NHS
Greater Manchester and Eastern Cheshire
Strategic Clinical Networks

Impact Report 2022 - 2023

The difference we have made to the health and care of people living and working in Greater Manchester and Eastern Cheshire.

Part of Greater Manchester Integrated Care Partnership

If you would like help understanding this report, or need it in a different format or language please contact us at england.gmec-scn@nhs.net

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Foreword

Welcome to our impact report for 2022/2023. This is our chance to look back at the accomplishments of our eight strategic clinical networks and to reflect on the difference we've made for people living and working in Greater Manchester and Eastern Cheshire.

Celebrating our highlights in no way diminishes the many challenges of the past year, including COVID-19, winter pressures and supporting colleagues through periods of industrial action. This year has also seen a huge change within the health and care system with the creation of the Greater Manchester Integrated Care Board and NHS Greater Manchester.

We are incredibly proud of our clinicians and care professionals, support team and wider network members for continuing to drive forward positive change during these challenging times. It is important that we take a moment to remind ourselves that we are making a difference, whatever difficulties we face.

This is a very special year for us as we celebrate our 10 year anniversary. For a decade now, we have been taking steps to achieve our vision of making health and care in the region comparable with the best in the world, and this report shows our commitment to this is as strong as ever.

Over the past 12 months, we have established new services to support people awaiting cardiac surgery, improved access to diabetes technology for children, young people and pregnant people, delivered training to our workforce and introduced an electronic system to coordinate end of life care to name but a few. You'll see that addressing health inequalities is the golden thread throughout our work.

Thank you for showing an interest in our clinical networks, we hope you enjoy the read. Please do get in touch if you are interested in any of our work.

Julie Cheetham, Director

Dr Peter Elton, Clinical Director

Who are we?

We are a collection of eight clinical networks led by local clinicians and care professionals. We have a proven track record of leading successful improvements in the region and we are now part of Professor Manisha Kumar, Chief Medical Officer's team within NHS Greater Manchester Integrated Care.

Our vision is for the health and wellbeing of local people and the care they receive to be comparable with the best in the world. Through the development of guidelines, policy, strategy and pathway changes, we work to:

- Create opportunities for collaboration
- Improve the quality of services across the region
- Improve health and wellbeing outcomes
- Address unwarranted variations in care

Who are we?

Our team of dedicated clinicians and care professionals are supported by a core team who facilitate the networks and ensure that initiatives are delivered successfully. Our core team provides:

- Programme management
- Quality improvement expertise
- Business intelligence
- Event management
- Project management
- Business management
- Network management
- Communication and engagement

Thank you to our core team for the support you have provided to the Networks, our clinicians and care professionals this year.

The qualities that make us unique:

Each network is led by clinicians who work in local services. Change is embraced and embedded as a result of their leadership.

Our core team have years of experience in health and care. They are experts in quality improvement and pathway redesign work.

Relationships are important to us. We work with people from across health and care, local people, carers and the voluntary sector.

We offer an independent clinical voice within the system. We recommend change that will improve the lives of local people, carers and staff using our honest broker approach.


YOUR
HEART
MATTERS

Engagement events

Building strong relationships with people living and working across Greater Manchester and Eastern Cheshire is an essential part of what we do. We organise regular events to bring people together and it has been fantastic to get back to more face to face events this year.

It should be noted that the numbers provided below will not cover absolutely everything that has happened within the clinical networks this year.

31 Total numbers of events held this year, with over...

2,300 individual attendees

Of the total number of events....

17 were held virtually

12 were held face to face

2 were hybrid

What were our events about?

- Build Back Fairer in Greater Manchester
- Cardiovascular disease prevention
- Clinical & Care Professional Leadership
- Asthma support for children and young people
- Free heart checks
- Dementia
- Maternity Equity and Equality Action Plan
- Promoting health weight in early years
- Addressing health inequalities in children & young people services (Core20PLUS5)
- Palliative and end of life care
- Low calorie diet service
- Reducing pre-term births
- Prevention and management of still births

You will read about some of these events in the individual network highlight pages.

Event pictures featured on page 5, from top left to bottom right:

- 'Your Heart Matters' bus
- Stroke and Neurorehabilitation Conference
- Palliative and End of Life Care Educators Event
- Children and young person health and wellbeing forum
- Clinical Leads and Associates workshop

Children and Young People Network

"A highlight for me this year was chairing our Stakeholder Forum in February where we were joined by over 130 colleagues to consider how we can address health inequalities and give our children and young people the best possible start in life.

The engagement and participation across a wide community from health, education, social care and the voluntary sector, and by using the lived experiences of children and young people is an essential part of our work.

Addressing health inequalities will continue to be the key thread as we work together to influence and steer the evolving plans and programmes for children and young people across the Greater Manchester Integrated Care Partnership to improve our services and meet the needs of our children, young people and families in ways that matter to them."

Dr Carol Ewing, Clinical Advisor

712,872
people aged 0 - 18 years of age living in Greater Manchester

2.822 million
total Greater Manchester population
source: ONS, 2019

approximately **34%**
of the total Greater Manchester population are aged 0 - 24 years

953,888
peopled aged 0 - 24 years of age living in Greater Manchester

420 0 - 19 years
577 0 - 24 years
Attendances at the Emergency Department due to Diabetes (Jan 22 - Jan 23)

6482 0 - 19 years
6950 0 - 24 years
Attendances at the Emergency Department due to Asthma (Jan 22 - Jan 23)

47%
of children and young people in Greater Manchester live in the most deprived quintile of the population

392 0 - 19 years
521 0 - 24 years
Emergency admissions to hospital due to Diabetes (Jan 22 - Jan 23)

1346 0 - 19 years
1509 0 - 24 years
Emergency admissions to hospital due to asthma (Jan 22 - Jan 23)

Source: GM Tableau

Addressing health inequalities

Health inequalities are increasing for children and young people, and this can have a lasting impact on their whole life.

The Core20PLUS5 framework, an approach to addressing health inequalities, was the topic at our Stakeholder Forum in February 2023.

Over **130** colleagues heard about inequalities that children and young people experience in access to health care and poorer outcomes, with respect to asthma, diabetes, epilepsy, oral and mental health

We considered how we can address health inequalities, for example by 'poverty proofing' pathways.

