

Cardiovascular Disease Prevention & Diabetes

A deep dive into Greater Manchester intelligence, priorities, performance & improvement work for CVD prevention and diabetes

November 2025

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- Dr Claire Lake, NHS Greater Manchester, Deputy CMO
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- Dr Aseem Mishra
- Matt Conroy, Analytical Service Lead (Primary Care)
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Introduction:

National ambitions and GM priorities for CVD and diabetes care

- Prof Manisha Kumar, NHS Greater Manchester, Chief Medical Officer

- Overview of:
 - National ambitions
 - Long-term plan
 - NHS three shifts
 - Treatment to prevention
 - Hospital to community
 - Analogue to digital
 - Why CVD prevention & diabetes are national priorities
- The strategic approach in Greater Manchester
 - NHS GM Sustainability Plan
 - Multi-year prevention plan
 - Addressing long-term conditions with healthcare system partners





Delivery happens at place



Greater Manchester Diabetes Transition Strategy

2024-2027

Strategy is developed in Greater Manchester

Greater Manchester Cardiovascular Prevention Plan

For people from across Greater Manchester (GM) to come together to support our system's ambition for delivering better quality of life and healthcare outcomes for all through tackling cardiovascular disease (CVD):

1. An improvement in population health.
2. A reduction in health inequalities aligned to CORE20+5 ethos.
3. The delivery of better more personalised care through the transformation of community-based care.

This document has been written by Dr Aseem Mishra and Catherine Cain in collaboration with the GM system.

December 2022

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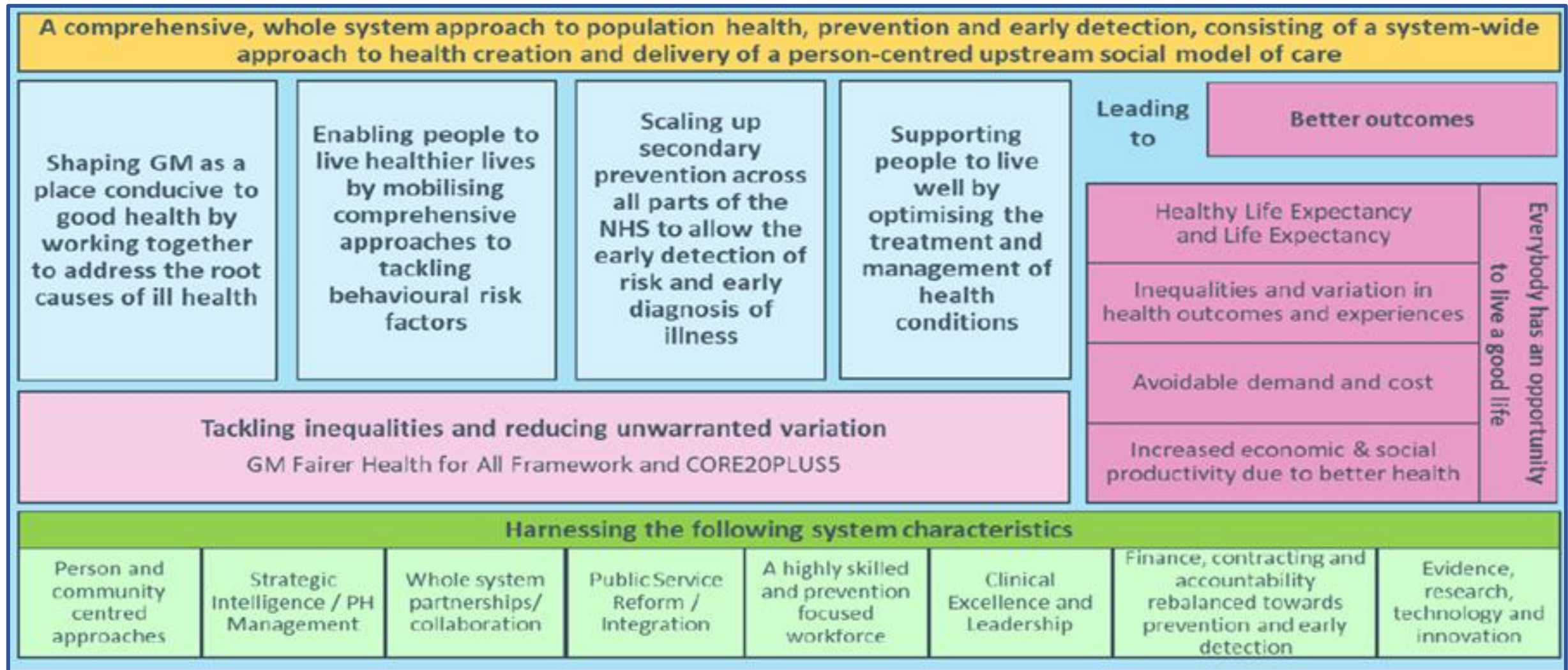
Part of Greater Manchester Integrated Care Partnership

