NHS
Greater Manchester and Eastern Cheshire
Strategic Clinical Networks

2024/25 Impact Report

Part of Greater Manchester Integrated Care Partnership

Contents

Introduction

JULIE CHEETHAM
DIRECTOR

While the recently-announced reforms which will see the abolition of NHS England and significant cuts to budgets will create a challenging future for us, it is really important we pause, evaluate and take pride in improvements we have achieved in patient services over the past 12 months.

The following pages demonstrate how our team of clinicians, who are working in hospitals, GP surgeries and the community today and are in the best place to know exactly what needs to change, are successfully leading our organisation.

They identify essential improvements and then work with our support team to get the programmes implemented, often bringing together several different organisations to agree pathways and approaches, before introducing the initiatives.

It's a perfect blend of clinical expertise and programme management which is improving the health and wellbeing of people in Greater Manchester, while, in many cases, making the health and care system work more efficiently.

We are determined to drive forward this work in 2025-26.

We play a unique, essential role in the city region and see this vital function continuing as Fit for the Future: 10 Year Health Plan for England gets underway.

DR PETER ELTON
CLINICAL DIRECTOR

At the moment the future looks challenging, but as the health landscape shifts, we will remain focused on our vision of making the health and wellbeing of local people and the care they receive comparable with the best in the world.

Lord Darzi's review of the NHS helped us confirm what our priorities should be, while many of the main themes in his report have played a major role in our improvement projects over the past 12 months (and beyond) and feature in this summary document, such as equality of care, the left shift from hospital to the community and prevention.

We know the Government is keen on clinically-led improvements to NHS services and the following pages are full of examples of this work.

We are now in our 13th year and this has allowed many of our networks to mature, not just within each clinical area, but between clinical areas.

This has created an impressive body of knowledge and expertise among our clinical leads and advisors and, partnered with the hard work of our support team, has delivered some excellent work once again.

The clinical leadership in Greater Manchester has greatly enhanced the work of the Networks.

Professor Manisha Kumar, chief medical officer, and her two deputies, Dr Claire Lake and Dr Stephen Knight, have worked closely with the Networks to ensure the clinical voice influences Greater Manchester health policies to improve the quality of our services and the health of our population.

We have enjoyed the close co-operation that has been necessary to make progress on the Integrated Care Board's strategic aims.

We hope we will be given the opportunity to build on this co-operation to enable the Networks to thrive in the future.

About us

- We are a collection of **seven** clinical networks led by health and social care professionals working in the system today.
- These experts **identify** where improvements are needed and work in partnership with our support team to create new ways of delivering better services to patients.
- This could be the **creation** of new pathways, or agreeing standards of care with the 10 local areas of Greater Manchester, and in many cases coordinating the training to make the changes happen.
- For 12 years we have been **making a difference** for patients, giving them the latest technology to monitor their conditions at home, identifying health risks before they become more serious and preventing them needing care in hospital.

The areas we cover are:
Cardiovascular
Children and young people
Diabetes
Maternity
Palliative and end of life care
Respiratory
Stroke and neurorehabilitation

We also lead programmes improving long Covid and rehabilitation services for all; and host the Local Maternity and Neonatal System (LMNS).

Right: GP Steve Doyle, who is part of our Respiratory Network, at his practice in Rochdale.

Vision and Role

Vision

"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."

Role

Our Networks provide the main point of interconnectivity between clinicians and the health and care system in Greater Manchester - a vital channel.

This ensures the voice of health professionals working in hospitals, GPs surgeries and the community today is heard by decision-makers, making sure every penny is spent on essential improvements to services in the right places, in many cases reducing financial and workforce pressures.

Since our launch in 2013, we have focused on areas which are are being called 'the left shift', moving from treatment to prevention, hospital to community and analogue to digital.

2024/25 Highlights

189

fewer child asthma emergency A&E admissions for quarter 3 in 2024/25, compared to same quarter in 2023/24, thanks to a Network-led programme

267

GP practices referring people to the NHS Type 2 Diabetes Path to Remission programme

109

fewer days for people with left-sided valvular heart disease to wait for treatment after diagnosis

1,500

refugee birthing people supported during pregnancy

1,150

maternity health professionals and managers reached with 10 events

238

people had mechanical thrombectomy - a life changing intervention to remove blood clots after a stroke