Following the event, the GM population health team in conjunction with the GM Business Intelligence team has used the report from the data workshop to inform the development of a health inequalities data dashboard.

Access to diabetes technology

Continuous glucose monitoring and insulin pumps enable people to manage their diabetes and have a better quality of life.

Data showed us that in Salford, Bury, Rochdale and Oldham there were inequalities in access to technology, particularly for those living in the most deprived areas and from ethnic minority groups.

Working with clinicians from the Northern Care Alliance NHS Foundation Trust we successfully bid for **£79,680** funding to try different approaches.

Resources were translated into different languages, evening and weekend clinics held and awareness sessions organised in local communities. We supported families from deprived areas with travel expenses to get to clinics.

Between January and March 2023, **34** children in Salford and **23** children in the Bury, Rochdale and Oldham service started on continuous glucose monitoring and pumps.

Asthma app

Improving asthma care is a key priority. In June 2022 we evaluated the pilot of our Asthma app, designed to support children and young people to better manage asthma.

Users of the app reported a high degree of usability and most interacted with it at least once a week. **78%** of users said that they agreed or strongly agreed that it increased their awareness of asthma medication and their confidence. **29%** reported having fewer asthma attacks.

Due to the success of the pilot, we will now move to the second phase which will allow the asthma app to link with Greater Manchester Care Record.

Asthma Friendly School Pilot

Children and young people must be supported to effectively manage their asthma at school.

Using data, we were able to identify schools whose pupils had high rates of asthma attendances and admissions to hospital.

Five primary schools and one secondary school are currently participating in Asthma Friendly Schools pilot. The schools have registered all pupils with asthma, developed a management plan, have a named person responsible for asthma and have put appropriate policies in place. Training was given to staff to increase knowledge and confidence.

Work on this will continue with our aim to standardise asthma care within all educational settings across Greater Manchester.

Improving maternity and neonatal services in Greater Manchester

Local maternity and neonatal system

The Local Maternity and Neonatal System (LMNS) was established to support maternity units to achieve more personalised, safer care. The LMNS is made up of people involved with providing, receiving or commissioning maternity and neonatal care. Our Maternity Network is a stakeholder of the LMNS.

LMNS
Greater Manchester and Eastern Cheshire
Local Maternity and Neonatal System

System board governance

The LMNS has supported the Greater Manchester Integrated Care Board in establishing a Greater Manchester Maternity System Board. The Board will provide oversight of maternity quality surveillance, planning, delivery and improvement of maternity services, supporting the Integrated Care Board with their responsibilities in maternity care.

Workforce

The LMNS launched an ambitious programme to reduce maternity workforce vacancy rates and to grow and support our existing staff. A programme of International Recruitment has commenced with recruits beginning to arrive in the country and undertake their training and examinations.

The LMNS commissioned a review of midwife numbers to support maternity providers with their individual workforce planning. At the end of March 2023, **20** midwives have been recruited from overseas with a further **38** to be recruited in wave 2, by the end of December 2023.

Equity and Equality Action Plan 2022 - 2027

It is safer than ever to have a baby in England. However, in Greater Manchester and Eastern Cheshire, some of our maternity outcome measures are not where we need them to be. Some measures, including stillbirth rates have increased during the pandemic and we are yet to see them return to pre-pandemic levels or match national averages.

In September 2021, national guidance was produced, directing all LMNSs to undertake a programme of work to improve equity and equality within maternity services and consider those wider determinants of health that impact on a pregnancy long before it begins.

The LMNS started working with stakeholders and has co-designed an Equity and Equality Action Plan that describes the steps to be taken by the end of 2027 to address gaps and improve outcomes for those most in need. The Greater Manchester Maternity System Board will oversee the delivery of this action plan.

Maternity Network

"Equity means that all mothers and babies will achieve health outcomes that are as good as the groups with the best health outcomes.

To achieve this, maternity and neonatal services need to respond to each person's unique health and social situation, with increasing support as health inequalities increase, so that care is safe and personal for all.

I am really proud of the incredible work of our Maternity Network and the wider Local Maternity and Neonatal Systems (LMNS) including our Maternity Voices Partnerships and voluntary sector colleagues.

We are working together to improve equity and equality that will help to ensure that Greater Manchester is the safest place to be pregnant, give birth and start parenthood."

Dr Akila Anbazhagan, Eileen Stringer and Dr Ghazia Saleemi,
Clinical Leads

34,945
births in Greater Manchester in 2022

49.9%
of the births in 2022 were vaginal deliveries

38.8%
of the births in 2022 were caesarean sections

153
babies in Greater Manchester were born sleeping in 2022
(stillbirth)

77
babies in Greater Manchester died shortly after being born
(early neonatal deaths)

3,528
Pre-term babies were born in Greater Manchester in 2022
(before 37 weeks)

66.1%
of women started breastfeeding
(2021 data)

282
successful planned home births in Greater Manchester in 2022

We will always remember the babies lost in pregnancy and those born sleeping.

Source: GMEC SCN Maternity Dashboard, 2022

Continuous glucose monitoring

People with type 1 diabetes can have a healthy pregnancy, but managing diabetes may be harder. Continuous glucose monitoring has the potential to reduce the risks and complications associated with diabetes in pregnancy.

This year was the second and final year of national transformation funding to embed the offer of continuous glucose monitoring for pregnant women with type 1 diabetes.

Work with our diabetes and maternity providers has resulted in over **100** women taking up the offer of continuous glucose monitoring this year.

To help evidence the impact of transformation funding and support the case for sustainability of local commissioning arrangements, a national peer review audit is underway of the continuous glucose monitoring in pregnancy programme.

Saving Babies Lives Care Bundle

There are over 3,000 still births in the UK every year. The Saving Babies Lives Care Bundle is part of a drive to halve the rates of still births by bringing together five elements of care that are widely recognised as best practice.

