Greater Manchester Health and Social Care Partnership

NHS
Greater Manchester and Eastern Cheshire
Strategic Clinical Networks

IMPACT REPORT

2021/2022

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Foreword

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Welcome to our impact report for 2021/2022. This is our chance to look back at some of our accomplishments over the last 12 months and how we have made a difference for the people living and working in Greater Manchester and Eastern Cheshire.

We are proud of the difference we are making to the lives of thousands of people in the region, with our clinical leadership driving positive change. For almost 10 years, 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.

We take a life course approach, from maternity to palliative and end of life care, with many long-term conditions in between, and use clinical leadership to identify where improvements are needed.

Over the past 12 months, we have helped establish long COVID services, launched an app for children to self-manage their asthma, introduced an electronic system to coordinate end of life care and saved lives by rolling out blood pressure monitoring at home.

Reducing health inequalities has remained a key focus of our work, improving services to everyone's benefit, regardless of where they live or what community they are from.

We play a unique role within Greater Manchester, our mix of expertise, partnership working and, importantly, independent clinical voices, combining to make essential improvements to health and care.

We hope you enjoy reading this report. Thank you for your interest in our networks.

Julie Cheetham, Director
Peter Elton, Clinical Director

Our approach

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We are **led by clinicians**

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

We have **expertise**

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

We **collaborate**

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

We can be **candid**

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

Our support team

Greater Manchester and Eastern Cheshire Strategic Clinical Networks

Our core team facilitate the networks. Working closely with our clinical leads we ensure that initiatives are delivered successfully.

We provide the following support functions across all the networks:

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

Maternity Network

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"I am most proud of the way the SCN has been able to support maternity service providers to continue quality improvement work.

In spite of significant challenges related to the pandemic, as a result of our efforts we have seen improvement in many outcome metrics in 2021."

Miss Karen Bancroft,
Clinical Lead
(2013 – 2022)

The Ockenden review

We have overseen the implementation of the immediate and essential actions identified in the Ockenden report across the region. The Ockenden Interim Report (2020) was based on the serious failings in maternity care raised by two bereaved families in 2016 at the Shrewsbury and Telford maternity hospital. The actions will result in safer and more effective maternity services for parents and children.

Black and Asian Maternity Advisory Group

As evidence has clearly shown that maternal outcomes for women/birthing people from Black and South Asian heritage are significantly worse than other ethnic groups the local maternity system set up the Black and Asian maternity advisory group to look into this further.

Based on the findings from 10 focus groups, involving the voices of 94 Black, Asian, and mixed ethnic minority women/birthing people and voluntary community sector organisations, we have produced maternity standards of care for Black and Asian women/birthing people.

The new standards of care have been ratified and next year we will work with our maternity providers across Greater Manchester and Eastern Cheshire to implement the standards and improve the experience and outcomes for these women/birthing people.

Digital Acuity Tool

Working with colleagues in the Greater Manchester Health and Social Care Partnership we have developed a digital acuity tool to ensure greater visibility of maternity provider status on a daily basis.

The tool is held on the Tableau system (a business intelligence system) that enables data to be shared across Greater Manchester. Our local maternity providers input data on a daily basis by 10am to describe their acuity status which can be updated at any time. The collection and view of data on Tableau enables us to see any pressure on the system.

There is huge value in this piece of work as it means that providers no longer need to submit multiple reports. The system prevents duplication and releases time for staff for clinical care.

The Acuity Tool can be viewed by both internal and external stakeholders, creating a clearer line of sight for senior trust leads, commissioners and the Local Maternity System (LMS).

Another benefit of the system is that reports can be extracted on a weekly or monthly basis for tracking of acuity trends and issues.

We are proud of the work that we have done and that is well received, not only within Greater Manchester, but also on a North West footprint, with plans to roll the tool out to other LMS' in the North West.

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Children & Young people Network

“I’m proud of our role in ensuring that the voice of children, young people, parents and carers is contributing to the refreshed plan for services in Greater Manchester.

As we move towards an Integrated Care System, I am pleased that priorities such as addressing speech, language and communication needs, improving asthma outcomes and helping them to be a healthy weight will be prioritised.”