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Tackling Diabetes Together

Greater Manchester Diabetes Strategy 2022-2027

Everyone has a role



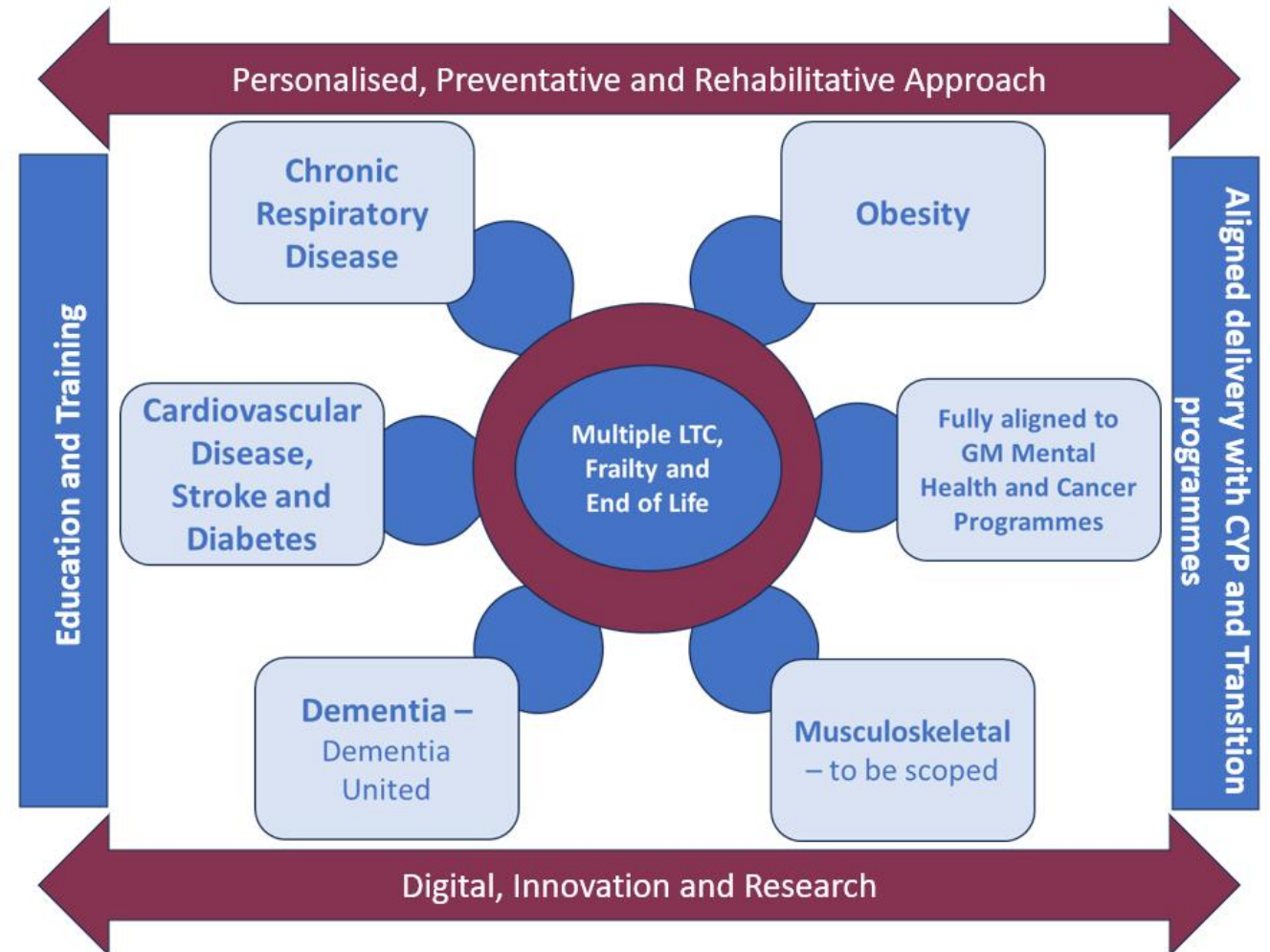
- The **Multiyear Prevention Plan** is a 'whole system' approach to prevention, starting with CVD and Diabetes, and working across the whole breadth of prevention activities. This includes:
 - Tackling the wider determinants of health and modifiable behaviours
 - Addressing primary and secondary prevention
- In 2024/25, specific priorities included on **CVD Prevention** and **Diabetes**.
- For 2025/26, the focus of the multiyear prevention plan remains on *system* delivery and achievement of the shared ambitions set out in the plan.
- In agreement with GM localities, **CVD Prevention** and **Diabetes** priorities have been retained.