We have undertaken several quality improvement initiatives to address the implementation of each element. We have:

- facilitated and supported champions within each maternity provider.
- funded additional midwives to undertake the 3rd trimester ultrasound training.
- commissioned a uterine artery doppler study day (a test to check the blood flow of the uterine arteries which can help inform if a baby will grow to its full potential).
- developed an Antenatal Fetal Monitoring Guideline with associated training and competency for staff
- commissioned the roll out of training of Intelligent Intermittent Auscultation, which works by helping midwives to link knowledge of fetal physiology to intermittent auscultation.
- held a study day for Perinatal Loss and Preterm Birth in March 2023.
- undertaken preterm birth sites, gap analysis and developed reports to help units.

Each Baby Counts Escalation Toolkit

Around 700,000 babies are born in the UK every year. The vast majority are born safely, but more than 1,000 will die or suffer a brain injury during or shortly after term labour. Each Baby Counts is a national quality improvement programme to reduce the number of babies who die or are left severely disabled as a result of incidents occurring during term labour.

We have commissioned the roll out of the Each Baby Counts Escalation Toolkit across all maternity providers in Greater Manchester and Eastern Cheshire. The campaign focuses on three interventions, “identify, communicate and act”. The overall aims of the campaign are to improve clinical escalation by reducing delays in escalation, standardising the use of safety critical language, empowering staff, promoting a positive culture and improving the ways in which we listen to people using maternity services.

Prior to the campaign launch an escalation behaviours questionnaire was sent out to allow maternity units to provide some insight. The engagement from maternity units has been fantastic and staff are eager to embed this approach as soon as possible.

mybirthmychoice

mybirthmychoice.co.uk

There are lots of things to consider when getting ready for the birth of your baby. The best environment for you to have your baby will feel safe, comfortable & relaxed. This website provides one place to access information about maternity providers in your area.

North West Maternal Medicine Network

"As the Lead Midwife for the North West Maternal Medicine Network one of my key aims is to enhance midwifery care and support for all who access maternal medicine services, regardless of where they live in the region.

Women/birthing people with complex medical needs require their midwife to understand the additional challenges they face in pregnancy. I am sure with the right support, training and education provided via the North West Maternal Medicine Network we will achieve this."

Catherine Chmiel,
Clinical Lead Midwife

Maternal Medicine Networks are central to NHS England's improvement plan for supporting all pregnant women/birthing people and their babies. The aim is to ensure women/birthing people with medical conditions have timely access to the best specialist advice and care at all stages of their pregnancy.

Under the leadership of the Greater Manchester and Eastern Cheshire Strategic Clinical Networks, the North West of England has joined together to form a Maternal Medicine Network. This Network covers Greater Manchester and Eastern Cheshire, Cheshire and Merseyside & Lancashire and South Cumbria. Three Specialist Maternal Medicine Centres are located within St Mary's Hospital Manchester, Liverpool Women's Hospital and Lancashire Teaching Hospitals (Preston) alongside services delivered in 19 local District General Hospitals supporting the population of the North West of England.

Objectives of the North West Maternal Medicine Network:

- to provide a high quality, fit for purpose Network, demonstrating value and providing strategic direction for maternal medicine provision across the North West.
- to facilitate and support the development of a maternal medicine service between the three Maternal Medicine Centres, that is aligned with service provision throughout the rest of the region.
- to support the delivery of equitable and timely specialist care and advice for all women/birthing people before, during after pregnancy.
- to monitor and drive improvements in quality of care.
- to put women at the heart of all maternal medicine services and support improvement in patient and family experience.
- to provide and support education, training and development of the workforce within the Networks footprint.

Diabetes Network

"It has been a year of change in Greater Manchester. We've started to recover from the COVID pandemic, which has been shown to have impacted diabetes diagnoses and care heavily.

I am proud of the way we have worked together to tackle operational and system challenges that have arisen in a strategic and comprehensive manner.

We have increased the diabetes clinical leadership team and built closer working relationships with networks such children's, cardiovascular disease prevention, frailty and palliative & end of life care.

This has allowed us to provide support to improve services for patients across the life-course; from pregnant women living with diabetes, through to children, young people transitioning into adult care and adults."

Dr Naresh Kanumilli, Clinical Lead

approximately
160,000
people living in Greater Manchester have diabetes

11,000
of people diagnosed with have type 1 diabetes

1 out of 3
of people diagnosed with diabetes are affected by diabetic retinopathy

expected that
over **25%**
people living in Greater Manchester will develop diabetes

over **1,000**
premature deaths a year in Greater Manchester caused by diabetes

people with diabetes
twice as likely
to experience depression and anxiety

people with diabetes
have **55%**
higher chance of having a heart attack

people with diabetes
have **34%**
increased risk of stroke

people with diabetes
have **164%**
increased risk of having renal replacement therapy

Source: Greater Manchester Diabetes Strategy, 2018 - 2023

Type 2 Diabetes Pathway to Remission

People living with type 2 diabetes can potentially put their diabetes into remission by following a low-calorie diet. This programme gives people three months of total diet replacement alongside support to improve diet and exercise, often leading to a reduced need for medication.

This year we focused on increasing referrals into the programme through training, support and information for referrers, plus the introduction of a financial incentive for practices.

There has been a **45%** increase in referrals, a **60%** increase in people starting the programme and ineligible referrals have decreased by **15%**. We have also worked on communication for people who speak different languages, such as Urdu. We can see from the data that there has been an improvement in the ethnic diversity of people starting the programme.

Derek from Stockport has taken part and achieved fantastic results, losing 12kg, reducing his blood glucose levels, feeling healthier and being more active.

Seamless transition

When children and young people transition into adult clinics, a negative experience can have a lasting impact on their care.

Working with NHS England North West we involved three local teams from Bolton, North Manchester and Wigan in a nine-month training programme to improve transition services. **29** people from the three teams reviewed their current services, identified areas to improve, and implemented changes.

Colleagues who took part in the programme evaluated it positively and felt that it gave them a structured process to identify service gaps and how to make things better for patients. We have demonstrated some real benefits for patients and their families; notably improved communication as they transition to adult services, and a reduction in emergency admissions.

The positive evaluation has helped to secure funding to offer the programme to other teams around Greater Manchester.

Diabetes MyWay

Approximately 160,000 people in Greater Manchester are living with diabetes. Diabetes MyWay is a tool that helps people to manage their diabetes. Through a website patients can access education, useful resources and view their records. The website is also a central repository for clinical support tools and resources. Education classes are offered in person or online.