Dr Carol Ewing,
Clinical Lead

Improving asthma care

Deprivation has a determinantal impact on health outcomes for children and young people with Asthma.

This year we established a GM Asthma Working Group and appointed a Children's Asthma clinical advisor to drive forward the improvements needed in this area.

We have begun to pilot an Asthma app in Manchester.

77 children and young people have downloaded the asthma app in Manchester meaning that they have instant access to resources to help them manage their asthma.

Supporting bed management

We led on the development of a digital dashboard for children and young people beds across GM.

This dashboard shows the number and type of acute hospital beds available across GM. It also captures data about the number of children admitted with COVID, mental health issues or bronchiolitis and respiratory syncytial virus (RSV).

The dashboard is supporting the effective management of inpatient services across the region. It is reviewed three times a week by the GM system to identify where there are available beds or where there are staffing pressures and is a valuable asset.

Speech, language and communication services

A deep dive into local services revealed that there are gaps in service provision for children and young people, variation in outcomes and long waits.

We co-produced an event for professionals across GM to raise awareness of the current challenges within services and the impact that speech, language and communication needs (SLCN) can have on a child's life.

As a result, SLCN is a priority in the forthcoming Greater Manchester Children's Plan. Resources have been identified to appoint a clinical lead and implement the Balanced System across Greater Manchester.

"Bee Counted"

Working in partnership with children, young people, their parents and carers is a top priority for us. This year we commissioned Youth Focus North West to deliver 'Bee Counted' inspections for children's services in GM.

At the end of March 2022, 9 inspections have been carried out and the findings shared.

The inspections made recommendations to providers including involving children and young people in a redesign of waiting areas, and use of online platforms and social media to ensure information is accessible to all.

Little lungs need BIG protection

We launched a campaign across GM in November 2021 to help raise awareness of bronchiolitis. There were a total of 236,211 impressions and over 85k people reached!

Visit our campaign page Gmhscp.org.uk/littlelungs/

MISS POLLY HAD A DOLLY WHO WAS SICK SICK SICK. SO SHE CALLED 111 FOR ADVICE quick quick quick

HOW TO TREAT BRONCHIOLITIS

More often than not bronchiolitis is treated at home by:

- ☑ Giving fluids little and often (very young babies tend to become breathless after a large feed)
- ☑ Keeping a baby cool and in a well-ventilated room
- ☑ Offer infant paracetomol (like Calpol) or Ibuprofen to bring down a temperature. Ibuprofen should be avoided if your child is not drinking adequately

The virus often clears within two weeks without the need for further treatment.

However about 3% of babies who develop bronchiolitis will need to be admitted to hospital after developing more serious symptoms such as breathing difficulties.

This is more common in premature babies (born before 37 weeks of pregnancy) and those with a heart or lung condition.

Cardiovascular Network

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> “I’m proud to be able to work with a pool of talented, committed clinicians and managers within our health and care system who continue to drive service improvement to make sure all our residents have equal access to care.”

Professor Farzin Fath-Ordoubadi,
Clinical Lead

Hypertension

We have recently reinvigorated our hypertension work, ensuring that early detection and effective treatment are placed at the heart of the Cardiovascular disease (CVD) prevention workstream. Working in partnership with a variety of stakeholders we are looking to develop a comprehensive case finding pathway for Primary Care Networks (especially those in the most deprived areas), as well as increasing the provision of opportunistic blood pressure checking amongst pharmacists, dentists, opticians and podiatrists. We will also look to empower patients to manage their own blood pressure through home monitors and the use of remote technology.

Cardiac rehabilitation

A priority for us this year was to increase the uptake of cardiac rehabilitation, particularly amongst diverse and potentially disadvantaged groups. Following successful bids for funding, we have supported projects in Bury, Manchester and Trafford. These projects looked to increase engagement in cardiac rehab programmes and to reduce the drop out rates.

The projects have helped us identify gaps in current cardiac rehab services, the barriers that people can face accessing such services and what we can do to address the barriers. One of the biggest barriers which has been identified is a lack of community venues, especially in areas which are some distance from hospital sites. We are working with commissioners and providers to look at innovative ways of increasing community cardiac rehabilitation provision.

