – Children and Young People: Asthma in Greater Manchester

Afia set the scene by talking about what we know about children's asthma for Greater Manchester stating that for children aged 0-19, asthma admissions in Greater Manchester are persistently higher than in Cheshire and Merseyside, and Lancashire and South Cumbria Integrated Care Systems.

Data from the Office for Health Improvement and Disparities (OHID) in 2020 to 2021 showed the rate of admissions for Greater Manchester to be 133.8 per 100,000, which is almost twice the national average, with the highest rates of admission being in the 5-9 and 10-14 age groups.

Asthma is clearly linked to deprivation, with the North West of England being the second most deprived region in England. There are significant health inequalities in asthma outcomes, directly linked to deprivation. For people living in the most deprived areas of Greater Manchester, the rate of admission for asthma was 2.4 times higher than for those living in the least deprived areas. Additionally, child poverty rates in Greater Manchester are much higher than the national average.

Factors influencing asthma admissions include air pollution, low-income families living in poor quality housing, high smoking rates and lack of asthma education.

Following the launch of the National Bundle of Care for Asthma, a Greater Manchester Children and Young People's Asthma Network was established to address these issues. The network has representatives from health, education, housing, population health as well as parent/ carer and children and young people voice representation. A clinical advisor for Children's Asthma was also appointed. The group identified a number of priorities to address during 2022/23 and beyond.

Priorities include implementation of an asthma friendly schools pilot programme and an asthma peer mentor programme which will identify and train asthma champions (young people). Evidence shows that connection with peers strengthens knowledge, confidence and enables them to share stories and experiences of their condition. The Greater Manchester Asthma app has been piloted and is currently in evaluation phase with a view to being rolled out widely across Greater Manchester in the next phase which will be a national pilot, to be launched in September this year.

As a further version of the app is developed, users will be able to order repeat prescriptions, set reminders to use their medication, access training videos and have access to the Personal Asthma Action Plan on their phone.

All of these priorities are key, love the idea of YP champions, and the app. Could the training be extended to parents as well as resources?

Other priorities include developing a specification for Asthma Diagnostic Hubs with recommendations for inclusion in Community Diagnostic Centres, review of existing clinical standards and pathways to bring them up to date with developments that have happened recently such as use of virtual consultations and technology, and review of the education and training standards framework against existing training that is available in Greater Manchester. Addressing housing issues in relation to asthma is a priority and a task and finish group has been working with social housing landlords to look at how poor-quality housing issues affect children's asthma and to develop escalation policies for housing providers. Additionally, the network is looking to develop stop smoking resources aimed at children, young people and their families. Work will be co-produced with children, young people, and families.

Could you please let me know about all the various networks so that I can get representation from our teams?

https://www.england.nhs.uk/north-west/gmec-clinical-networks/our-networks/

Michael Hargreaves, Transformation Programme Manager for Manchester Local Care organisation – Asthma Friendly Schools Pilot

Michael provided some background and an overview of the Asthma Friendly Schools programme which is being piloted in Manchester. The pilot is funded from NHSE Children's Transformation funding and an expression of interest was submitted jointly by Manchester University Hospitals NHS Foundation Trust and the Manchester Local Care Organisation, to deliver over a period of 18 months. It is based on Asthma Friendly Schools programme, developed by Islington CCG and Healthy London Partnership with an overall aim of improving outcomes for children with chronic asthma and enabling schools to achieve recognition and meet agreed standards for asthma.

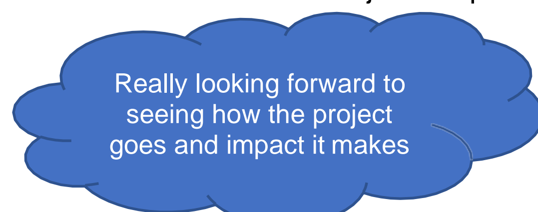
This project is in its developmental stage and funding will provide a Band 7 specialist asthma nurse and administrative support who will work directly with six schools- five primary and one secondary school as a minimum, to deliver asthma education and training.

Asthma champions will be identified within schools and participating schools will be supported to develop and embed best practice. The project will work with schools to develop a system for identifying asthma-related school absence so that resources and responses can be targeted appropriately. The project will also develop an accreditation scheme for Asthma Friendly Schools.