At the end of March 2023, over **8,900** patients have registered to use the Diabetes MyWay service. A total of **175** GP practices have signed up to data sharing to enable patients to be onboarded and **164** GP practices have taken up the offer of administrative support to get more patients signed up.

Over **410,000** users have visited Diabetes MyWay. Research on the clinical outcomes for patients is still being carried out but provisional analysis indicates that the support from Diabetes MyWay has a significant positive impact on HbA1c, blood pressure and cholesterol reading.

Improving access to Diabetes MyWay has been another priority for us. We have developed multi-language resources to support the wide range of communities living in Greater Manchester. Next year we will be rapidly scaling up Diabetes MyWay and estimate that **20%** of our diabetes population will access it by the end of this year.

Stroke and Neurorehabilitation Network

"The Network's strong emphasis on facilitating effective collaboration, communication and innovation has helped to drive forward more equitable access to stroke and neuro specialist care from acute into community and longer-term recovery across the Greater Manchester footprint.

There is a strong focus on the continual professional development of our workforce so we can support them to be equipped to deliver the right care, at the right time in the right place.

Stroke, cardiovascular disease prevention and reducing health in equalities will continue to be a key driver in the next year."

Tracy Walker and Dr Shivakumar Krishnamoorthy, Clinical Directors

1 in 5
deaths in the UK are due to a neurological condition
Source: Brain Research UK

4,158
Strokes in Greater Manchester in 2022

40.5%
of people diagnosed with a stroke in 2022 had no disability prior to stroke

There are a greater number of stroke related deaths in women
Source: Stroke Association

Men are at higher risk of having a stroke at a younger age than women
Source: Stroke Association

People from more deprived areas have an increased risk of stroke & more likely to experience severe strokes
Source: Stroke Association

3
Hyper Acute Stroke Centres at Salford Royal, Stepping Hill and Fairfield General...

...offering thrombolysis
(clot busting drugs)

8.8%
people who had a stroke in 2022 had thrombolysis
(arriving at hospital within 4 hours of onset of stroke symptoms and eligible)

Telemedicine to support decision making

Sometimes patients with suspected strokes are not taken to the best hospital to be able to treat them quickly. In Greater Manchester we aim to take patients who have just had a suspected stroke to one of three Hyper Acute Stroke Units for specialist care.

To help ambulance crews make a more accurate assessment of where patients needed to go, we tested using video calls en route with a specialist stroke consultant.

During the pilot, **100%** of patients were taken to the right hospital. Patients had access to a specialist stroke consultant in the very early stages of their NHS care. It also reduced the number of unnecessary transfers between hospitals by ensuring the patient got to the right place the first time.

Education and professional development

The quality of care people receive is directly impacted by how staff are supported in their professional development.

To support our workforce during 2022 we provided a hybrid training package which included:

- **9** webinars (all uploaded to YouTube)
- **7** face to face events
- **7927** views on our YouTube channel
- **329** subscribers to our YouTube channel

We believe that training is key to ensuring that staff provide evidence based services that meet national standards and help reduce variation in service provision across the region.

We are delighted to be able to offer training and education the majority of it at no cost, for our local workforce.

The impact of health inequalities in life after stroke

Stroke survivors don't always get access to the support they need for life after their stroke. We commissioned the Stroke Association to learn about people's experiences in North Manchester.

Stroke survivors and carers from Oldham, Rochdale, Bury and North Manchester took part in listening events and interviews.

The north of Manchester is very ethnically and culturally diverse and we learned that patients and carers were not always having their needs met.

Now we understand how we can improve referrals and use of life after stroke services and will be working on this as a priority.

Transforming specialist community services

Access to effective and timely community services can maximise the chance of recovery after stroke and ensure people have a better quality of life or when living with a neurological condition.

Specialist community care was historically a postcode lottery across Greater Manchester, with some areas offering no support at all.

This year, the final two localities in Greater Manchester (Trafford and Manchester) invested new funding to enhance their specialist services. This means all ten localities in Greater Manchester now offer evidence based care that meets the needs of patients, regardless of where they live and the type of condition.

Cardiovascular Network

"Cardiovascular disease is one of the leading causes of disability and death in Greater Manchester but is preventable through healthier lifestyle choices, earlier detection and improved management of risk factors.

Within the Network we focus not only on how we can improve treatment pathways and outcomes, but how we can prevent people from developing cardiovascular disease and how we can support them to get better and stay healthy after illness.

I'm proud to be able to share just a few examples of the work led by the Cardiovascular Network this year. The delivery of these projects would not have been possible without the energy and dedication of our clinical leads, clinical associates, support team and wider network members such as Heart Valve Voice and Valve for Life UK."

Professor Farzin Fath-ordoubadi, Clinical Lead

around **330,000** people are living with heart and circulatory diseases in Greater Manchester

around **56,000** people have been diagnosed with atrial fibrillation in Greater Manchester

around **99,000** people are living with coronary heart disease in Greater Manchester

around **28,000** people have been diagnosed with heart failure by their GP in the Greater Manchester area

around **27,000** people have a faulty gene that can cause an inherited heart-related condition in Greater Manchester

around **419,000** people in Greater Manchester have diagnosed high blood pressure

27% of adults in Greater Manchester have obesity

around **3,000** out of hospital cardiac arrests each year in the North West

1 in 13 people survive an out of hospital cardiac arrest in the North West

Source: British Heart Foundation, January 2022

Cardiac home monitoring service

Addressing planned hospital care waiting list backlogs and supporting people while they wait is a priority in Greater Manchester.

Working with Manchester University NHS Foundation Trust, FCMS, a community healthcare provider and Docobo we introduced a new home monitoring service for people awaiting specialist cardiac procedures, such as coronary artery bypass grafts or valve replacement.

Patients are visited at home and given equipment to monitor their blood pressure, heart rate and blood oxygen levels, plus a tablet to input the results. The results are reviewed by FCMS who support the patient at home.

The service acts as a 'safety net' which takes a proactive approach to supporting patients at home. Approximately **60** patients have been supported since it launched in December 2022.

Avoiding delays for coronary angiography

Approximately 3,500 people in Greater Manchester require a coronary angiogram every year, a procedure that uses X-ray to see your heart's blood vessels. Patients needing this procedure must be transferred to one of the specialist centres in the region: Manchester Royal Infirmary; Wythenshawe Hospital; Fairfield General or the Royal Albert Edward Infirmary.