Heart failure

In 2020 we developed a GM Heart Failure care plan to promote self-help for patients and reduce avoidable admissions following a diagnosis of Heart Failure. We have developed this further by working with Health Innovation Manchester to get this moved from a paper version to a digital version within the GM care record.

The digital version of the Heart Failure care plan, and a related patient app, is shortly being trialled in the Tameside & Glossop and HMR localities, with a view to eventual rollout across Greater Manchester. The availability of this to both clinicians and patients will support better communication and patient care.

We have also reviewed the number of heart failure specialist nurses (HFSNs) across the region and found that we currently do not meet the British Society for Health Failure Standards, which recommends a minimum of 3 to 4 HFSNs per 100,000. Through the network we have developed a business case to obtain more funding to increase the workforce to enable us to meet the standard and improve patient care. This has now been passed to GM Gold Command for consideration

With the successful completion of bid to support elective recovery, we are in the initiation phase of a GM wide project that is supporting us to transform the way we manage our Heart Failure patients using digital technology.

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Diabetes Network

"I am extremely proud the that we finally managed to agree Information Governance for the large scale roll-out of Diabetes My Way. This took ten months of negotiation but now means that up to 185,000 people in Greater Manchester can access their own GP diabetes data if they register on Diabetes My Way.

This success is down to the persistence and dedication of the diabetes team in the SCN and will mean that many people in GM will now be better able to manage their condition to achieve better clinical outcomes."

Dr Naresh Kanumilli,
Clinical Lead

Tackling health inequalities

We partnered with the British Muslim Heritage Centre to raise awareness of diabetes in the Muslim community. Working with Imams, cultural community centre and women influencers to engage with the community. 60 influencers have been trained so far!

Training materials were produced in Urdu and Bengali and are being used to deliver training to those that have difficulty in understanding English, based on the teachings of the Quran and practical actions of the Prophet Muhammed (PBUH). A khutbah narrative is included for Imams to use as part of their sermons after Friday prayers.

National diabetes prevention programme

We've worked to raise awareness and increase referrals into Healthier You (the National Diabetes Prevention Programme). This has included:

- Developing promotional materials and a video showing GPs how they can refer to the programme;
- Funding 4 engagement officers to work closely with GP practices across in GM;
- Developing an 'opt out' text message referral process.

The engagement officers have improved the average referral rates to 1,029 per month in the 9 months they've been in post. This is a marked increase from 422 per month in the 9 months prior to appointment. The text 'opt out' referral process has also resulted in a massive uplift of referrals 1759 in December 2021, 1441 in January 2022 and 3061 in February 2022

Governance

We have established a Senior Responsible Officer (SRO) role for diabetes in GM along with a new governance structure. There are steering groups that report into the new GM Diabetes Board to cover prevention, education, treatment and care, foot and lower limb care and specialist nursing and inpatient care. This will enable the new ICS to oversee the development of services and allocation of funding.

The DigiBete App

DigiBete is an online platform that supports young people and their families to manage their type 1 diabetes. Together with colleagues from the North West Coast Clinical Network we rolled out DigiBete across the North West. The North-West is one of the top ranked regions for uptake of DigiBete and it is now widely used in all paediatric clinics in GM. It is now being rolled out to young adult clinics across the North West.

NHS Low Calorie Diet Programme

The NHS Low Calorie Diet Programme has been rolled out in all 10 localities in GM. This programme supports people with type 2 diabetes to improve their health and potentially reverse their diabetes. 141 people in GM have started the programme and the average weight loss is 17.5kg over 12 months.

Greater Manchester Health and Social Care Partnership

With the support of people living with diabetes and Diabetes UK we developed a leaflet which describes the wide range of support available in GM. Click here to view it online!

DIABETES SUPPORT, SERVICES AND EDUCATION FOR PEOPLE LIVING IN GREATER MANCHESTER

Diabetes can be a worrying condition, especially if you have only recently been diagnosed – but help is here to support you.