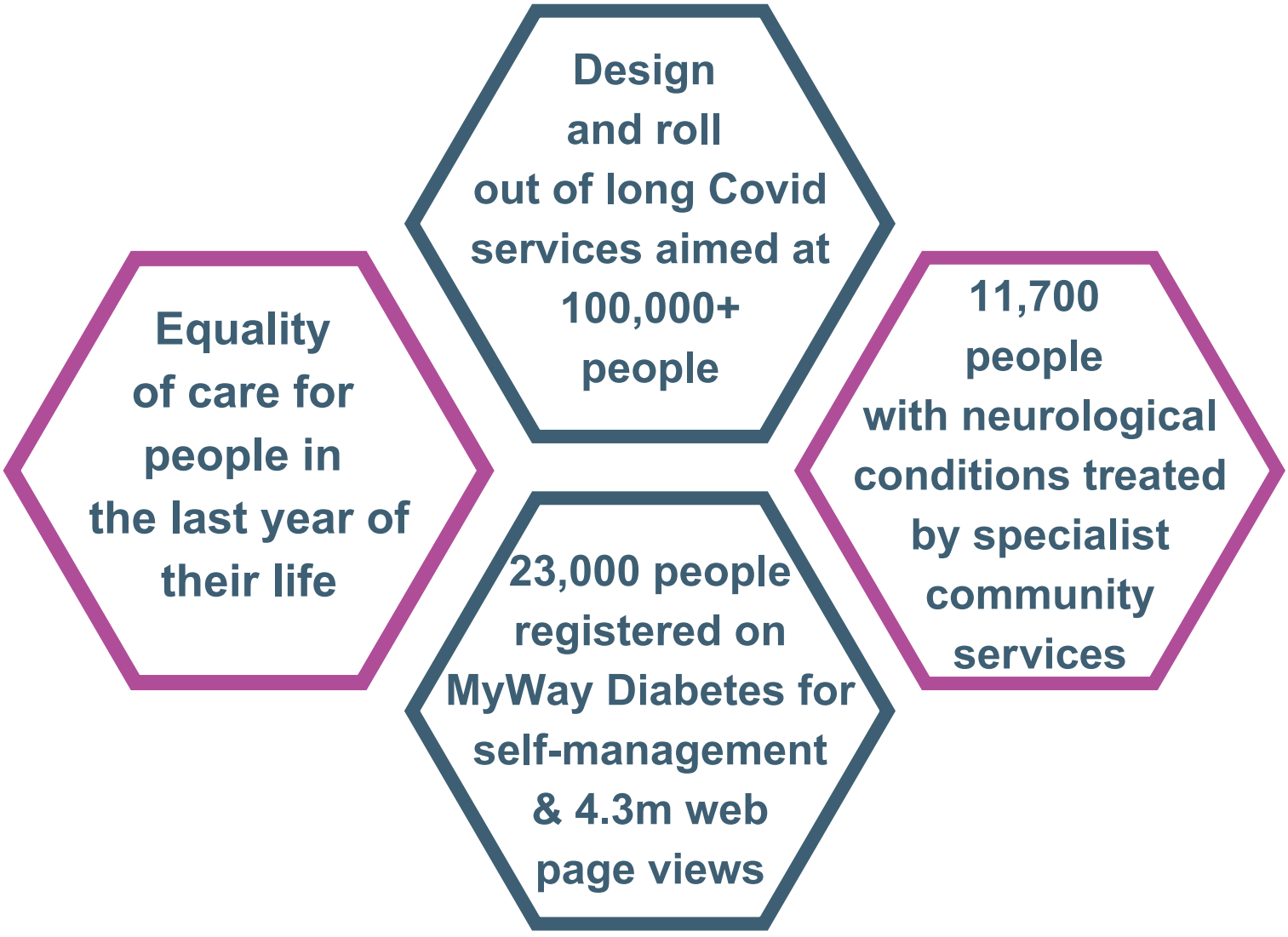
3,000

people identified as being in last year of life, allowing appropriate care and preferences to be planned in the latest roll out of a new tool in Wigan and Tameside

Supporting the left shift

It often takes time to evaluate the benefits of improvement work we have either led or played an important role in introducing.

Here are several of the best results from the last few years, some of which support the approach prescribed by Lord Darzi in his 2024 review of the NHS, with its focus on moving from treatment to prevention, hospital to community and analogue to digital.


Design and roll out of long Covid services aimed at 100,000+ people
Equality of care for people in the last year of their life
11,700 people with neurological conditions treated by specialist community services
23,000 people registered on MyWay Diabetes for self-management & 4.3m web page views

Focused on delivering strategies

Every programme we work on is designed to achieve the aims of national or Greater Manchester programmes or guidance.


Stroke GiRFT report recommendations
NHS England National Stroke Model
National bundle of care for children and young people with asthma
Neurology GiRFT report recommendations
NHS Long-term Plan CORE 20 Plus 5 CYP Framework for Health Inequalities
ICB Statutory responsibility for palliative and end of life care
National children and young people epilepsy bundle of care
Primary care blueprint
Cardiac multi-year prevention plan

Networks:

Long-term conditions

Left: Shabana Younis, senior respiratory occupational therapist for Oldham Care Organisation, at a pulmonary rehabilitation session.

Cardiovascular

PROF FARZIN FATH-ORDOUBADI

CARDIOVASCULAR TRANSFORMATION NETWORK CLINICAL LEAD

“The work carried out over the past 12 months, led by our cardiac experts as part of this well-established network, will lead to significant improvement in lives saved.”

ACTIONS AND ACHIEVEMENTS

Out of hospital cardiac arrest pathway

The Network has been dedicated to improving the survival rates and outcomes of people suffering out-of-hospital cardiac arrests.

Around 3,600 people in Greater Manchester suffer cardiac arrests outside hospitals and only one in 13 survive.

- A pilot study was carried out in the Stepping Hill and North Manchester catchment areas, directly transferring patients to specialist heart attack centres at Wythenshawe or Manchester Royal Infirmary, bypassing local emergency departments
- The study showed the survival rate almost doubled as patients had their arteries widened, by the use of a balloon, much earlier when they were taken directly to a specialist centre
- This programme has now been implemented as business as usual across Greater Manchester, potentially saving thousands of lives

Inter-hospital transfer of patients with cardiac devices

Patients with cardiac devices, such as pacemakers, were receiving inconsistent care when transferred between hospitals in Greater Manchester.

- The Network established a standard operating procedure across the city region

- Procedure guidelines stated only consultants or patients can request transfers; medical history and device information must be in place for receiving hospital and all documentation must be up to date, mandatory training was also introduced
- Agreement that the receiving hospital will arrange follow-up appointments
- The new approach has significantly improved the consistency and quality of care for cardiac patients with devices

Launch of rapid access valve clinics

In Greater Manchester, the average time taken to treat someone from the first symptoms of left-sided valvular heart disease has been reduced from an average of 350 days to 240.

The city region has a younger population impacted by heart valve disease, due to higher levels of deprivation.

Conditions such as diabetes, obesity and hypertension are also more prevalent in Greater Manchester, further contributing to the likelihood of developing heart valve disease.

Earlier detection was crucial to prevent severe symptoms and improve survival rates.

- In collaboration with Manchester University NHS Foundation Trust, rapid access valve assessment (RAVA) clinics launched in January 2025 to streamline the referral to treatment pathway
- Clinics were established at Wythenshawe Hospital, North Manchester General Hospital and Manchester Royal Infirmary
- One-stop rapid access clinics are staffed by specialist valve experts
- Number of appointments from referral to intervention significantly reduced from 9 to 3, optimising clinical resources and reducing unnecessary consultations
- Early diagnosis and timely intervention has reduced complications, hospital admissions and the need for emergency interventions, ultimately improving patient outcomes and reducing morbidity and mortality.

Right: A patient undergoes cardiac tests in Manchester.

Single point of access for patients with aortic stenosis

Aortic stenosis (AS) is a condition characterised by the narrowing of the aortic valve, leading to restricted blood flow from the heart to the rest of the body. Severe AS can result in significant symptoms and complications, including heart failure and premature death.

Early detection and timely intervention are crucial to improving survival rates and quality of life for patients with AS.

In Greater Manchester, higher levels of deprivation have led to increased cases and a fragmented and prolonged referral process was delaying treatment for patients.

- Working with Manchester University NHS Foundation Trust, a single point of access pathway was introduced to speed up diagnosis and treatment
- The pathway directs patients to the most appropriate team (surgical or transcatheter aortic valve replacement) using agreed criteria
- This has led to reduced treatment delays and improved use of resources
- The number of appointments before referral has reduced
- The time from referral to intervention has reduced
- The number of appointments from referral to intervention has significantly reduced, optimising clinical resources and reducing unnecessary consultations
- There are reduced complications, hospital admissions and the need for emergency interventions

Improving end of life experience for people with ICDs

Implantable cardiac defibrillators (ICDs) are critical devices for patients at risk of sudden cardiac death due to arrhythmias. However, as patients approach the end of life, the shock therapies provided by ICDs can cause unnecessary distress.

The Network recognised the need for clear guidelines to manage the deactivation of these therapies, ensuring patients and their families are involved in the decision-making process.

Right: Award-winning cardiac nurses Kieley Lewthwaite and Lauren Gazada from Bolton NHS Foundation Trust. They exemplify the high standard of care across Greater Manchester and received a national Pumping Marvellous award after being nominated by a patient.

- The new framework suggested early discussions with the patient and family about deactivation, clear pathways for the work 24 hours a day and integrating the discussion into advanced care planning
- Templates and letters used for communication were agreed, and training was introduced
- Evaluation showed improvements in quality of care, patient and family satisfaction, and healthcare provider confidence

Implementation of innovative pathway to improve heart failure care

Researchers from Manchester University NHS Foundation Trust successfully rolled out an innovative remote management strategy which uses health data from pacemakers and defibrillators to improve care of patients with heart failure.