The North West Ambulance Service (NWAS) usually provides the transfer, however, due to recent constraints on the service patients would often get transfers cancelled, which would cause delays to their care.

To solve this issue, a private ambulance service was commissioned to undertake the transfers, resulting in zero cancellations, thus supporting colleagues in NWAS to focus on other calls.

Heart valve disease

Around 1.5m people in the UK aged 65 or over are thought to have heart valve disease (British Heart Foundation). Increasing awareness and identification of this condition is a priority.

We partnered with Heart Valve Voice and Valve for Life UK to host the 'Your Heart Matters' bus in Manchester City Centre in September 2022.

Stethoscope and pulse checks were provided to **430** people, **51** of which were given a letter to take to their GP practice for further review.

The event gained significant media attention helping us to spread the word about heart valve disease. We plan to replicate this work in other areas in Greater Manchester.

Access to cardiac rehabilitation

Cardiac rehabilitation is an important part of helping people recover from a heart problem. We supported three localities in Greater Manchester to improve access, in Bury, Trafford and Manchester.

Bury focused on understanding barriers to accessing the service, they introduced a nurse and re-established classes in community venues. Trafford focused on a 'step down' model that would help people maintain health behaviour change. Manchester piloted a class in a community setting and found there was **85%** uptake compared to **67%** in hospital-based settings.

Work will continue next year to standardise cardiac rehabilitation services across Greater Manchester. Community classes are reaching more diverse communities.

Know your blood pressure numbers

Cardiovascular disease prevention

"Cardiovascular disease has been identified as the biggest single area where the NHS can save lives over the next 10 years. In Greater Manchester cardiovascular disease remains the leading cause of premature death and health inequalities and we have some of the highest rates of heart attacks and strokes in England as a whole.

A Prevention Oversight Group has been established to set the strategic direction for local prevention initiatives. The initial focus of this group is the recommencement of systematic detection. In the case of hypertension, for example, the intention is that GP practices should focus on the appropriate management of patients with an existing diagnosis, whilst the wider primary care and community system should focus on case finding and opportunistic screening."

Dr Aseem Mishra, Clinical Lead for Cardiovascular Disease Prevention

Cardiovascular Disease Prevention Plan

A Greater Manchester Cardiovascular Disease Prevention Plan (December 2022) has been developed to provide a coordinated approach to the detection, diagnosis and management of hypertension, atrial fibrillation and high cholesterol. The plan has a strong focus on reducing health inequalities, particularly deprivation and ethnicity.

Our vision is for all Greater Manchester stakeholders to work together to enable our system's ambition to tackle cardiovascular disease prevention. We want to ensure that we support a better quality of life and healthcare outcomes for all through our agreed aims to:

- recover from COVID.
- meet the national ambitions for detection and control.
- reduce health inequalities.
- support the priorities of the Greater Manchester Integrated Care Partnership.

Our Cardiovascular Network will continue to lead the improvement and transformation of cardiovascular services, working with colleagues across the system. They will report into the Cardiovascular Disease Oversight Group.

Respiratory Network

"It has been another busy year for our Network leading the development of long COVID services across Greater Manchester. There have now been over 6,000 referrals into our local long COVID services and our work continues to raise awareness of this condition and the support available. As we learn more about this new condition we will be able to refine services.

Another big priority for us this year was our work to improve awareness and access to pulmonary rehabilitation services. These services help people to live as well as possible with long term lung disease.

In March 2023 we launched our pulmonary rehabilitation campaign 'Keep Active, Breathe Better' and are already seeing early signs that this is having the impact we hoped."

Dr Jennifer Hoyle and
Dr Murugesan Raja, Clinical Leads

Poor respiratory health plays a key role in driving health inequalities, a crucial area of focus for the NHS.

37.9%
of neighbourhoods in Greater Manchester are in the fifth most deprived neighbourhoods nationally

in 2021/22 **24,695**
emergency admissions in Greater Manchester relating to respiratory disease

in November 2022 **6,683**
people in Greater Manchester were on a waiting list for respiratory care

in September 2022 **7,850**
full time equivalent (FTE) doctors in hospitals and community health services in Greater Manchester

in 2021/22 **6.9%**
people in Greater Manchester aged 6+ were diagnosed with asthma and prescribed asthma medication in the last 12 months (6.5% for whole of England)

in 2021/22 **2.2%**
people in Greater Manchester diagnosed with chronic obstructive pulmonary disease (1.9% for whole of England)

Source: Respiratory Health in Greater Manchester, Taskforce for Lung Health

Pulmonary Rehabilitation

Pulmonary rehabilitation helps people with long term lung conditions to gain strength, reduce anxiety and to better manage everyday life activities.

Across Greater Manchester there are 13 pulmonary rehabilitation services. We have formed a Pulmonary Rehabilitation Collaborative to explore new ways of working, to improve access and to improve outcomes for people living in Greater Manchester.

The network has supported all 13 pulmonary rehabilitation services in Greater Manchester to sign up to the Royal College of Physicians Pulmonary Rehabilitation Services Accreditation Scheme which demonstrates that services are of high quality and safe. We are actively working with services over the next year to ensure they meet the accreditation standards by the end of March 2024.

We have worked to rebrand pulmonary rehabilitation services in Greater Manchester as 'Keep Active, Breathe Better' and developed a range of resources to improve access, to improve referral rates and to reduce inappropriate referrals. A patient education booklet has also been developed which will be given to people attending pulmonary rehabilitation classes. Visit www.pulmonaryrehabgm.co.uk for more information.

Data has been used to identify areas in Greater Manchester with the greatest need and why people are declining pulmonary rehabilitation to help us better target our communication and engagement efforts.

Green inhalers

Inhalers make a significant contribution to Greater Manchester's carbon footprint. In any given month, there are over 300,000 inhalers prescribed in the city region with an environmental impact equivalent to the emissions from 28,000 cars.

Networking with specialist green inhaler clinicians, we have supported the roll out of carbon friendly inhalers, by providing training across hospitals. Our aim is to ensure junior doctors, nurses and health care professionals are aware of green inhalers, inhaler techniques and inhaler disposal.