The expression of interest was developed with engagement from and collaboration with clinical and managerial leads, with sign off from Manchester City Education and Public Health colleagues. This engagement with the wider system is supportive of the data requirements for the project, and also provides the necessary expertise which includes project management from the Royal Manchester Children's Hospital, Manchester Health and Care Commissioning clinical leadership, pharmacy input, head of Children's Community Nursing Team and asthma team leader, and informatics input.

A working group was established, and project plan developed. One task was to recruit to the two roles (B7 specialist nurse and administrative), and whilst that was ongoing, data analysis was undertaken to identify potential schools for participation in the pilot.

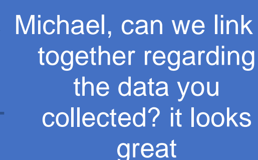
Data analysts from the Royal Manchester Children's Hospital and Manchester City Education reviewed all schools in Manchester, looking at number of pupils, demographics, attendance, admission profiles, and school attendance over the previous two years. Informatics colleagues were able to present A&E attendances and hospital admissions for asthma for each school, and by identifying those with higher attendances and admissions, they were able to long-list schools for potential involvement in the project. Manchester City Education further reviewed the identified schools, considering local intelligence and readiness of the schools to join the pilot at this time.



The Band 7 role has required NHS job evaluation prior to advertising, which takes time. If the role is appointed to internally, there will be back-fill to cover the secondment of the appointee.

The working group plans to appoint to the roles and identify the schools over the summer, and then look to include patient and education representation on the group, to ensure true co-production.

Comments in the chat indicated that there was a real interest in the pilot, particularly about co-production with children and young people, and about how the data had been used to identify the schools. Michael confirmed that the data showed there to be a mix of many individual children presenting at A&E/ being admitted, and also a smaller number of children with many presentations. Michael stated that NHS numbers were linked through Manchester's Child Health Information Service to the schools, enabling this kind of analysis.



Contact details for Manchester's Asthma Friendly Schools pilot:
Project management - michael.hargreaves@mft.nhs.uk
Nursing related queries - lead is Sarah Clayhills (Head of Service, CCN Acute) - sarah.clayhills@mft.nhs.uk

Carol thanked Michael and all the speakers before moving into workshops for further discussion.

Workshop Summaries

The second part of the stakeholder event consisted of facilitated workshops whereby attendees were placed randomly into virtual rooms to discuss questions pertaining to Community Diagnostic Centres (CDCs)/ Asthma Diagnostic Hubs, asthma prevention through a connected approach, and connecting care in Greater Manchester. A table of responses can be found at **Appendix 2.**

Workshop 1: Community Diagnostic Centres (CDCs)/Asthma Diagnostic Hubs

Attendees discussed the opportunities for input at design phase as these are in their infancy, stating that there should be children-focused hubs, rather than all-age, and that under-5s provision is lacking. Examples were given of current practice in various localities that would benefit or be benefited by the implementation of hubs.

Workshop 2: Asthma prevention through a connected response

Attendees stated that in planning, there should be consideration for hours of services for children who are in school. The potential to increase health inequalities was noted due to CDCs only being available in three (at the time of the event) areas in Greater Manchester. There was discussion about priority-setting within the Integrated Care Board, but also at locality level, and how children and young people could contribute to the developments.

Workshop 3: Connecting Care in Greater Manchester

Many opportunities were identified for connecting care related to the culture of collaborative working and integration in Greater Manchester, and an ability to focus on prevention. With regards to whom people should be connecting with, responses included various healthcare settings and disciplines, particularly within primary care, the voluntary, community and social enterprise sector (VCSE), and the education sector. At a system level, people felt there was a need to connect with housing and mental health. Challenges were identified as capacity within the system, understanding the new system and winter pressures.

Actions were suggested within each workshop and these have been incorporated into the action plan below.

Event Close

Dr Ewing closed the event by thanking all the speakers, in particularly our parent carer for giving us such clear insight into her lived experiences and what needed to change to improve her son's care. She also thanked all participants for their responses to questions, contributions to workshops and through their interactions, questions and responses in the chat – all will be used to develop a document reflecting the event and with an action plan.