Called the TriageHF Plus pathway, it has been implemented across the Greater Manchester system:

- The pathway integrates algorithm-based remote monitoring with structured clinical intervention
- Alerts trigger a structured telephone assessment by a specialist heart failure nurse
- It enables early identification of problems, reducing risk of hospitalisation
- There is a reduction of 58% in non-elective hospitalisations
- The pathway is a low-burden, high impact strategy and forms the basis of new NICE guidance

Clinicians leading the Network

Clinical lead: Professor Farzin Fath-Ordoubadi
Clinical project lead for Heart Failure: Helen Oxenforth
Clinical project lead for Diagnostics: Wendy Javaid
Clinical project lead for Cardiac Rehab: Susan Casnello

Cardiac tests are carried out on a member of the public at a mosque in Manchester, as part of an initiative to raise awareness of heart health.

Cardiovascular disease prevention

DR ASEEM MISHRA

CARDIOVASCULAR DISEASE PREVENTION CLINICAL LEAD

“From HSJ nominations and CVNeed analytics, to topping North West lipid targets, proactive care pilots and BP checks in pharmacies and opticians—we've made CVD prevention everyone's business. I'm inspired by our teams' dedication and proud to lead our shared successes across Greater Manchester.”

ACTIONS AND ACHIEVEMENTS

Greater Manchester has some of the highest rates of cardiovascular disease (CVD) in the country.

Some communities across the city region are impacted more than others.

By aligning intelligence-led, NHS-driven prevention models with patient, public and community engagement, Greater Manchester is leading the way in cardiovascular disease prevention.

Through targeted risk stratification, cross-sector collaboration and culturally competent public engagement, the CVD Prevention Network is proving that CVD inequalities can be systematically addressed through strategic and scalable action.

Primary prevention

People receiving lipid lowering medication before they have a cardiovascular event because they have been assessed as having a high risk of CVD:

- Greater Manchester has achieved 65.83%, exceeding the revised national ambition of 65%
- The most deprived quintile performs better (67.06%) than the least deprived (59.79%), and uptake is also highest in Asian (72.2%) and Black (66.5%) groups, demonstrating progress in tackling inequality.

People being treated for hypertension:

- Greater Manchester performance: 67.48% – the highest in the North West and above the regional average of 66.75%
- 6 of the top 15 primary care networks (PCNs) regionally are in Greater Manchester, highlighting system impact.

Secondary prevention

People being treated with statins after diagnosis of CVD:

- Greater Manchester has achieved 86.2%, leading the North West region
- Variation between localities is narrowing, with strong, consistent delivery supported by the city region's lipid optimisation pathway

Optimising reduction of lipids in people with established cardiovascular disease:

- City region performance: 48.56%, above both North West and England averages
- All top five PCNs in the North West for this indicator are in Greater Manchester, reflecting clinical leadership and strategic focus

Clinician leading the Network

Clinical lead: Dr Aseem Mishra

Diabetes

PROF NARESH KANUMILLI

DIABETES NETWORK CLINICAL LEAD

“Our Network is achieving great things. Whether people have diabetes, multiple long-term conditions or are at risk of experiencing associated symptoms, our programmes are reaching thousands of GM residents and changing lives. That’s why diabetes is a key focus in the NHS Greater Manchester Multi-Year Prevention Plan.”

ACTIONS AND ACHIEVEMENTS

Increase in referrals to type 2 diabetes path to remission programme

The Network wanted to increase the number of people referred to the type 2 diabetes Path to Remission programme.

The programme provides a low calorie, total diet replacement treatment for people who are living with type 2 diabetes and who have obesity or are overweight.

- Monthly meetings with providers were held to generate referrals and improve delivery
- Demographic data was reviewed to ensure equity of access among age groups and communities
- Primary care patient events were organised
- Webinars were held to raise programme awareness and how to complete a referral form
- The work led to 539 people starting the programme, beating the target of 250, a total of 1,146 people were referred
- A total of 267 practices have referred into the programme
- 180 practice staff attended the webinars, leading to an increase in eligible referrals
- Average weight loss at the end of the programme was 12%
- Retention rates remain high at 85% at the end of the total diet replacement stage, as well as 60% at the end of the programme

Improved care for people with early onset type 2 diabetes

The Network wanted to increase awareness of early onset type 2 diabetes among health professionals, as well as access to prevention and remission programmes.

- Lunchtime sessions were organised
- Meetings were held with locality leads and health development coordinators
- A resource sheet for health and care professionals was developed
- Outputs included increased awareness of optimised holistic care
- There is increased awareness of prevention and remission programmes by community groups and locality leads
- The number of people receiving contraception and preconception advice, being referred to structured education or the type 2 diabetes remission programme has increased

Diabetes and pre-conception: Healthy Pregnancy Planning

There was a need to raise awareness of diabetes among women across all communities when planning a healthy pregnancy.

- The team began a programme of engagement with relevant organisations
- Two education sessions were held across Greater Manchester via an online training hub
- Engagement with health development co-ordinators and well women's leads, was carried out with a view to including diabetes care within contraceptive services
- A resources page via a QR code for health care professionals working within primary care and within communities was developed
- There have been meetings with Sure Start teams, with a plan to introduce train the trainer programmes and include in future pregnancy planning and meetings with contraceptive commissioners to raise awareness of diabetes and NHS programmes

Above: Diabetes Network clinical team. Left to right, Nicki Milne, Dr Jaweeda Idoo, Prof Naresh Kanumilli, Dr Jonathan Schofield, Dr Hood Thabit, Nas Ahmad, Dr James Hider.

Type 2 structured diabetes education engagement

The Network worked with NHS Greater Manchester to implement an engagement programme to find out the views of people on type 2 stuctured diabetes education.

- More than 200 people completed an online survey
- There were seven targeted focus groups, reaching 135 people from South Asia and black African Caribbean communities, as well as those with learning difficulties, and interviews with people with lived experience
- Outcomes of engagement will inform redesign of future structured diabetes education
- An improvement in NHS Healthy Living online programme data following the engagement, including a 58% increase in signposting of people to register by GP practices
- There have been 470 registrations between October 2024 and March 2025

Healthier You NHS Diabetes Prevention Programme

The Network carried out activity to increase referrals to the NHS diabetes prevention programme.

- Programme locality leads were asked to complete an action plan and attend assurance meetings
- A toolkit was launched to support new referral pathway for women with previous gestational diabetes
- New HbA1c protocol has been installed on GP systems to support primary care workforce reviewing results
- The new starter target between April 2024 and March 2025 was exceeded by 27%
- There were 17,035 referrals over 2024/25

My Way Diabetes

The My Way Diabetes online self-management support platform for people living with diabetes continues to grow in popularity.

Backed by research evidence that demonstrates that users are achieving improved clinical outcomes, the platform now has:

- 23,000-plus patients registered for use
- 292 GP practices registered to share data with patients
- 870,000-plus total web platform visits
- 4,362,000-plus total web page views
- 4,900-plus diabetes education courses started

Right: Clinical lead Professor Naresh Kanumilli at the Greater Manchester Diabetes Clinical Network event in May 2025.

Retired truck driver John, from Rochdale, lost more than five stone on the NHS Healthier You programme, managed by the Diabetes Network in Greater Manchester.