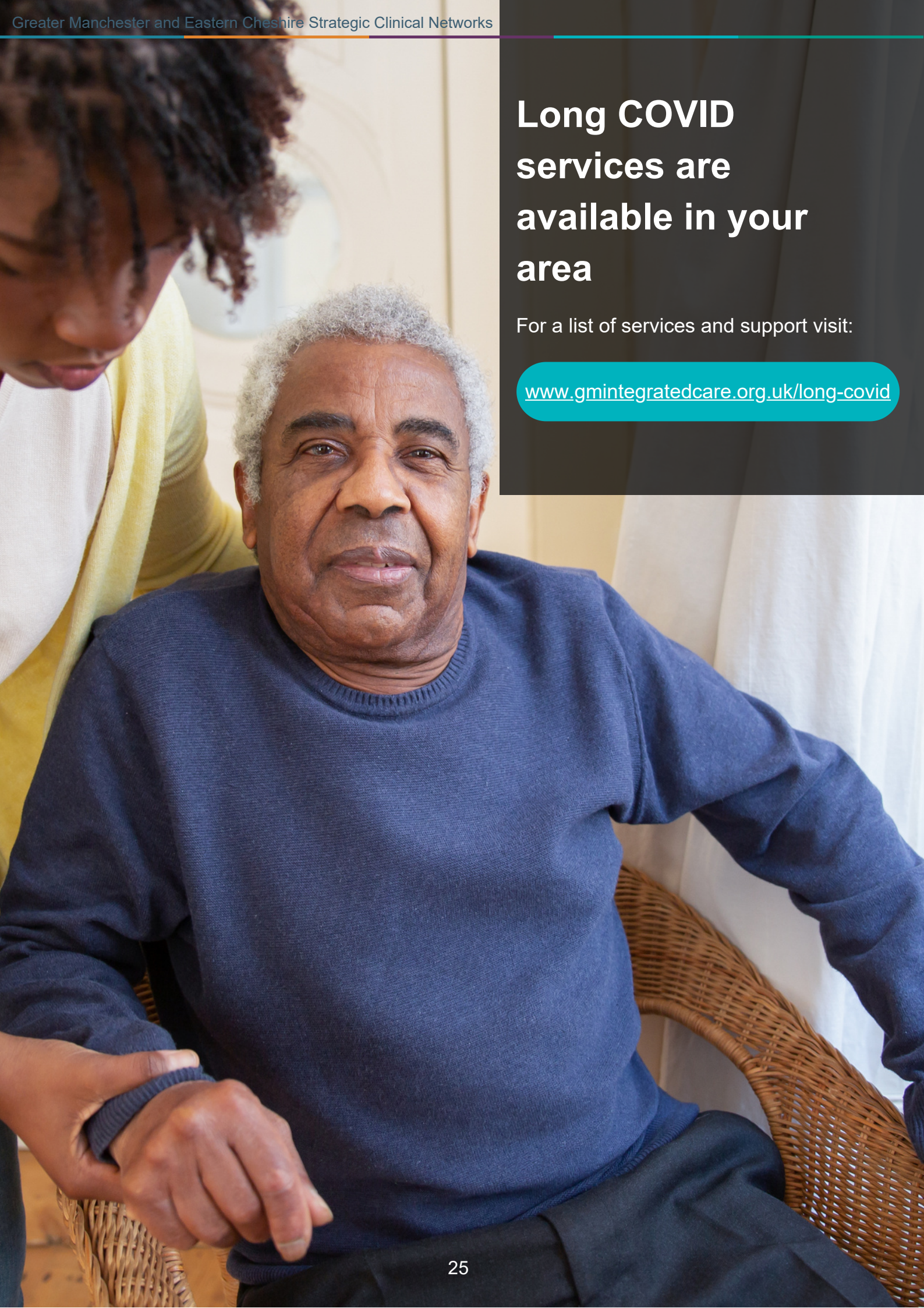
A further e-learning training package is being developed by clinicians at Wythenshawe hospital which will be launched later in the year and rolled out to all health care professionals.

Spirometry

Spirometry is an essential test to help diagnose and monitor certain lung conditions by measuring how much air you can breathe out in one forced breath. Access to spirometry was limited during the COVID pandemic and it is urgent that it is restarted to help drive up diagnosis rates. We have worked on a plan to restart spirometry testing in Greater Manchester.

In June 2022 we developed a Frequently Asked Questions (FAQ) document to support clinicians across the region. We have also commissioned **10** courses since September 2022, training approximately **330** professionals.

All but 1 of our 10 localities in Greater Manchester are providing some level of spirometry service. Work will continue to improve access to spirometry testing next year.



Long COVID services are available in your area

For a list of services and support visit:

www.gmintegratedcare.org.uk/long-covid

Long COVID services

Our Respiratory Network was asked to lead on the development of long COVID services on behalf of the Greater Manchester system. Long COVID is a new condition that is still being studied and the expertise of our clinical leads and network members meant they were best placed to establish new services. They delivered:

- **9** adult long COVID services
- **2** mental health hubs
- **1** children and young persons long COVID hub
- **1** tier 4 service
- a Greater Manchester treatment and care framework and pathway
- support to produce and report data and activity
- an oversight of progress, risks and issues
- the allocation of monies received into Greater Manchester

The amount of time it takes to recover from COVID-19 is different for everybody. Many people will feel better within a few days or weeks and most will make a full recovery within 12 weeks, but symptoms can last longer for some people.

There are many long COVID symptoms and they can change over time. The top 3 are extreme tiredness (fatigue), shortness of breath and problems with memory and concentration (brain fog).

Approximately **6100** referrals into services were accepted (April 2021 - end of January 2023)

Long COVID research

Help BEAT Coronavirus is a dedicated campaign supporting people to take part in research looking to discover new ways to prevent, diagnose and manage COVID-19 and long COVID.

Professor Nawar Bakerly, a member of our Respiratory Network is leading on long COVID research in Greater Manchester.

This is a National Institute for Health and Care Research Clinical Research Network backed initiative using a 'consent for approach' model to recruit participants.