Next Steps

An action plan will be developed incorporating themes and suggestions from the event, which will be presented to the Greater Manchester Children's Health and Wellbeing Executive Board for endorsement. The plan will aim to contribute to improvement in asthma outcomes for Children and Young People and use the outputs of the event to progress integration and move to a preventative and early intervention model. The report from the event will be shared with other relevant Boards which have a responsibility for child health and wellbeing.

Presentations from the event will be used in conjunction with the Integrated Care System framework to support spatial planning for localities, with an ambition to develop a Greater Manchester **Connecting Care for Children (CC4C)** model, applying the CC4C logic model. This ambition will be realised by working in conjunction with Dr Mando Watson, Clinical Lead for CC4C and colleagues.

The role of primary care and the interface between primary and secondary care will be developed further in collaboration with Primary Care Networks, Local Authorities, neighbourhoods, VCSE and CYP parent carer voice. Consideration will be given to the opportunities for integrating care with emerging family hubs, and to input into the development of specifications for Community Diagnostic Centres.

Reflecting on Mando's presentation, existing enablers will be key to the development of this integrated approach and to determining if it is making a difference i.e. professional leadership, innovation, lived experience and data.

There is a strong emphasis on Improving wider collaboration and connections in our GM ICS and in particular working with transport and housing, also sharing good practice regionally and nationally 2 ways. Some of this work has already begun through the GM Asthma Network and will be strengthened by the inclusion of Asthma as a priority in the Greater Manchester Children's Plan.

Co-production with CYP and families is also a priority for healthy and care services and in the GM Children's plan, and it is important that this is embedded routinely into service developments and practice. We will continue to work with our partners Youth Focus North West, the North west Parent Carer forum, and other CYP, parent and carer groups throughout Greater Manchester to improve health outcomes through integrated care for Children and young People.

It is clear that this work will need sufficient resource including workforce capacity, leadership and sponsorship to progress, so it is recommended that this work becomes a priority for the GM Integrated Care Board (ICB) and Children and Young People's Transformation Programme in Greater Manchester, and that a working group is established to deliver it.

Recommendations

1. Children's Health and Wellbeing Executive Board should endorse the ambition to develop a Greater Manchester model for Connecting Care for Children and include in its Children and Young People's Transformation Programme.
2. This report should be socialised widely, and recommendations and actions incorporated into GM System wide, organisational, neighbourhood and locality plans for Children and Young People.
3. The development of family hubs led by Greater Manchester Combined Authority and in conjunction with the 10 Greater Manchester Local Authorities and the Office for Health Improvement and Disparities, should consider how they can contribute to improved outcomes for asthma for children and young people.
4. All areas should review the priorities in the Greater Manchester COVID Recovery Plan, with consideration given to how improvement in asthma outcomes can be included within locality recovery plans.
5. Enablers such as Parent/ Carer and Children and Young People's Voice, data, leadership and innovation should be incorporated into all plans for integrated care for children and young people.
6. In developing plans to improve asthma outcomes for Children and Young People, Greater Manchester's spatial framework model should be applied.

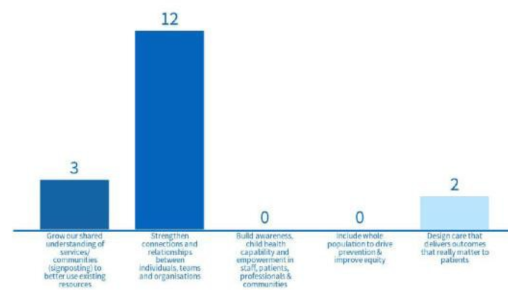
Suggested Actions

	Action	Owner
STRATEGIC		
1.	Presentation of the report recommendations and actions to GM Children's Health and Wellbeing Executive Board for endorsement and inclusion in CYP transformation programme for GM.	
2.	Adoption and endorsement of recommendations at locality and organisational level for inclusion in local and organisational plans and commissioning intentions.	
3.	Development of locality improvement plans for asthma in response to priorities set out in the GM Children's Plan, the national Bundle of Care for CYP Asthma and the GM Asthma Programme.	
4.	CYP, Parent and Carer voice to be included and embedded at all levels of the GM spatial framework for CYP physical health, including asthma.	
5.	Gap analysis/ scoping exercise to determine gaps in integrated working e.g. with primary care.	
6.	All primary and secondary care strategic and operational plans to include plans for Primary/ Secondary Care interface and integration.	
7.	Consideration of a strategy to mitigate the potential for exacerbating heath inequalities in those areas that do not have Community Diagnostic Hubs.	
OPERATIONAL		
7.	Establishment of a GM working group to develop the GM CC4C model.	
8.	Development of a model GM CYP asthma specification for Community Diagnostic Centres (CDCs) with associated resource implications, costing and business case for implementation.	