Make every contact count more

Consultant vascular surgeon Naseer Ahmad has led the pioneering Manchester Amputation Reduction Strategy over the past few years – a trailblazing programme which has reduced lower limb amputations by 21%.

- 18,000 men attending the abdominal aortic aneurysm screening were given additional checks
- Previously undiagnosed hypertension and arrythmias, mainly atrial fibrillation, were detected and referred back to their general practice
- Some patients had undiagnosed high blood pressure or irregular heartbeats detected

The pilot has led to increasing the number of people identified, at low cost, who will benefit from prevention.

Further programmes

- The team established a clinical leadership and diabetes technology advisory group and now has specialist clinicians able to advise and debate the latest technology
- A long-term conditions operational engagement group was launched to build a network of leads, including diabetes, across every locality and includes sharing of best practice and guidance, with the aim of improving care
- There was clinical and programme support for the development of diabetes-related standards in Greater Manchester GP Quality Standards
- Proposals to use metformin to treat people with non-diabetic hyperglycaemia were developed

Clinicians leading the Network

Clinical lead: Professor Naresh Kanumilli
Primary care diabetes specialist nurse: Nicola Milne
Diabetes prevention lead: Dr James Hider
Structured diabetes education lead: Dr Jaweeda Idoo
Vascular and diabetes footcare lead: Mr Nas Ahmad
Diabetes transition lead: Dr Hood Thabit
Diabetes technology lead: Dr Jonathan Schofield
Maternity and ante-natal lead: Dr Moulinath Banerjee
Type 2 Diabetes to remission: Dr Sarah Steven

Right: Michelle O'Rourke and Claire Butterworth, vascular screening technicians helping to prevent strokes and aneurysms as part of the Network's Make Every Contact Count More programme.

Neurorehabilitation and stroke

DR SHIVAKUMAR KRISHNAMOORTHY

CLINICAL DIRECTOR

“The region’s pathway is designed to provide the elements of stroke care rapidly, saving lives and disability. Our pioneering community stroke and neurorehabilitation services are national exemplars in their model of care delivery.”

ACTIONS AND ACHIEVEMENTS

Updated stroke ambulance pathway

A pre-hospital pathway had previously been introduced across Greater Manchester, increasing the speed at which patients with a suspected stroke were diagnosed and treated, saving lives and reducing the risk of disability.

Evidence showed that some patients not originally included on the pathway could benefit from its early tests and interventions.

Also, patients in other parts of the North West were not benefitting from the improvements.

Work and achievements in 2024-25 included:

- Scope widened to include patients who may not initially show the ‘classic’ signs of stroke, but could still be at risk
- North West Ambulance Service and North West stroke services implemented a standardised approach, creating equity of care across the region
- As a result, patients were CT scanned more quickly on arrival at hospital
- More people had thrombolysis and/or mechanical thrombectomy to treat blood clots causing a stroke
- Fewer inappropriate referrals to the hyper acute stroke unit

Implementation of Patient Pass

There was a need to reduce the use of telephone referrals to the Comprehensive Stroke Centre at Salford Royal Hospital.

The existing process lacked governance and was inefficient.

Patient Pass, an online referral system was introduced to ensure a quick response from the stroke team using an auditable platform which supports patient safety.

- New process ensured appropriate patients were referred, reducing unnecessary transfers and use of hyper acute beds
- 2,619 referrals in 2024/2025
- Average response time of 27 minutes
- Telephone calls were reduced by 67%

Supporting workforce development in Greater Manchester stroke and neurorehabilitation services

The Network provides a comprehensive training programme for new and experienced professionals (NHS and non-NHS).

Key outputs:

• Produced a training report highlighting key achievements for 2024

• 12 training events including our annual conference

• Added to our extensive portfolio of training videos on YouTube

• Facilitated 4 x introductory stroke training programmes across the city region

• Training webinars viewed 8,242 times for more than 905 hours with 96 new subscribers on YouTube

• Face-to-face training events attended by more than 500 people

• 8 new webinars produced

• 85-100% of attendees rated training events as excellent or good, depending on which event they attended

• 3 x 1 day introductory stroke events delivered by Trusts attended by more than 100 local professionals

Right: A meeting of the Network's patient and carer group.

Creating a step change in patient and carer involvement

The Network wanted to increase the role of patient and public involvement (PPI) in shaping and giving feedback on its programmes.

In 2022, they appointed a PPI Co-ordinator to promote engagement with those with lived experience of neurological conditions across strategic planning and quality improvement initiatives.

This has resulted in:

• Strengthened and diversified the Network Patient and Carer Group, with more localities represented

• Patient and carer newsletter in plain English produced quarterly

• Equipped the Network team and Greater Manchester stroke and neurorehabilitation teams with PPI expertise to be more effective in their quality improvement projects

• Held a webinar to launch a new toolkit and developed online training to support use by teams

• A greater number of Network projects now include PPI

• Group members have provided positive feedback and feel more engaged

• Active PPI is now underway in a number of key workstreams including multiple sclerosis and visual impairment pathway development and improvement.

Support for patients' emotional health and wellbeing

- Clinical lead for psychology appointed to improve support for emotional wellbeing in stroke and neurorehabilitation patients
- Developed and delivered a training programme in Acceptance and Commitment Therapy (ACT), including funded clinical supervision for teams lacking a clinical psychologist
- 80 clinicians in GM were upskilled in ACT, which supports patients to live well through diagnosis and treatment
- The Network lead reinvigorated a regional peer support group for psychologists
- The lead helped local clinical neuropsychologists become better connected and supported the recruitment in this small sub speciality

Clinicians leading the Network

Clinical director: Dr Shivakumar Krishnamoorthy
Clinical lead for inpatient rehabilitation: Rachael Collins
Clinical lead for acute stroke: Dr Jungim Kwon
Community Clinical Lead: Christine Hyde

A patient undergoes balance therapy as part of improvement work carried out by the Greater Manchester Neurorehabilitation and Stroke Delivery Network, in line with the updated National Clinical Guideline for Stroke (2023).

Palliative and end of life care

DR LIAM HOSIE

PRIMARY CARE CLINICAL LEAD

“2024-25 has seen further progress with both the EARLY toolkit and EPACCS system in selected localities. These developments can aid in identifying palliative patients and improving information sharing.”

ACTIONS AND ACHIEVEMENTS

Electronic Palliative Care Coordination System (EPaCCS)

In the past, health and social care professionals in Greater Manchester could have difficulty finding out the preferences of someone in the final months of their life, due to limited access to patient records.

- The Network is supporting the implementation of EPaCCS key information within the Greater Manchester Care Record (GMCR), which gives 24-hour access to an individual’s preferences, such as where they would like to die
- The network have partnered with Health Innovation Manchester and now have 7/10 localities in GM live with EPaCCS on the GMCR
- This shared space aims to ensure health and care professionals are aware of an individual’s and their family’s wishes
- It supports consistent and personalised care for people entering final months of life
- Feedback from palliative and end of life stakeholders across the city region has been positive

EARLY identification

Early identification of individuals who may be in the last 12 months of their life is important because this gives people the opportunity to be involved in planning for their future care.

This could include thinking about the type of care they would like or would not like, where they would like to be cared for, who should be involved in their care, and can help with planning for loved ones.