Professor Nawar Bakerly, Lead for Long COVID research in GM

With support from the Respiratory Network we are:

- engaging with underrepresented communities, for example Caribbean and African Health Network and the Federation of Jewish services, to encourage people to sign up.
- promoting the research across Greater Manchester to encourage people to register their details, with over **5,000** people now registered.

Frailty Network

"This year I am especially proud that despite ongoing and system-wide operational challenges, colleagues from across the Network, spanning disciplines and sectors, have continued to dedicate their time to come together as a growing and vibrant community of practice.

We have assembled a formidable array of clinical, academic and care professional expertise willing and able to share their knowledge and experience and to provide offers of support to service development and academic endeavour.

This year our work has not only included addressing the immediate impacts of frailty but also how best to improve population health through better ageing and beginning to understand how to address known and emerging inequalities. There is much to do but our ongoing strength lies in our collective shared purpose and commitment to enabling better ageing for all."

Professor Martin Vernon, Clinical Lead

falls are the second major cause of death and disability after road traffic accidents

£2.3 billion
estimated cost of falls to the NHS every year

falls are more common in areas of social deprivation

> 150,000 million
people aged 65+ in Greater Manchester fall at least once

in 2019/20 **10,810**
emergency hospital admissions in Greater Manchester due to falls in people age 65+

women are more likely than men to fall and often sustain fragility fractures as a result

5 - 10%
of those that fall sustain serious injury

6 out of 10
Greater Manchester boroughs recorded higher hospital admissions due to falls than England overall

fear of falling potentially increases anxiety, distress and medication use

Source: Greater Manchester Falls Prevention: Delivering Integration and Reconditioning

Frailty Care Reference Group

People living with frailty are at increased risk of adverse events including hospitalisation, nursing home admission and death. Our vision is of a society where people living with frailty will live as well as possible for as long as possible in the environment that suits them.

Our Frailty Network is relatively new, having been established in 2021, and the focus has been on building a community of practice who can support each other rather than on delivering specific projects.

We have established the Frailty Care Reference Group, a network of **90+** people working across different disciplines and sectors who dedicate time to improve care and services for people living with frailty. We are an advisory support group to the Greater Manchester Integrated Care Board.

The Frailty Care Reference Group has created an environment for discussion and support which did not exist previously, focusing on outcomes of importance to patients and their families.

Examples of some of the work we have supported this year:

- advice we have produced around falls prevention has supported the delivery of a Falls Collaborative pilot to identify people at risk of a fall, offer the right interventions and develop an effective delivery model.
- we brought commissioners and providers together to discuss acute frailty services and how we can improve front line services.
- we provided support to colleagues in Bury at locality meetings and workshops to assist them in the development of a place-based strategy to improve frailty services and patient outcomes.

Frailty Care Reference Group

Understanding and addressing health inequalities is an important part of our work. We are working on a frailty outcomes dashboard that will enable to use data to track areas to focus our efforts of improvement.

Whilst still in development we expected the frailty outcomes dashboard to cover:

- transition between frailty states, e.g. mild, moderate, severe.
- transition from independent living at home to dependent living in a care/nursing home.
- presentations at the Emergency Department as a result of a fall.
- place of death

The frailty outcomes dashboard is an exciting development for the Frailty Care Reference Group as it will enable us to identify opportunities for improvement at place and throughout Greater Manchester.

Palliative and End of Life Network

"This has been another great year for our Network. We are truly inspired by the dedication of our palliative and end of life colleagues working across health and care, hospice and the voluntary sector supporting people to live well until they die.

A notable moment for us was our event at the British Muslim Heritage Centre in January 2023 where we brought together 120 colleagues from across Greater Manchester.

Our first in person event since the pandemic was a wonderful opportunity to reconnect and restate our shared ambitions in the Greater Manchester Palliative and End of Life Care Commitments.

On the next page are just a few examples of our work and how we are supporting the improvement in palliative and end of life care."

Dr David Waterman and Dr Liam Hosie, Clinical Leads

27,000
deaths approximately a year in Greater Manchester

Source: Office for national statistics, 2021

12,000
of the deaths in 2021 were not identified as having palliative care needs

Source: Quality outcomes framework, 2020/2021

1129
mortality rate per 100,000

Source: Office for national statistics, 2021

75%
of deaths can be anticipated

Source: Quality outcomes framework 2020/2021

research suggests most people would prefer to die at home

Source: Gomes et al, 2013

46.1%
of deaths in GM took place the usual place of residence (50.5% national average)

Source: Q1 2021/2022 financial year, Tableau 2022

lack of cultural diversity in the specialist palliative care nursing workforce

Source: GM Specialist palliative care workforce survey 2021-2022

9
localities reporting difficulties with recruitment

Source: GM Specialist palliative care workforce survey 2021-2022

45%
of specialist palliative care nursing workforce due to retire over the next decade

Source: GM Specialist palliative care workforce survey 2021-2022

EARLY identification

Recognising patients who have palliative and end of life care needs is important to ensure they receive the level of care they want and need. Historically, identification has been weighted to those with a cancer diagnosis, but we are addressing this with our EARLY identification tool.

The EARLY identification tool enables GP practices to identify patients from their clinical system who are likely to be in the last year of life.

This year we worked with **10** Primary Care Networks to support them to implement the EARLY search tool effectively. All practices involved showed an increase in the number of patients identified as having palliative and end of life needs, enabling proactive conversations to take place. During the pilot practices were able to identify more non-cancer patients (**77%** of the total) which was a huge benefit.

Our work will continue to roll this out in more practices across Greater Manchester.

Inequalities bitesize education

A Different Ending (2016), a Care Quality Commission Report highlighted 10 groups of people that don't receive equal access to palliative and end of life care services:

- people with conditions other than cancer
- older people.
- people with dementia.
- people from ethnic minority groups.
- gypsies and travellers.
- people with a learning disability.
- people with a mental health condition.
- people who are homeless.
- people who are in a secured/detained setting.
- people from the LGBTQIA+ community.

In response to this, we have worked with the digital team at the Christie Hospital to produce a web based, bite-size learning package to improve services for people from these groups.

This resource for health and care professionals uses a variety of interactive media with the aim of increasing awareness and giving them the knowledge and skills to design inclusive services for the people they support.

