## NHS Greater Manchester case studies

The following case studies have been fed into the 10 Year Health Plan Working Group.

**Healthy Hyde** – making changes to someone's life early on, in order to improve their life before they hit crises. The range of support includes help with employment, housing, health, nutrition, social care, pre and post-natal education

**Accelerating the Deployment of the GM Care Record** – providing health and care workers with access to vital patient information to provide better informed direct care and treatment on the frontline.

**Social prescribing** – A new role which is dedicated to supporting people with Type 2 diabetes and a high BMI, or those at risk of developing the disease.

**Better outcomes – better lives** – improving people's independence by focusing on what they can do (their strengths) rather than what they can't do, known as a strengths-based approach.

**Making Smoking History in Greater Manchester** – a whole-system approach to creating a smokefree city region.

**Targeted lung health checks** – aimed at past and current smokers aged 55 to 74 through a series of roadshows and mobile CT scanner units set up in supermarket car parks.

## Hospital to Community

In GM, there are 88,995 members of NHS employed staff, 63,000 in Adult Social Care, 22,000 in Primary Care and 75,610 paid employees in the VCSE sector. These go alongside 496,609 volunteers and 280,000 unwaged carers. These figures reflect the importance of considering those outside NHS employment when looking at a community-led approach. It is a key priority of GM for the workforce to be representative of the communities it serves.

GM also trailblazed a blended roles programme, which focused on improving career pathways for the workforce across the system and providing better support for people, by integrating health and social care roles. The design of the programme was a collaborative effort, bringing together district nurses, local authorities, independent sector social care providers, the voluntary sector, NHS, primary care and other sector experts. Further information on the results of the programme can be found here - Supporting integrated working through blended roles | NHS Employers.

The top three tips from the programme were -

1. Committing to high-quality resources for six to eight months is necessary for successful program implementation. This includes design, training, and ensuring competency.
2. A dedicated role in the district nursing team ensures ongoing resources for training and competencies.
3. Success in the programme requires a shared vision among leaders of healthcare and social services, with a commitment to collaboration and utilising expertise towards a common goal.

## Treatment to Prevention

2024/2025 is the first year of delivery of NHS GM's Multi-Year Prevention Plan, The system agreed to prioritise **CVD and Diabetes** prevention in year 1. This is the first time that they have collectively agreed prevention priorities at system level.

System learnings from initial work on CVD and Diabetes prevention –

1. The model of locality workshops to establish a shared understanding, build relationships, identify challenges and share learning were well received by both locality and GM teams
2. GM Operating Model: delivery of prevention sits within localities, and locality prevention programmes demonstrate true partnership working and delivery within neighbourhoods and communities

3. Resources: Finances for prevention activites have been reduced at both GM and locality level. To realise prevention at scale, a new model of sustained funding needs to be agreed
4. Capacity: GM Priorities need to align with locality priorities in order to ensure locality teams have sufficient capacity to deliver

GM are also developing proposals for a **'Live Well GM Prevention Demonstrator'** which will work across the range of prevention. The aim of the Demonstrator will be to bring together existing Live Well work and VCSFE strengths and provision with targeted prevention activity across all public services (Delivered through Live Well Centres and Spaces). A key priority will be shifting resources towards neighbourhood provision which integrates primary care, community care, social care, mental health, employment support and voluntary services to offer coordinated support, reducing the reliance on acute, emergency and high-cost services.

There is also a report on the impact GM's whole system approach to **Population Health & Inequalities** which is available to share upon request.

## Cross-cutting case studies

***Healthy Hyde***

Healthy Hyde began in December 2021 after its Primary Care Network (PCN) was tasked with improving the health and wellbeing of the most deprived 10% of its local population.

The programme aims to make changes to someone's life early on, in order to improve their life before they hit crises. Much of their work is with the homeless population, refugees, asylum seekers, food bank users, children struggling in schools, and parents with young children. The range of support includes help with employment, housing, health, nutrition, social care, pre and post-natal education.

Funded through the Locally Enhanced Service scheme, Healthy Hyde is run from the 30-strong PCN office comprising a variety of health and wellbeing practitioners, a PCN manager and two clinical directors. The team partners with housing

organisations, domestic violence organisations, voluntary and community groups, the local council, housing shelters and statutory services at a variety of levels.

By taking the time to get to know their communities, listen to what they want and adapt their offer to fit their needs, Healthy Hyde has introduced a number of initiatives, including English lessons for refugee and asylum seekers – with incorporated wellbeing checks, advice sessions at local food banks, health drop-in sessions for homeless people, post-natal courses, mum and toddler groups with an emphasis on health matters, and a memory café run by mental health practitioners aimed at combating loneliness among carers.

***Accelerating the Deployment of the GM Care Record***

The GM Care (GMCR) provides health and care workers with access to vital patient information to provide better informed direct care and treatment on the frontline. It is also providing the platform for research and secondary uses and the basis of digital transformation of clinical pathways.

Since the GMCR was launched during the pandemic, it is now being accessed by over 18,000 frontline workers to support the care and treatment of over 180,000 patients each month. It has become a major digital asset for Greater Manchester, with the potential to support programmes to tackle health inequalities and transform care in areas such as dementia/frailty, virtual wards and heart failure.