As well as the routine care you receive, there are a number of free services available to people of all ages across Greater Manchester, many of them accessible at home via your smart phone, tablet or computer.

- GENERAL INFORMATION
- PREGNANT WOMEN
- CHILDREN <18 YEARS
- ADULT 18+ YEARS
- SUPPORTING DIABETES RESEARCH

GMCA GREATER MANCHESTER COMBINED AUTHORITY

in Greater Manchester

Frailty Network

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> Despite challenges created by the pandemic, I am proud of the sustained enthusiasm, commitment, engagement and leadership demonstrated by Greater Manchester's clinicians, care professionals and subject matter experts to support implementation of the GM Ageing Well programme. It's been truly remarkable.

Martin Vernon,
Clinical Lead

Ageing well priorities

We have formed a Frailty Care Reference Group which is attended by clinicians and care professionals from across all localities in GM. The group is formally linked in as a member of the GM Ageing Well Steering Group. Together we work on improving services and outcomes for people living with frailty, their families and carers.

Through our Frailty Care Reference Group we have been able to ensure that the Ageing Well priorities for GM reflect the needs of people living with frailty and the services offering care to them. It enables our clinicians and researchers to have a direct route into discussions on policy and decisions being made about funding for frailty services.

Review of local services

Through our Frailty Care Reference Group, we gathered information about the ageing and frailty services available in our 10 GM localities. We collected information about urgent community response services, care homes, anticipatory care and acute frailty services.

We now have a baseline understanding of the services available across our 10 localities in GM and how they work. We can also see where there is variation in service and areas we can work together to improve.

Working with our network members we are developing an 'offer to the system' which aims to set out what people living in GM with, or at risk of, frailty should be entitled to expect.

Falls prevention

We have developed an anticipatory care approach for people at risk of falling. Through the GM Care Record database, we are now able to identify people who are living with frailty and/or complex needs and may be at risk of falls. The GM Care Record has all data from GP records.

Once identified, the person can be proactively offered support to help them stay as independent and healthy for as long as possible. This support may be in the form of structured exercise, home environment risk assessment, medication reviews or mental health interventions.

The University of Manchester is incorporating our work into a 'how to' guide which will form part of GM policy around falls prevention. We were proud to be able to speak about our work at the GM Falls Prevention conference held in January 2022.

Through our work on the GM Care Record we have also developed intelligence to help us better understand health inequalities that exist in the region. We can see for example that certain ethnic groups are more at risk of severe frailty and that those living in more deprived areas experience more frailty than those from wealthier communities. This ongoing view of demographic data will help to guide our discussions and efforts to improve services across the region and to build back better after the pandemic.

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Respiratory Network

"We are very proud of all the work we have done in collaboration with colleagues and patient voices across the system to rapidly establish long COVID services in the region. Long COVID is a new multisystem condition that requires a holistic approach to assessment, treatment and care. We have achieved so much in a short space of time to get new services in place to help both adults and children.

There is still more work to be done as new treatments are being explored, and we receive more feedback on the services available and we are actively working towards that with research. Our services have also garnered international attention and we are very proud to put Greater Manchester in international circles."

Dr Murugesan Raja & Dr Jennifer Hoyle
Clinical Leads

Long COVID services

We led on the design, development and coordination of long COVID services in GM. The clinical leadership and engagement through our network was essential to the success of setting up these services for this new condition.

Our work included the development of the pathway and framework for services that all localities signed up to. We also established the governance and decision-making functions that were necessary to develop the services.

We have set up:

- 10 adult long COVID services
- 1 children and young people's long COVID hub (covering GM, Lancashire and South Cumbria)
- 2 mental health hubs
- A GM Tier 4 service

As of March 2022, the long COVID clinics have assessed around 3000 people and supported them with advice and treatment to help them recover. Many more patients have been supported by the mental health hubs and tier 4 service.

We have established a GM wide long COVID stakeholder group to provide ongoing communication on national directives and local decisions. The group also enables us to share best practice and tackle risks and issues together.