8.	Equalities and Health Inequalities Impact Assessments for Community Diagnostic Centres to identify potential inequalities of access and care that may arise for those patients in areas without CDCs.	
8.	Development of cross-organisational referral forms for CYP with asthma e.g. from health to housing providers.	
9.	Invitation to share learning and good practice across GM through the GM Asthma Network.	
10.	Adoption of data methods from Manchester Asthma Friendly Schools pilot across localities to better understand and determine a targeted approach to CYP asthma-related school absence.	
11.	Adoption at scale of recommendations from Asthma Friendly Schools pilot.	

Appendix 1: Full list of responses to questions

The logic behind the model (primary drivers) - what are you doing well?



Name a local professional role who might embrace this opportunity?

Have you a relevant outcome measure for 'better quality of care'?

friends and family	Patient experience	Patient feedback
Friends and family test	PROMS	Friends and family trst
Patient journey case studies	Improved patient journey	Reduced hospital admissions

Have you a relevant outcome measure for 'better quality of care'?

- Friends and family
- focus groupsfriends and family
- Hospital readmissionS
- Reduced attendances to A&E
- Improved school attendance
- Whole family approach
- Reduction in admissions and inpatients

Have you a relevant outcome measure for 'better population health'?

- smoking prevalence
- asthma rates
- School absence
- Reduction in YP smoking
- Reduced hospital attendances/shorter hospital stays
- Increase in physical activity
- School attainment
- Reduced attendance at unscheduled care with acute respiratory illness
- school days missed due to illness

Have you a relevant outcome measure for 'better population health'?

- School attendance
- CYP surveys
- Reduction in parental smoking
- Hospital redamissions
- Reduced school days missed
- unplanned hospital attendance
- Unplanned hospital admissions
- SATOD
- Better housing/environment

Have you a relevant outcome measure for 'better population health'?

- Better LTC management
- Hospital attendances
- Reduction in obesity
- Better understanding of medication prescribed
- Number of bed days per admission
- Improved inhaler technique/education, less admissions
- Reduction in prescription

Have you a relevant outcome measure for 'reduced per capita costs'?

- Reduction in haspital admissions/readmisions
- Reduction in cyp Ed attendances and admissions
- Sustained employment
- A & E attendance
- Reduced A&E attendance
- no. of frequent flyers
- Improved standards of living
- Reduction outpatient clinic appointments
- Reduced emergency attendance/admissions

Have you a relevant outcome measure for 'reduced per capita costs'?

- Reduce gp referals
- Improved access to advice and guidance
- Nhs staff survey
- sickness absence rates
- Reduce medicines cost
- Staff survey
- retention

Have you a relevant outcome measure for 'better staff experiences'?

Retention of staff	Staff survey	Improved retention
Staff survey	Reduced sickness abscence	Improved sickness levels
Nhs staff survey	Management supervision	Improved well-being

Have you a relevant outcome measure for 'better staff experiences'?

sickness absence	Staff knowledge increased	retention
Improved recruitment figures	Improved mental health	Reduction in Sickness and absence due to work related stress
Staff satisfaction survey	Improved physical activity	Relationships with colleagues

Have you a relevant outcome measure for 'better staff experiences'?

Retention of staff	Collaborative approach across the system	Access to education and training
Work with and empower families to be confident in managing asthma	Improved diagnosis	Diagnostic hubs to include services for C&YP

Is there anything to add with respect to improving asthma outcomes?

NHS England

- We need to do now
- wider determinants measures
- Better educated primary care staff
- Need more capacity at operational level to deliver
- Standardised templates leaflets etc
- Let's think creatively working with our CYP and families eg filming cyp telling their lives experiences
- MDT involved Pts public involvement
- Improve access to primary care appointments
- what are the touch-points for CYP with asthma?

Is there anything to add with respect to improving asthma outcomes?