- The EARLY identification search tool works within GP electronic patient records
- It has been rolled out across different parts of the city region since 2019
- It identifies people who may be in last year of life
- A clinician will then review the results of the tool to clinically validate individuals for a proactive care review
- The network delivered phase three of the programme
- This increased GP access to the tool
- There has been a rise in the number of advance care plans created and uploaded onto EPaCCS
- The project ensures more people have personalised care and wishes in place
- It supports care for individuals in a place of their choice and has been welcomed among health and care professionals
- A pilot phase in Wigan and Tameside over 2024-25 saw 3,000 people identified as being in the last year of life

Palliative and end of life care dashboard

The Network helped to design, coordinate and launch the palliative and end of life care dashboards on the GM Intelligence hub, which gives health and social care professionals information on a population, locality and PCN level.

- The dashboards have information on the last 90 days of life and place of death
- There is an activity system dashboard – outlining the activity in the last 30, 60 and 90 days of life and the impact on system wide services
- Primary care data is available on the dashboards

Warmth on prescription initiative

People in the last months of their life can struggle to pay their energy bills due to a change in their circumstances and the requirement to run medical equipment at home.

- The network partnered with a national energy charity to provide support for costs for those with a life limiting illness
- They delivered training sessions for professionals and helped to link individuals with the scheme

Specialist palliative care rapid review

The Network supported the leadership of a rapid review for NHS Greater Manchester, concluding with a set of recommendations to support the sustainability of specialist palliative care provision in Greater Manchester.

Above: The Network's clinical and support team.

Palliative and end of life care: Babies, Children and Young People Programme

The Network took action to evaluate and improve services for babies, children and young people, as part of this programme, which ran separately to the adult network.

- Our clinical leads launched a service mapping project to review services in Greater Manchester

- The report contains details of inequalities in services between localities and has key information for any consideration of redesign of services
- There is monthly advance care planning training run by network clinical leads, including online resources and trainer support, to ensure choices and wishes at end of life and provide guidance for the workforce

- The Network was the conduit for children's hospice grants, ensuring access to funding and supporting sustainability of specialist palliative care services.
- We are supporting NHS Greater Manchester in designing services to address inequity across Greater Manchester and grow Greater Manchester's provision

Clinicians leading the programme

Clinical lead: Dr David Waterman
Primary care clinical lead: Dr Liam Hosie
EARLY clinical advisor: Dr Jayne Kennedy
Babies, children & young people clinical advisor: Dr Lydia Bowden
Babies, children and young people clinical advisor: Anna Oddy

Above: Clinicians and support team at 'Transforming Palliative Care in Greater Manchester for babies, children and young people' event in 2024.

Respiratory

DR JENNIFER HOYLE

RESPIRATORY NETWORK CLINICAL LEAD

“In 2024- 2025 the respiratory team has focused on improving access to evidence-based respiratory care, with prevention and quality of care at the heart of the patient journey.”

ACTION AND ACHIEVEMENTS

The city region has some of the highest rates of respiratory disease in the country, with significant variations across localities.

There are a total of 142.9 deaths per 100,000 people for all ages and it has some of the highest admissions to emergency departments in the country. There are around 7,000 chronic obstructive pulmonary (COPD) disease admissions every year, costing £20 million.

The Network has prioritised the likes of chronic obstructive pulmonary disease (COPD), asthma and pneumonia and aims to reduce the number of people with them, and the severity of them, with targeted interventions and strategic initiatives.

One of these programmes has been the improvement of pulmonary rehabilitation sessions, led by 13 services across the city region.

Three of the teams have now been accredited to the Pulmonary Rehabilitation Services Accreditation Scheme, with the others continuing to work towards it.

A respiratory deep dive was held to highlight the progress made by the Network to date and recommendations for future priorities, which include COPD, interstitial lung disease (ILD), asthma and pneumonia.

Our aim is to reduce the number of people with them, as well as the severity of them, with targeted interventions and strategic initiatives.

Achievements from 2024-25 include:

- Developed initiatives through existing search tools which lead to early diagnosis and prevention
- Supporting the development of business case for delivery of quality assured spirometry and FeNO testing, which will improve diagnostic accuracy and early detection of conditions
- Integrated care pathways between primary and secondary care established to manage viral surges and acute respiratory infections during winter months, which will be widened across the city region for winter 2025/26
- Review of ILD pathways and services to reduce duplication and provide care closer to home for patients. This work has so far contributed to a significant reduction in patient waiting times and provision of medication and monitoring closer to home.
- Introduction of virtual wards has enabled better management of respiratory conditions in the community, reducing the need for hospital admissions
- Secondary prevention and management a success with localities' accredited pulmonary rehabilitation programmes seeing improved outcomes and reduced hospital admissions for COPD and asthma patients
- Publication of Greater Manchester Medicines Management Group's asthma guidelines for adults and Respiratory Beyond Core Contract will help identify high-risk patients and improve care
- Introduction of point of care testing at acute respiratory infection hub at Hyde
- Making every contact count, establishing pathways for vaccination in respiratory clinics, with referral links into employment support, housing and citizen advice services

"New initiatives such as the Greater Manchester Medicines Management Group's asthma guidelines for adults will not only reduce the number of asthma admissions, but also decrease the carbon footprint associated with the misuse of inhalers."

Primary care clinical lead Dr Murugesan Raja (pictured above left).

Improving access to spirometry

Spirometry is a critical diagnostic tool for assessing lung function and identifying respiratory diseases, but access to services has been limited, leading to delays in diagnosis and treatment.

The Network has supported the development of a business case to improve and expand services across Greater Manchester. The case, which has been developed over the past 12 months and is awaiting final sign-off, will help improve outcomes for patients.

- It will increase access, ensuring everyone across the city region can be tested
- It will improve accuracy and speed of diagnosis
- There will be better management of respiratory conditions through regular spirometry assessments
- Recommendations include an increase in number of spirometry service providers, providing training, raising awareness among patients to get tested, and integrating services with existing respiratory care pathways
- The business case includes funding for new equipment and training programmes
- It ensures collaboration with primary care providers and community health services to ensure wide access
- The impact is expected to include improved health and wellbeing of patients, efficient use of resources and reduction of hospital admissions and increased patient satisfaction.

Right: A man takes part in a pulmonary rehabilitation session in Greater Manchester.

Long Covid

Long Covid, myalgic encephalomyelitis/chronic fatigue syndrome and clinically similar syndromes

Dr Clare Gibbons, pictured above, our Greater Manchester clinical lead for long Covid for the last three years, has led with the team on the clinical development of a new combined service for long Covid, myalgic encephalomyelitis/chronic fatigue syndrome (ME/CFS) and other clinically similar syndromes.

The Strategic Clinical Networks (SCNs) has played a crucial role in supporting the strategic commissioning of this joint service.

Greater Manchester remains committed to delivering high-quality post-Covid services and improving access to ME/CFS services. It has made significant progress in developing a proposal for a more resilient, sustainable and equitable commissioned service model, targeted for implementation from Q3 2025.