Pulmonary rehabilitation

We have been working with local pulmonary rehabilitation services to improve quality. Pulmonary rehabilitation is designed to help people with lung disease to stay as health and active as possible. We have been working to improve the quality of services across the region and have funded services to embark on Pulmonary rehabilitation accreditation.

We have set up a Pulmonary rehabilitation collaborative which enables all 13 teams in the region to support each other to improve the delivery of structured exercise and education. We have developed and agreed a GM plan that reduces unwarranted variation, and waiting times and increases referrals, attendances and completion of rehabilitation. We are also supporting all services to become quality accredited services by 2023.

Going into the next year, we will be rebranding and relaunching pulmonary rehabilitation as our Keep Active, Breathe Better programme. This will be a promotional campaign that will feature a website and information resources.

Quality Assured Spirometry (QAS)

Spirometry is a test used to help diagnose and monitor certain lung conditions such as COPD and asthma. In GM, we have developed a plan to improve diagnosis by ensuring spirometry is quality assured and only being performed and interpreted professionals who are accredited. We are supporting this plan with consistent training and post training support that includes examinations and registration. We are also providing pathway and equipment support that will lead to consistency in future practice and benefit patient care.

Stroke and Neurorehabilitation Network

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"The pandemic has put services in Greater Manchester under huge pressure. We are proud of the way the network has helped support its teams, in hospital and the community, to keep our local specialist services fully operational.

We have worked hard together to maintain standards of stroke and community neurorehabilitation care to ensure that patient outcomes and experience have not been compromised by the challenges the pandemic has brought.

We are hugely proud of how the Greater Manchester stroke and neurorehabilitation "family", which also includes the voluntary sector, have come together and worked in partnership for the benefit of our patients and their families."

· Dr Adrian Parry-Jones,
Clinical Lead (hospital)

Tracy Walker,
Clinical Lead (community)

Blood pressure monitoring at home

We worked with our 10 community stroke teams to implement blood pressure monitoring at home. The national protocol was aimed at GP practices but we made the decision through our network to implement via our community stroke teams as they have more contact time with patients.

The programme has proven to be highly successful. It reduced BP significantly in most stroke patients who took part and prevented many from being over medicated as their BP measurements returned to target range through more accurate monitoring at home.

Integrated community stroke services

We have worked across the region to improve access to Integrated Community Stroke Services (ICSS) – a national model. From 16th May 2022 all 10 localities in GM will provide the ICSS model of care.

This model will ensure that patients can access high quality, multi disciplinary care regardless of their postcode or level of dependency for up to 6 months. National data indicates 70% of GM stroke patients leaving hospital have accessed a community stroke service which is significantly above national average. Similar improvements have also been made in community teams treating other neurological conditions.

6 month reviews

National guidance recommends that stroke patients receive a review 6 months after their stroke to assess if they have any unmet needs. The reviews are locally commissioned and carried out either by the Stroke Association or local community stroke teams.