NHS England

- Work with and empower families to be confident in managing asthma
- Improved awareness in schools and settings
- Diagnostic hubs to include investigations for C&YP
- Collaborative approach

NHS England

CYP Voice - Stuart Dunne

With regards to asthma, what do you need to know from children and young people and why?

- What does good look like?
- What affects their life and what can we do as professionals to make a difference
- What do they need?What can we do to help
- what makes a difference to them - what is important in the service offer, what changes would they like eg outcome measures
- Where should support be accessed ?
- What do they know about asthma?
- How their asthma affects their daily life
- How and where would you like to receive your care
- What matters to them

With regards to asthma, what do you need to know from children and young people and why?

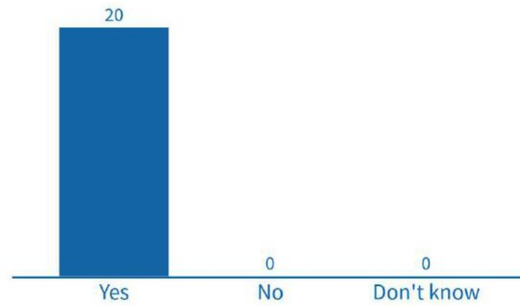
- Why they don't always comply with meds, what can we do to change that
- Does the CYP understand their asthma and triggers. Are they confident managing it
- What a day in their life feels like and how it impacts
- How it directly affects their quality of life
- Transition look like
- Where do you want clinics to be
- What would they like from us?
- What would help them to understand asthma?
- What is important to them

With regards to asthma, what do you need to know from children and young people and why?

- What support do they need
- Do they feel in control of their asthma and if not why
- Yes
- And what does good feel like?
- Yes
- 0-5 Years
- What would make the biggest difference
- Wha t are their asthma symptoms , how do they feel ? What helps ? We're do they want to access services ?

Do we need to differentiate age groups or target other groups of children and young people?

NHS England



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If so who?

NHS England

Under 6 years	0-5	Early years
Minority groups	0-5, transition age,	Teenagers
Pre schoolTeenagers	Early years - early identification and intervention	Early years

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If so who?

NHS England

Under5s	SEND	SEND
Early Years, Primary, Secondary	Tenagers	Differentiate dependant on age and then and additional group of send/lac
5-10	Frequent flyers	0-5yrs 5-10yr 10-16yrs 16-18yrs 18-25yrs

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If so who?

How will the views of children and young people impact on practice?

Appendix 2: Workshop Summaries

The second part of the stakeholder event consisted of facilitated workshops whereby attendees were placed randomly into virtual rooms to discuss questions pertaining to Community Diagnostic Centres (CDCs)/ Asthma Diagnostic Hubs, asthma prevention through a connected approach, and connecting care in Greater Manchester.

Community Diagnostic Centres/ Asthma Diagnostic Hubs

What are the opportunities in NHS GM? (these have been themed)	
Design	• CDCs are in their infancy currently so an opportunity to have CYP in the design at the beginning rather than as a bolt on to an adult service at a later date

	• Children's focused hubs rather than mixed or adults. Children have their own needs and requirements. Practitioners who are used to working with children would be invaluable in the hubs • Hospital staff going into community to perform diagnostic tests to support primary care WF • Under 5s provision really lacking
Redesign	• One stop service currently in Bolton using spirometry and diagnostics to filter out referrals who need diagnosis. Filters back to respiratory nursing team if required. • Also use assistant practitioner who runs a FeNO clinic and feeds back to respiratory nursing team the results • Oldham – consultant who does FeNO and spirometry but would be better to have in community rather than needing secondary care referral for diagnostics
Who should we be connecting with and how?	
Health care	• GPs – secondary care connecting to GPs to try to prevent admissions to secondary care (Oldham). • School nurses and schools to look at poor attendance • Locality chief nurses to support priority in localities • CCNTs – awareness of those children who are frequent presenters
Parents/ Carers/ CYP	• Parents / CYP who have been through the system re accessibility
What are the quick wins and the longer-term actions, and how do we achieve them?	
Longer-term	
Quick wins	• Baseline current offer • Draft business cases / standard spec • Sharing good learning across localities • housing referrals templates from paediatrics/GP's to Housing
How?	
What are the difficulties anticipated and how do we plan for them?	
Difficulties	**Planning for them**
Process for accessing them	If its Mon-Fri children are in school, need to be after school and weekend appointments
Inadvertently increase inequalities as only 3 (CDCs) in GM	