Key achievements to date include:

- Extensive stakeholder engagement across the conurbation, involving providers through stakeholder groups, workshops, task and finish groups, design sessions, patient engagement forums, regular catch-ups and governance meetings
- Establishment of a steering group comprising representatives from the ICB, SCNs, general practice, acute and community providers, clinical leads and patients, this group provides oversight, assurance and supports the delivery of the future model
- Comprehensive mapping of the current commissioning and delivery model across Greater Manchester, alongside the development of a financial baseline
- Co-design of a future integrated clinical model and pathway for long Covid and ME/CFS
- Ongoing review of evidence and best practice to inform service design and delivery.

We are currently finalising a proposal outlining the future model and pathway.

This includes activity, workforce, capacity and financial modelling to assess feasibility.

The proposal is due to be presented to the steering group in early July 2025.

Following this, it will undergo clinical and non-clinical scrutiny and approval through the ICB.

To maintain momentum and minimise risk to current service delivery, commissioners have maintained regular communication with providers and confirmed their commitment to continue current funding arrangements until the new model is approved, at which time commissioners will work with providers to achieve a smooth transition to the future model.

ACCESS4ALL

Reimagining rehabilitation across Greater Manchester and Eastern Cheshire

Led by clinical lead Dr Steven Whatmough, pictured above, the ACCESS4ALL project aims to reimagine rehabilitation across Greater Manchester and Eastern Cheshire through a system-led, patient-focused approach that addresses inequalities in access and outcomes.

In 2024-25, we established a strong multi-agency collaborative including our networks, representatives from Manchester Metropolitan University (MMU), Health Innovation Manchester (HInM), GM Active, GM Moving, Nuffield Health and Pennine Care.

Together, we are developing an evidence-based system pathway for rehabilitation that uses Greater Manchester datasets and predictive modelling to enable triage and delivery at scale.

Whether someone has been affected by, say, a stroke or heart condition, our aim is to deliver improved services to them, whichever community they belong to and wherever they live.

Our work is currently research-focused, with a dedicated PhD student investigating barriers to accessing rehabilitation in deprived communities.

ACCESS4ALL has been designated a priority project within the MMU–HInM strategic partnership, and we have started to offer early research-led rehabilitation services through a collaboration between MMU and Nuffield Health.

Looking ahead to 2025/26, we plan to refine and test our rehab model and continue embedding research-led services into care pathways.

A key priority will be securing funding through health research grants, with several major applications already in development or under review.

Clinicians leading this work

Clinical lead: Dr Jennifer Hoyle
Primary care clinical lead: Dr Murugesan Raja
Long Covid clinical lead: Dr Clare Gibbons
Greater Manchester long Covid research lead: Dr Nawar Bakerly
ACCESS4ALL / Rehab clinical lead: Dr Steven Whatmough

Networks:

Children and young people Maternity LMNS

Left: Sisters Tori and Nola with their new little brother Jaxx, born at the Royal Bolton Hospital on New Year's Day 2025.

Children and young people

DR EASWARI KOTHANDARANAN
NETWORK CLINICAL LEAD

“The work of the Network is incredibly important as it provides a vital connectivity point, getting the clinical voice into the health and social care system.”

ACTIONS AND ACHIEVEMENTS

Asthma Bundle of Care/Core 20 Plus 5

Thousands of children in Greater Manchester live with asthma, with many of them suffering from acute asthma attacks, leading to emergency treatment.

Some of these attacks are caused by poor management of their condition, both at home and at school.

- The team launched the severe asthma pathway and network
- Promotion of the digital health passport, which young people can use for their asthma action plan, track symptoms and read information about their condition is ongoing
- They developed TAPES (a care bundle) toolkit for primary care and introduced TAPES in emergency departments
- A monthly multi-disciplinary team was launched for children with severe asthma and attended by clinicians across the North West
- An asthma friendly guide for schools was created

Right: Greater Manchester asthma friendly school lead nurse Claire Slattery visiting a local primary school.

- The Asthma friendly schools project was incorporated into the Manchester Healthy School Programme
- An education strategy and pack was developed with clinical leads providing training for primary care
- There were 190 fewer emergency admissions for quarter 3 in 2024/25 compared to same quarter in 2023/24
- There were 600 fewer emergency admissions for asthma in 2024 than in 2019
- 704 children and young people, parents and carers using the digital health passport (the highest number in ICS areas in England)
- More than 2,100 health and social care professionals, as well as school, youth and voluntary workforce have accessed online NHS training

Diabetes transformation programme/CORE 20 Plus 5

There are thousands of young people who live with diabetes in Greater Manchester.

The Network launched programmes in 2024/25 to improve diagnosis and treatment.

- A risk stratification pilot for type 2 diabetes was launched in Oldham and Stockport with community weight services, supported by referral and treatment pathways
- There has been an increase in uptake of technology, including hybrid closed loop, with equal access across demographic groups
- A transition strategy, supporting young people moving into adult services, was launched in partnership with the adult diabetes programme
- There has been a reduction of 25 cases in emergency admissions for diabetes, from 2019-2024, despite an increase in population size and diabetes team caseloads of 15%
- Among children who accessed the new service known to have type 1 diabetes, the number of episodes of DKA (diabetic ketoacidodosis) has been halved

Epilepsy bundle of care/CORE 20 Plus 5

The team took a number of steps to improve epilepsy care for children and young people.

- The epilepsy specialist nurse offer was reviewed and a paper was produced for commissioners
- Shared mental health and wellbeing resources to support young people were developed
- Standardised transition documentation for use in epilepsy services, for those moving from children to adult services
- Teams in Oldham and Salford participated in projects around transition and mental health and learning was shared
- The health care youth worker pilot in Heywood, Middleton, Rochdale and Oldham was implemented
- There were 76 fewer admissions for 0-18 year-olds in 2024 than in 2019
- From May to December 2024, 79 young people with epilepsy benefited from youth worker activities.

Further programmes of work

- The team supported trusts to implement the National Paediatric Early Warning Score (PEWS); there are now a total of 10 inpatient PEWS leads and 12 emergency department leads across six Trusts
- Coordination with Trusts to establish mental health champions. There are currently 11 champions covering 6 Trusts and 9 inpatient units
- Clinical leads appointed to guide asthma, epilepsy and diabetes programmes and to contribute to North West governance groups

Clinicians leading the Network

Clinical lead: Dr Easwari Kothandaraman
Diabetes clinical lead: Dr Chris Cooper
Clinical advisor: Julie Flaherty MBE
Asthma clinical leads: Professor Dr Clare Murray, Alison Senior
Epilepsy clinical leads: Debbie Garner, Dr Amy Wilson

Our Children and Young People's team's asthma friendly school project is helping children manage their condition and reduce admissions to accident and emergency.

Maternity

EILEEN STRINGER

MIDWIFERY CLINICAL LEAD

“Our Maternity Network has a strong focus on safety and we strive to create services where all individuals, regardless of background, receive the same high-quality, personalised care.”

ACTIONS AND ACHIEVEMENTS

Saving Babies Lives bundle

The Network monitors safety, working towards meeting the national maternity safety ambition to halve rates of perinatal mortality and morbidity, which remains challenging nationally, as well as regionally

They wanted to improve safety outcomes through the full implementation of a care bundle for reducing perinatal mortality known as Saving Babies’ Lives (SBL)

The bundle consists of six elements that provide a framework for best practice in maternity care

A networked approach standardises care, reduces variation and provides leadership and peer support to specialist roles who work autonomously within maternity providers.