Rules of thumb

It's estimated there are currently over 30,000 people living with dementia in Greater Manchester. Dying with dementia brings unique challenges that can be difficult to manage without appropriate support and training.

Funding was received to develop a dementia end of life training package for Primary Care Networks and care home teams, based on the Rules of Thumb programme created by Dr Nathan Davies and the University of College London. We transformed the Rules of Thumb training package into a flexible online resource that could be used with different audiences.

Delivered this year across **5** localities, the evaluation showed attendees had an increase of **26%** in knowledge, **27%** in skills and **30%** in confidence to deliver palliative and end of life care to people with dementia. **93%** of attendees said that they would make changes to their future actions and behaviours in how they support people with dementia.

We were delighted to present this work alongside Dr Nathan Davies to **900** people from across the UK at the Marie Curie Research Conference in February 2022.

peolc.net

A resource for people working in Palliative and End of Life Care in Greater Manchester

Palliative and End of Life Care Zonal Network for Babies, Children and Young People

"Our mission is to ensure that all babies, children and young people with life threatening and life limiting conditions have access to high quality supportive and palliative care throughout their journey from diagnosis to end of life.

Working with the Palliative and End of Life Network has resulted in a significant development and enhancement of the Greater Manchester Palliative and End of Life Care Zonal Network.

The highlight of this partnership saw us work with adult colleagues in February 2023 to hold an all ages end of life summit enabling a complete picture of palliative care support from before birth through to old age ."

Anna Oddy and Dr Lydia Bowden, Clinical Leads

Dr Lydia Bowden, Consultant Neonatologist and Anna Oddy, Children's Complex and Palliative Care Specialist Nurse lead on this Network. Working with Dr Waterman and Dr Hosie, they co-delivered the palliative and end of life event in February 2023. A work programme has now been set which aligns to the national palliative and end of life programme for babies children and young people.

Key programmes of work include:

- working alongside Lancaster University to conduct a point prevalence survey across Greater Manchester, involving partnership with acute, community services and hospices. Identifying babies, children and young people who may have palliative care needs supports the development of more comprehensive palliative care services.
- mapping services across Greater Manchester to understand the extent to which babies, children and young people palliative care services are being provided in the region in a way which is consistent with the new NHS service specification. Support will be provided to any areas to address gaps.
- undertaking a learning needs analysis with our local workforce to understand any gaps in knowledge, skills and confidence when caring for babies, children and young people with palliative and end of life care needs.
- enabled 30 colleagues in Greater Manchester to undertake Babies, Children and Young People End of Life Communication Skills Training.
- developed an Advance Care Plan Awareness Training Package and delivered this to colleagues and families virtually. This training package has been extended across the North West Region.

The Palliative Care Journey - online resources

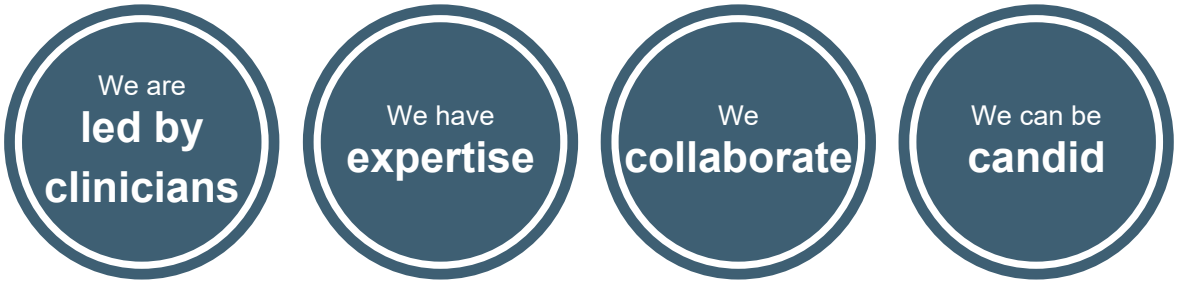
A website containing resources to support professionals caring for babies, children and young people with life limiting or life-threatening conditions. It covers all ages from new-born to young adult life and is based on symptoms and needs rather than any particular diagnoses. Click here to visit.

Our plan on a page 2023 / 2024

Our vision is for the health and wellbeing of local people and the care they receive to be comparable with the best in the world.

Eight strategic clinical networks led by clinicians who work in local services, taking a whole life course approach.

- Children and young people
- Maternity
- Diabetes
- Stroke and neurorehabilitation
- Cardiovascular
- Respiratory
- Frailty
- Palliative and end of life care



Objective 1	We will create opportunities for clinicians and people living and working in Greater Manchester to shape local services and improve health and care (collaboration)	• Develop our networks and cross network links • Provide clinical and care professional leadership • Involve as many clinicians and other staff as possible • Work in partnership with users and carers
Objective 2	We will find ways to make health and care services in Greater Manchester better (quality improvement)	• Develop strategy, policy, guidelines and pathway • Focus on personalised care • Identify and share good practice • Use insight from patient and carer experience • Use data systematically to give feedback on unwarranted variation and performance
Objective 3	We will work to improve the quality of life of people living and working in Greater Manchester and support them to have their wishes known and supported (outcomes)	• Agree desired outcomes and processes tracking progress over time • Develop training and education • Support organisations to implement and manage change • Provide assurance
Objective 4	We will reduce avoidable and unfair inequalities in health and care between groups of people and communities in Greater Manchester in line with the Core20Plus5 approach (health inequities)	• Use business intelligence and feedback to identify health inequalities • Work, as network members, to identify solutions • Track progress and monitor outcomes • Work in partnership with local people, patients, carers and staff

Our clinical leads and associates

Children and Young People Network

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Dr Carol Ewing
Julie Flaherty
Julia Birchall-Searle
Dr Easwari Kothandaraman
Nathan Griffiths
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Amy Wilson
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Maternity Network

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Prof Edward Johnstone
Dr Samiksha Patel
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Information correct as of April 2023

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NHS
Greater Manchester and Eastern Cheshire
Strategic Clinical Networks

Contact us

Thank you for reading our impact report. If you have any questions about this report or if you want to get involved in any of our networks please get in touch.

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Greater Manchester and Eastern Cheshire Strategic Clinical Networks

We would like to thank our support team (pictured right) for all the work they do to support our Clinical Networks. Thank you!