Asthma prevention through a connected approach

What are the opportunities in NHS GM? (these have been themed)	
Priorities	• Set a strategic direction- what is being agreed within ICB • How do we get partners to take responsibility for delivery? • How do we set the priority within the locality?- there are priorities coming from all over. Need to get the same messages . Needs to be system priority. • Priorities set through provider collaborative. • Involve CYP- what are their issues. Feed their stories in. Decision-makers. • Neighbourhood v locality v ICP-level

Collaboration/ integration	• Bring secondary and primary care together. • Involve CYP- what are their issues. Feed their stories in. Decision-makers.
Blockers/ solutions	• Unblocking- do we need to do anything to bring primary/ secondary care together?
Delivery/ operationalising	• Asthma network mirrored at locality level. CYP focus group- what do they need/ want? • Early help workers.
Enablers	• Use the data
Who should we be connecting with and how?	
Organisations	• Other agencies – housing (local authority/private) • Pop Health
Parents/ Carers/ CYP	• The young people – use their stories to feed back into the wider team
Roles	• Early Help workers
Places	• Gyms, sports venues, sports clubs, • Family hubs
What are the quick wins and the longer-term actions, and how do we achieve them?	
Longer-term	• Engagement with pop health
Quick wins	• Localities • current initiatives • share evaluation and learn from them • co-production at a number of levels
How?	• Use the data, learn from it, getting the data in a different way (as per AFS pilot)
What are the difficulties anticipated and how do we plan for them?	
Difficulties	**Planning for them**
System-wide change	Engagement
Pressure on people's time	Needs to be seen as part of the 'day job'
If systems aren't user-friendly	

Connecting care in Greater Manchester

What are the opportunities in NHS GM? (these have been themed)	
GM culture	• History of collaborating – keep doing what we do well
Collaboration/ integration	• Shared learning/experiences – we are not all working in isolation – working to same outcomes • Opens up conversation with PCNs – get GPs on board
Inequalities and Inequity	• Opportunity of levelling up – no matter where a child attends receives the same care
Leadership and strategy	• During this time of change – gives us an opportunity/spotlight to ensure priorities are met • Happy that CYP SRO will be present at ICB level

<table>
<tr><td></td><td>Family hubs can ensure CYP are centre as previously more of an adult focus</td></tr>
<tr><td>Prevention</td><td>Able to focus on preventative measures</td></tr>
<tr><td colspan="2">Who should we be connecting with and how?</td></tr>
<tr><td>Organisations</td><td>PCNs (everyone GPs, practice nurses & Managers)
Are there PCN leads for children?
Connecting with OHID (old PHE)
VCSE sector: CYP voice, Carer voice, services that they provide
Schools & colleges
Wider health services</td></tr>
<tr><td>System</td><td>Mental health
Housing
Health & Wellbeing board</td></tr>
<tr><td>Places</td><td>Family hubs – need consistency</td></tr>
<tr><td colspan="2">What are the quick wins and the longer-term actions, and how do we achieve them?</td></tr>
<tr><td>Longer-term</td><td>Longer term actions: Improvement plan for Asthma</td></tr>
<tr><td>Quick wins</td><td>Good networks already – build on them
Utilise regional functions and others within system
Action plan from this workshop to inform all relevant parts of the system</td></tr>
<tr><td>How?</td><td></td></tr>
<tr><td colspan="2">What are the difficulties anticipated and how do we plan for them?</td></tr>
<tr><td>Difficulties</td><td>Planning for them</td></tr>
<tr><td>Capacity within the system</td><td>Making sure we have consistent clinical leadership</td></tr>
<tr><td>Winter pressures</td><td>Time & resources for effective co-production</td></tr>
<tr><td>Challenges with new system/new positions – continue to inform and influence – CYP</td><td>How do we get the most out of other connections within the system?</td></tr>
<tr><td>Not to lose sight of each locality’s uniqueness</td><td></td></tr>
</table>

Appendix 3: Attendees

Afia	Ali	Project Manager	Greater Manchester Health and Social Care Partnership	afia.ali@nhs.net
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