This has been achieved by:

- Monthly meetings with SBL Champions, Smokefree Pregnancy midwives and SBL clinical leads to help drive implementation forward
- Sharing learning and driving implementation forward
- Developing a local Futures Platform for the sharing of resources between providers
- Supporting training and development of 21 midwifery ultrasound practitioners to help meet the demand on the increased numbers requiring third trimester scanning

- Developing a standardised core SBL training day across all maternity providers, delivered as part of mandatory training for all clinical staff
- Quarterly specialist interest forums for fetal growth restriction, fetal monitoring and preterm birth; each forum is attended by obstetric leads and lead midwives from every maternity provider
- Collaboration with the North West regional maternity team on the development of guidelines for fetal monitoring, preterm birth and reduced fetal movement
- A quarterly assurance process to ensure all providers meet required standards, with all providers sharing work on how they are targeting health inequalities in relation to their own population and demographics
- Development of patient information leaflets for aspirin, cholestasis and uterine artery scans, which are translated and printed into key languages

The stillbirth rate is now 4.35 per 1,000 live births, which is the lowest it has been since 2019, and an 11% reduction on the previous year.

Intrapartum brain injury figures are 0.52 per 1,000 live births, meaning Greater Manchester and Eastern Cheshire is significantly lower than the national average. This has reduced by 37.5% over two years which means babies born with brain injuries has fallen from 40 to 15.

Right: Midwives from across Greater Manchester at a preterm and stillbirth event.

Reducing pre-term birth/optimising perinatal care

Greater Manchester and Eastern Cheshire is seeing a downward trend in pre-term birth, but the rate remains above the national ambition.

As pre-term birth prevention clinics embed into clinical practice, along with improvements such as patient education and optimising perinatal care to improve preterm outcomes, it is hoped there will be a greater decline.

The work so far has included:

- Scoping of preterm birth clinic provision across all maternity providers to identify outliers and provide additional support
- A third annual preterm birth study day, with 65 delegates sharing learning and knowledge
- Plans to target the most at risk populations, which include those living in deprivation, as well those in Black and Asian ethnic groups
- More than 50% of preterm births are to women with no identified risk factors, the Network worked in partnership with the Maternity and Neonatal Voices Partnership to produce a 'Signs and Symptoms of Preterm birth' leaflet, that will be given to every woman in early pregnancy across the region (see page 54)
- Where pre-term births do occur, the team has been working to optimise the condition of the preterm infant
- The region has demonstrated 73% overall compliance with the perinatal optimisation pathway, one of the highest rates nationally, and in some interventions Greater Manchester and Eastern Cheshire is excelling.

Improving effective fetal monitoring during labour

Following clinical incident reviews through the safety workstream, the Network identified effective fetal monitoring and escalation of concerns as a priority for improvement.

This has been progressed by:

- Developing standardised and interactive training packages across Greater Manchester for fetal monitoring with a digital competency assessment developed for all providers to use within their own mandatory training platforms

- Rollout of the Intelligent Intermittent Auscultation (IAA) project across all providers by a dedicated clinical project lead, to improve the early recognition and signs of deterioration in fetal wellbeing, enabling appropriate and timely action to be taken
- Launch of the Royal College of Obstetricians and Gynaecologists' Each Baby Counts programme across all providers by a dedicated clinical project lead. To date, a total of 1,501 midwives and 210 doctors have completed the escalation and behaviours training

Improving care for people who have suffered perinatal loss

The Network wanted to standardise and reduce variation in the provision of high standard and compassionate care of women and families experiencing perinatal loss.

The work has included:

- Developing a neonatal death guideline and integrated care pathway to assist in the delivery of high standard care, which included collaboration with regional and neonatal stakeholders
- Facilitating the 11th Annual Perinatal Loss Study Day – shared learning and knowledge across the Network which was attended by 65 delegates
- Undertaking a formal review of the stillbirth guideline with an accompanying integrated care pathway to assist in the delivery of high standard and compassionate care
- Facilitating a quarterly bereavement midwives forum for peer support

Clinicians leading the Network

Clinical lead obstetrician: Dr Ghazia Saleemi
Clinical lead midwife: Eileen Stringer
Perinatal loss clinical lead: Dr Elaine Church
Clinical lead for fetal monitoring: Dr Samiksha Patel
Clinical project lead for IAA: Amanda Fieldhouse
Clinical project lead for Each Baby Counts: Chloe Hughes

Local Maternity & Neonatal System

DR AKILA ANBAZHAGAN
LMNS MATERNITY CLINICAL LEAD

‘The LMNS has once again had a successful 12 months, showing how different teams of people can work together to make real improvements for everyone in across our many different communities.”

The Greater Manchester and Eastern Cheshire Local Maternity and Neonatal System (LMNS) is a hosted function within the SCNs, with its clinicians and support team overseeing its work.

Implementation of Maternity and Neonatal Voices Partnership

The Greater Manchester and Eastern Cheshire Maternity and Neonatal Voices Partnership (MNVP) is a group of women, birthing people and their families, midwives, doctors and commissioners working together to review and develop care.

Their work during 2024-25 has included:

- Roll out of eight MNVP leads across the area, mirroring the maternity and neonatal units
- Creation of the network bringing under one umbrella different projects and workstreams, (including 15 Steps for Maternity observational visits and Walk The Patch activities), along with targeted co-production activity across the service area
- Co-production of pre-term signs and symptoms leaflet, addressing a specific need among South Asian service users
- Organisation of the 15 Steps initiative, which is an observational walk around maternity units with service users.

15 Steps for Maternity and Neonatal

This programme aims to make small but important changes to maternity units based on feedback from families.

They are organised by each MNVP lead in their local Trust.

- The initiative sees service users and voluntary, community and social enterprise representatives visit different areas of hospital sites, including, for example, ante natal clinics, labour wards, triage, birth centres and postnatal wards
- The purpose of the visits to look at maternity services through the lens of a service user, with families asked how the environment makes them feel
- Feedback is provided under the themes of welcoming and informative, safe and clean, friendly and personable and organised and calm
- This is the first year that 15 Steps has been run in partnership with Spoons, a charity which aims to ease stress and reduce isolation for families who experience neonatal care in Greater Manchester
- Examples of actions which have been taken as a result of 15 Steps visits include the development of visual information supporting active birth on the labour ward at North Manchester and a handbook for users of maternity at Wigan, which includes key information, including maps and how to get food, especially during the night

Left: Maternity team, service users and VCSE representatives at a 15 Steps event to assess quality of services.

Co-production project: Signs & symptoms of pre-term birth leaflet

This co-developed project aimed to develop new resources addressing a specific need within South Asian service users in Greater Manchester in recognising the signs and symptoms of pre-term birth.

Previous resources for this demographic were known to be harder to access, often said to be too medical or academic.