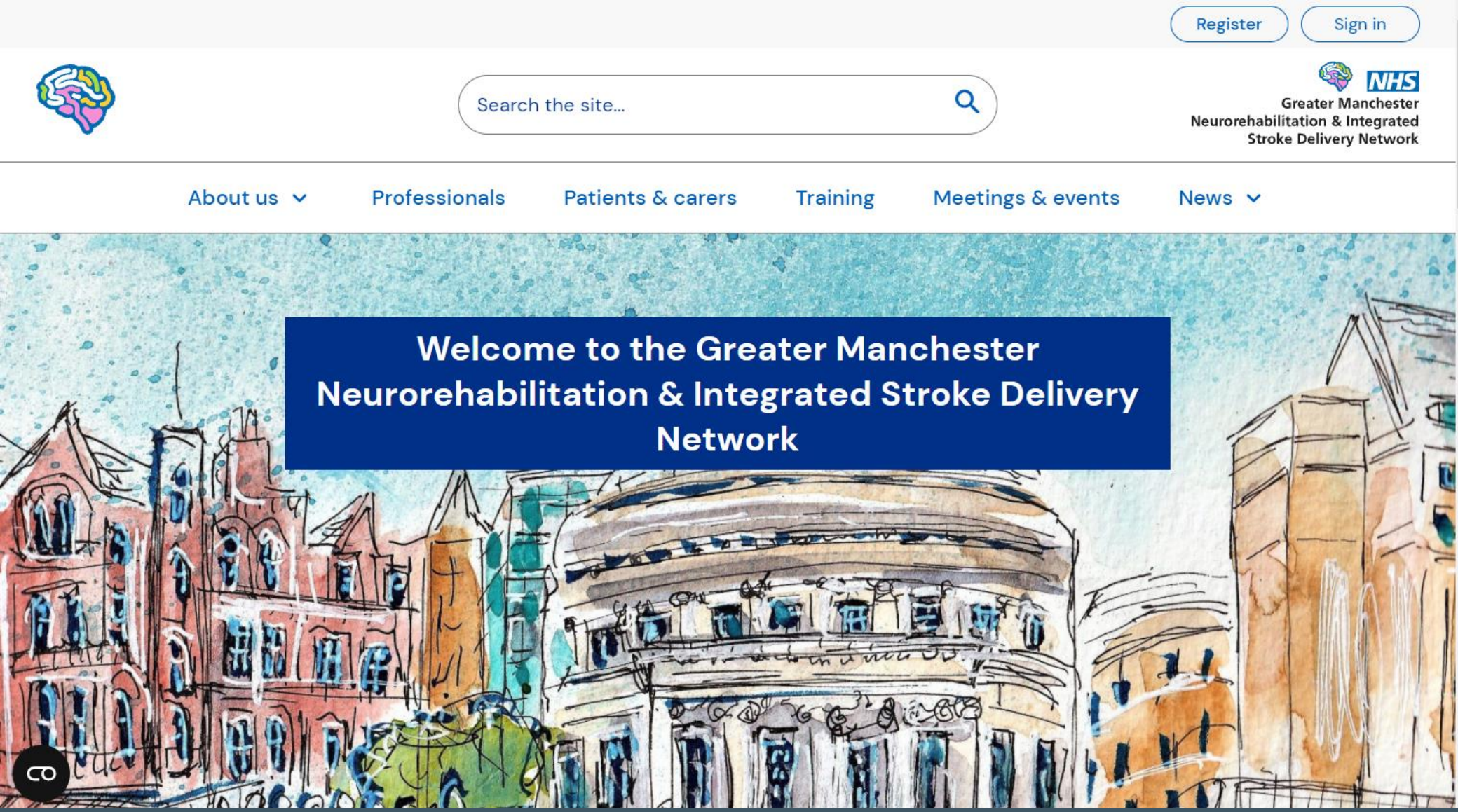
We have worked to improve the conduct of these reviews and to collect data to enable us to understand where to target our efforts to address unmet need.

12 out of 14 teams in the region who are commissioned to undertake the reviews are now returning data for wider analysis. The data has shown that there is variation in how reviews are conducted and what happens when unmet need is identified; we are now working to address this variation.

Collaboration between stroke and neurorehabilitation

In October 2021, the Greater Manchester Integrated Stroke Delivery Network and Greater Manchester Neurorehabilitation Network merged. A single budget has now been agreed with providers and the team are currently expanding and transforming to lead a growing programme of work across both care pathways.

There is more efficiency and consistency in terms of ways of working and management of projects, and the new approach allows for better strategic alignment.



In December 2021 we launched our new website that brings together the best of Stroke and Neuro-rehabilitation. Professionals can register on the site to gain access to extra resources.
Click here to visit.

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Palliative and End Of Life care Network

"I'm proud of how the palliative and end of life community has continued to work together and support each other over the last couple of difficult years. We have continued to identify innovate ways to work to ensure education and care delivery has continued to be provided to the people of Greater Manchester and Eastern Cheshire"

Dr Liam Hosie,
Clinical Lead

Electronic Palliative Care Coordinating System (EPaCCs)

We have developed a Greater Manchester electronic summary form (EPaCCS) to help coordinate end of life care, with patients and support clinical decision making. The EPaCCS is now live on the GM Care Record. We have a GM vision and agreement for each locality to work towards using the EPaCCS within the GM Care Record. Our network has an ongoing role in offering clinical leadership, peer support and learning to help localities with the change process.