During the pandemic and through close collaboration between the GM clinical-academic community, health and care partners and citizens, 22 COVID-19 related research studies using de-identified data from the GMCR were approved to understand the impact on the communities of Greater Manchester. In future, data from the GMCR will help researchers to understand other major health and care issues affecting the city-region through GM's Secure Data Environment.

All of this activity to support both direct care and research has been underpinned by engagement and strong governance across GM data controllers, providers, commissioners, and central GM bodies.

***Social Prescribing***

Recruited in March 2022, alongside a Network Dietician, the Diabetes Social Prescribing Link Worker in Gorton and Levenshulme Primary Care Network offers an alternative approach to managing a health condition with medication alone.

The role is dedicated to supporting people with Type 2 diabetes and a high BMI, or those at risk of developing the disease; working with them to find out what matters to them and what they want to achieve.

Darab, for example, a 39-year-old with limited English, moved to England in 2016 after serving in the armed forces. His wife and children remain in another country.

He had a part-time job but wanted to improve his English to enhance his working ability and access to services. He also wanted to lose weight, join a gym and learn about healthy eating so he could improve his health. After visiting his GP a number of times with low mood and joint pain, Darab was diagnosed with pre-diabetes and referred to the social prescribing service.

Working together with the social prescriber and with the help of an interpreter, Darab was able to join a smoking cessation service, English lessons and secure a gym membership. He also received visual information sheets to help with healthy eating.

In just two months, Darab has increased his health confidence scale from 4 to 12 out of 12; lost more than 16kg in weight, reducing his BMI from 30.2 to 25; and stopped smoking. He goes to the gym four times a week, and now walks daily. He has also reduced visits to his GP and seen an increase in his mood and confidence.

He said: “This service has helped me so much; I have managed to make many changes to better my health and wouldn’t have known where to start without it. I am now eating better, feel fitter and have lost weight.”

***Better outcomes – better lives***

Manchester’s Better Outcomes, Better Lives is improving people’s independence by focusing on what they can do (their strengths) rather than what they can’t do, known as a strengths-based approach. This approach has led to the prevention, reduction and delay of people needing formal adult social care services.

This strengths-based practice is embedded within teams through behaviour change and a shared passion for the preventative approach, with a robust performance and evidence-based framework in place to drive improvement.

Through a combination of strengthened commissioning arrangements, improved early support with the right interventions, support for people to regain independence and a focus on safeguarding people in a timely manner, the programme has successfully met increased demand without a proportionate increase in workforce.

As well as contributing to the wider adult social care service delivering within budget, other achievements include a 10% reduction in the use of Manchester's residential care, a decrease in the cost of 22% of care packages following review, and a total of 66% of people not needing a package of care at the end of a reablement intervention.

***Making Smoking History in Greater Manchester***

Smoking is the single biggest cause of preventable illness and premature death in the world, and the greatest driver of health inequalities. It pushes people into poverty and ill health with a devastating impact on individuals, communities, and the economy. Illnesses where smoking is a major risk factor include cancer, heart disease, stroke, and respiratory diseases. Non-smokers that are exposed to second-hand smoke (also known as passive smoking) are also at risk of the same illnesses – especially vulnerable adults, children, and babies.

In 2017, Greater Manchester Integrated Care Partnership (previously Greater Manchester Health and Social Care Partnership) published its 'Making Smoking History' strategy, taking a whole-system and hugely ambitious approach to creating a smokefree city region. Against a challenging backdrop of higher-than average smoking prevalence and exacerbated health inequalities, Greater Manchester has made huge progress in reducing smoking rates – saving thousands of lives and providing millions in cashable savings to the NHS and public services.

As a result, smoking prevalence has fallen to the lowest on record, from 18.4% in 2016 to 15.4% in 2021 – meaning there are now 66,000 fewer smokers living in Greater Manchester. Furthermore, smoking at time of delivery (SATOD) – the benchmark used to measure smoking status for women at the time of giving birth –

has declined by a quarter, from 12.6% in 2017-18 to 9.5% in 2021-22, preventing many tragic outcomes in pregnancy and birth.

***Targeted lung health checks***

People at risk of lung cancer had the disease detected at a much earlier stage thanks to a pilot scheme in Manchester and Tameside.

The Lung Health Check was aimed at past and current smokers aged 55 to 74 through a series of roadshows and mobile CT scanner units set up in supermarket car parks.

Lung cancer is the most common cause of death in Manchester in people under the age of 75, and most cases are diagnosed at a late stage when survival is poor.

Through targeted screening, the Lung Health Check detected lung cancer and other lung conditions such as Chronic Obstructive Pulmonary Disease (COPD) at a much earlier stage than they would normally have been diagnosed – after reporting symptoms, for example.

As a result, people were offered potentially curative treatment and advice to manage their previously undiagnosed disease. Early detection, intervention and treatment is not only beneficial for the patient but also less costly for the NHS.

In Manchester, more than 2,500 individuals undertook a lung check with just over half deemed to be high risk and qualifying for a CT scan on site. The team found 46 lung cancers affecting 42 individuals, with the majority (8/10) being at an early stage and therefore offered potentially curative treatment (9/10). In comparison, half of lung cancers diagnosed outside of screening are advanced and therefore curative treatment is not an option.