- The LMNS worked in partnership with a well-established charity which supports women from South Asian heritage, Chair Project's groups in Oldham and Trafford, which are attended by more than 70 women from minority ethnic groups, as well as asylum seekers and refugees
- A leaflet has been produced and plans are in place to distribute 20,000 copies across Greater Manchester. It will be translated into the five most-spoken languages

Management of safety specialist interest group

The LMNS established and managed a monthly safety specialist interest group (SIG) to share learning and improve services.

Maternity professionals from across Greater Manchester's six maternity providers attended to discuss the previous month's safety events, recommendations from MNSI, complaints and coroner inquests.

- Working together we provided a network of support and an opportunity to share learning from serious incidents, discuss ideas, share good practice, work collaboratively and be proactive
- The group ensures actions from the Ockenden Report and recommendations of the three year delivery plan for maternity and neonatal services were carried out
- A Safer by Sharing document is issued after each meeting to capture themes and highlight areas for improvement, this is cascaded and shared with wider teams
- Safety and outcomes in maternity services are regularly monitored, with analysis also including relationship between deprivation and minority ethnic groups
- Several online and in-person events have been held to support the aims of the group

Supporting safer maternity and perinatal care

The Department of Health and Social Care instructed the establishment of the NHS Maternity Incentive Scheme (MIS) to encourage Trusts to actively adopt best practices and implement essential safety measures.

- MIS financially rewards Trusts that can demonstrate they have implemented core safety actions, if they are members of the Clinical Negligence Scheme for Trusts
- In 2024-25, the LMNS continued to support Greater Manchester providers to achieve compliance with 10 safety actions, which support national ambitions
- This included reducing the number of stillbirths, neonatal and maternal deaths and brain injuries, or other harm that can lead to negligence claims, from the 2010 rate by 50% before the end of the year
- All GM maternity provider Trusts applied for the scheme and five of the six achieved compliance to all 10 safety actions in 2024-2025
- LMNS support will continue into 2025-26.

Providing maternity assurance

The LMNS provided assurance for maternity services, with the aim of improving standards of care across localities.

It carried out this important function in the following ways:

- Assurance visits on behalf of the ICB, included gathering insights on a provider beforehand and giving key lines of enquiry before the visit
- Senior leadership team provided evidence, with extra checks put in place if needed
- Improvements in care were seen in triage facilities and increased support for junior doctors
- Instigation of a quality and escalation framework to reassure families that maternity services were being monitored
- LMNS supported where needed, or escalated to ICB level
- Maternity perinatal performance and oversight panel reviewed specific performance metrics and gained assurance from providers on standard of services
- Priorities set out in NHS operational planning guidance were monitored, including reducing stillbirth, neonatal mortality and serious intrapartum brain injury
- Compliance with Ockenden recommendations was monitored
- Maternity and neonatal services are progressing well and on track to achieve 59 deliverables within the three year plan

Maternity triage project

In July 2024, an innovative approach was adopted with a new programme of work for maternity triage.

The key focus was to agree a standardised model of triage for Greater Manchester and Eastern Cheshire, in line with new RCOG recommendations, and support maternity providers in achieving this.

- Key principles of maternity triage were introduced and adopted by all maternity units with the aim to create a standard level of maternity triage care across all 8 providers, using the Royal College of Obstetricians and Gynaecologists' Good Practice Paper
- Quality improvement support was offered to all providers to increase compliance to the standards
- Women being seen at triage within the recommended 15 mins of arrival moved from 74.6% in October 24 to 81.5% in June 2025

Perinatal pelvic health service

During 2024/25 the LMNS has led on the commissioning and establishment of perinatal pelvic health services (PPHS) in providers.

- In January 2025, a post-partum pelvic health service standardised care pathway was developed and adopted into a commissioned service by NHS Greater Manchester.
- A networked approach has been taken across Greater Manchester with monthly network meetings playing a key role in supporting the new and existing specialist perinatal pelvic health midwives and physiotherapists.
- Network creates a community of clinical practice, developing skills and sharing of good practice, future-proofing the PPHS in Greater Manchester

Equity and Equality Plan

In 2021, national guidance was produced directing all local maternity systems to start a programme of work to improve equity and equality and consider wider determinants of health that impact on a pregnancy long before it begins.

The LMNS developed an Equity and Equality action plan, describing steps which need to take place to improve outcomes.

- Over 2024-25, the team worked through 167 actions and completed 67 of them, with 70 in progress, all improving services for birthing people and families
- The 86% complete or in progress rate followed a significant increase in work streams and provider benchmarking
- The team worked hard to increase the representation of communities and different groups within the Equity and Equality implementation group and secure regular maternity provider attendance
- The As Soon As You Are Pregnant campaign encouraged early screening and a new website was launched
- Key leaflets were produced on topics such as aspirin and cholestasis in pregnancy, and translated into key languages
- A project with Maternity Action has seen 1,500 refugee women supported during pregnancy
- Another partnership with Maternity Action, the Greater Manchester Maternity Rights at Work Project, was launched to support reproductive wellbeing in the workplace

Clinicians leading the Local Maternity & Neonatal System

Clinical lead obstetrician: Dr Akila Anbazhagan
Clinical maternity assurance lead: Val Clare
Safety lead midwife: Karen Clough

From April 1, 2025, Greater Manchester and Eastern Cheshire LMNS has been re-named to become Greater Manchester LMNS, as East Cheshire Trust forms part of NHS Cheshire and Merseyside LMNS.

Beth Ashcroft and her partner Matt with their New Year's Day 2025 arrival Reuben at the Royal Bolton Hospital maternity unit. The midwifery team at Bolton has been involved with the Maternity Network in rolling out improvements for families.

Corporate functions

Communications

4,500

stakeholders a month reading our monthly newsletter. Open/click rate treble health sector average

Events

3,000

health and social care stakeholders attended 46 events we organised for both us and NHS Greater Manchester

Corporate support

Enabling

and supporting recruitment, onboarding, finance, and providing support to meetings

Data intelligence

Latest

data ensuring Maternity Network makes decisions based on new trends

Next steps

Our clinicians and support team, like the whole of the NHS system, find themselves focusing on their important function of improving patient services, while awaiting confirmation of what our role will be and where we will sit within the reformed health system.

As we write, the Government has just published Fit for the Future: 10 Year Health Plan for England, with its anticipated focus on moving from hospital to the community, analogue to digital and sickness to prevention.

The plan also confirms that integrated care boards will be responsible for strategic commissioning with multi-year budgets, to make sure money is put to the best possible use to improve population health and reduce inequalities.

This Impact Report offers many examples of programmes which have achieved all of these aims.

Strong clinical leadership will spearhead future work in these areas and we believe our Networks offer unique expertise in Greater Manchester and has much to offer the new-look health and social care world.

Right: A schoolboy in Manchester correctly using an inhaler as part of the asthma friendly school project.

Thank you

We would like to thank every clinician, doctor, nurse, midwife and therapist, as well as all health and social care professionals who have played an important role in our achievements over the past 12 months.

A big thank you also to our super support team, whose energy and agility has seen proposals and plans transformed into improved services for people in Greater Manchester.

Below left: Dr Carol Ewing, left, our former clinical advisor for children and young people, with our clinical lead for children and young people, Dr Easwari Kothandaraman.

Below right: Group photo of the support team.

Contact Us

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Greater Manchester and Eastern Cheshire Strategic Clinical Networks

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