EARLY identification

The EARLY identification of people approaching the end of life is a GM commitment. We provided clinical leadership and support to 39 practices to run the electronic EARLY identification tool on GP primary care systems. We provided training and supported GPs to have important personalisation conversations with patients. The work is currently being evaluated and wider roll out anticipated.

End of Life Care Model

In collaboration with the North West Coast SCN we updated the "NW Model for Life Limiting Conditions" and published good practice guidance. It supports clinicians to identify people in the last year of life. We delivered a number of workshops as part of Dying Matters week to educate people about the model.

Tackling health inequalities

We worked with St Anne's Hospice and Springhill Hospice to produce a film to help raise awareness of the health inequalities that exist in palliative and end of life care.

We also designed and delivered a series of educational workshops for all health and care staff to cover the things that they can do to reduce health inequalities and improve their services.

The workshops looked at the 10 inequality groups. Professionals focused on how they can work with the communities to earlier identify people approaching end of life and use advance care planning to coordinate and personalise their care.

Advance Care Planning

We have presented in a number of forums and groups across the region to emphasise the importance of advance care planning and shared decision making. We have also supported staff to undertake the 'train the trainer' programme for the Mayfly programme which is a North West advance care planning training. Alongside refresher training for those who have already completed it.

Supporting the education and training of staff around Advance care planning increases the opportunity for GM residents to have a good quality advance care planning conversation that enables their wishes to be understood and support them in their place of care and death.

Our clinical leads & associates

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Maternity network

Miss Karen Bancroft
Dr Akila Anbazhagan
Dr Ghazia Saleemi
Eileen Stringer
Kathy Murphy
Dr Elaine Church
Prof Alex Heazell
Prof Edward Johnstone
Dr Samiksha Patel
Faye Bruce

Children and young people network

Dr Jim Bruce
Dr Carol Ewing
Julie Flaherty
Julia Birchall-Searle
Dr Kal Dixit

Diabetes network

Dr Naresh Kanumilli
Mr Naseer Ahmad
Dr James Hider
Dr Moulinath Banerjee
Dr Jaweeda Idoo

Cardiovascular network

Professor Farzin Fath-Ordoubadi
Dr Aseem Mishra
Dr Samrina Ahmed
Dr Yahya Al-Najjar
Dr Mamta Buch
Dr Niall Campbell
Dr Colin Cunnington
Dr VJ Karthikan
Dr Kamal Khan
Dr Abhishek Kumar
Dr Philip Lewis
Neil Mackay
Dr Mani Motwani
Ruth O-Rourke
Dr Washik Parkar
Dr Eleri Roberts
Dr Sanjay Sastry
Toni Weldon
Wil Woan

Respiratory network

Dr Jenny Hoyle
Dr Raja Murugesan
Dr Huda Badri
Professor Nawar Bakerly
Karen Lewis Jones
Jonny Lee
Sue Mason

Stroke and neurorehabilitation network

Dr Adrian Parry-Jones
Tracy Walker
Julie Emerson
Jenny Harrison
Christine Hyde
Dr Janice MacKenzie
Dr Aseem Mishra
Carolyn Shimwell
Louise Worswick

Palliative and end of life network

Dr David Waterman
Dr Liam Hosie
Dr Sophie Harrison
Dr Nicholas Bloomfield
Dr Jayne Kennedy
Dr Charlotte Reddick

Frailty network

Professor Martin Vernon
Dr Saif Ahmed

Correct as of June 2022

Our year ahead 2022/2023

NHS
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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 our local services.

Taking a whole life course approach, our networks cover:

- Maternity
- Children and young people
- Cardiovascular
- Diabetes
- Frailty
- Respiratory
- Stroke and neuro-rehabilitation
- Palliative and end of life

50 clinical leads, associates and advisors who work with our 30 plus support team.

Our unique approach

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

Contact Us

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If you have any questions about this report or if you want to get involved with our networks, please get in touch.

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england.nhs.uk/north-west/gmec-clinical-networks/

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