- CVD Prevention & Diabetes are part of a co-ordinated GM Secondary Prevention Long-term Conditions Programme.
- The programme is overseen by the *GM Secondary Prevention & LTC Oversight Group (SP/LTC)*, a sub-group of GM CEG.
- CVD Prevention and Diabetes oversight groups feed into SP/LTC.



GM Clinical Strategies to underpin GM Long-Term Condition work:

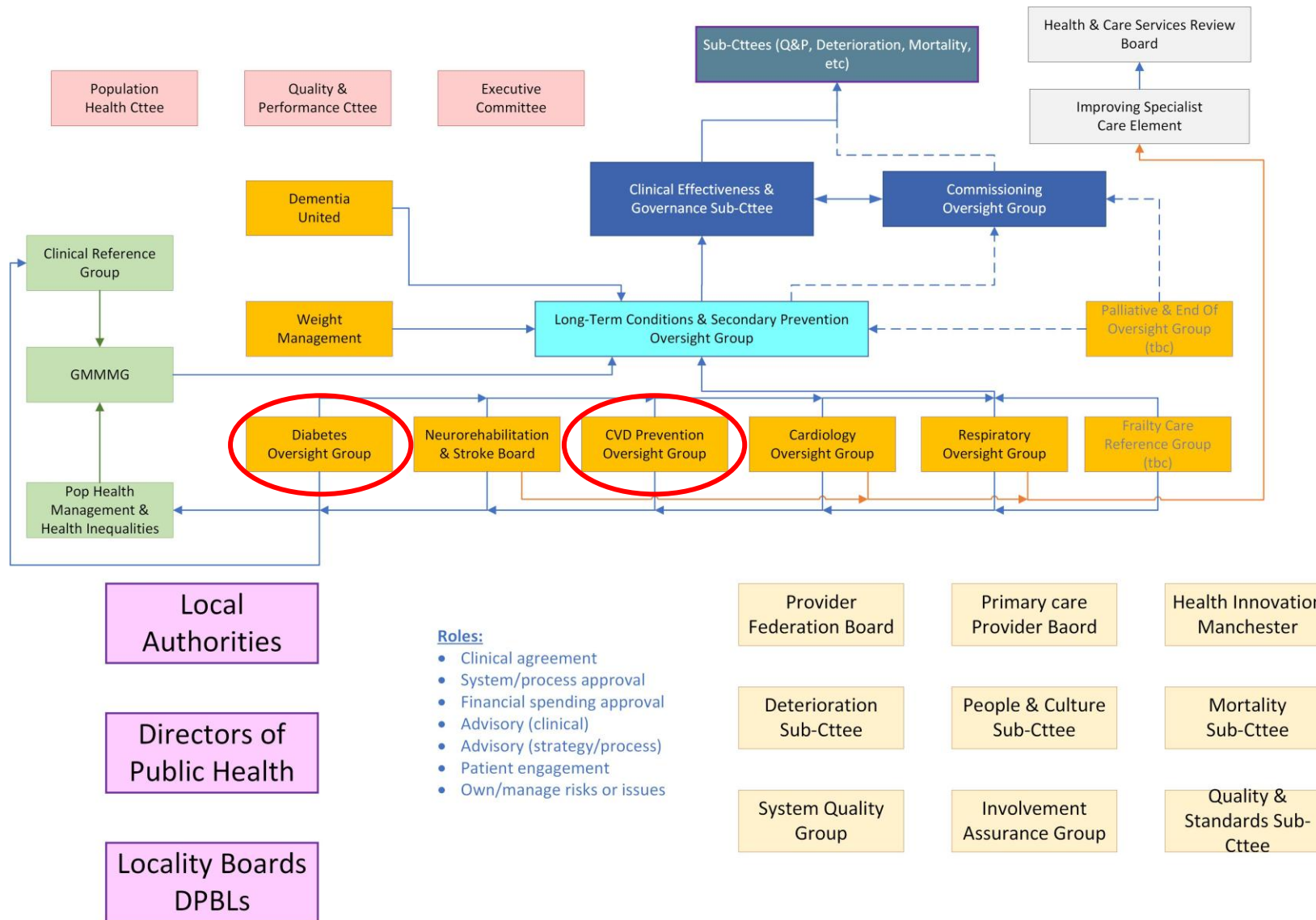
1. **Cardiovascular Disease:** [GMCVD.com](https://gmcvd.com) and [GM CVD Prevention Plan](#)
2. **Diabetes Strategy:** [Tackling Diabetes together-GM Diabetes Strategy 2022-2027](#)
3. **Stroke:** [Network launches new strategy - GMNISDN](#)
6. **Dementia:** [Dementia-and-Brain-Health-Delivery-Plan-2023-to-2025.pdf \(dementia-united.org.uk\)](#)
4. **Palliative and End of Life:** <https://www.england.nhs.uk/wp-content/uploads/2022/07/Palliative-and-End-of-Life-Care-Statutory-Guidance-for-Integrated-Care-Boards-ICBs-September-2022.pdf>
5. **Aligned to: Mental Health and Wellbeing Strategy:** [Mental Health and Wellbeing Strategy 2024 - 2029 \(gmintegratedcare.org.uk\)](#)
6. **Aligned to: Cancer Alliance Programme:** [Home - Greater Manchester Cancer Alliance \(gmcancer.org.uk\)](#)



How we work in NHS GM



Greater Manchester



Case Study: Live Well - Greater Manchester

Live Well¹⁷⁰ is Greater Manchester's movement focused on tackling health, social and economic inequalities by changing how partners work together across public services, voluntary organisations and communities. Its aim is to ensure people in every neighbourhood can access the right support, at the right time, in the right place. This includes integrated access to financial, employment, wellbeing, health and social support through Live Well centres, spaces and offers, backed by a connected and proactive workforce.

The approach follows what's already working across Greater Manchester's neighbourhoods and aims to grow consistent, community-led, preventative models of support—reducing reliance on public, especially crisis, services and improving lives for individuals and communities.

Source: [Fit for the future: 10 Year Health Plan for England](#)

- **Greater Manchester will work in partnership with Government to become the 'Prevention Demonstrator' for the whole of the UK – this aims to reform public services at a place level with initial focus on preventing ill health, reducing economic inactivity and demand pressures on local authorities and other public services.**
- In practice this means increasing collective accountability for the public purse at the city region level, funnelling resource and activity through our integrated delivery model (Live Well GM) around populations of 30-50k - systematising prevention by bringing together the key capabilities which have the biggest impact on the outcomes of residents. Through this proposal we will:
 1. Respond collectively to the to the underlying challenges of **economic inactivity and ill health**
 2. Respond directly and systemically to the **financial and demand** pressures in public services
 3. Make best use of **public spend** in a place and deliver integrated public service delivery through a combined or 'Total Place' (2.0) approach.
 4. Respond to the underlying causes of current demand but prioritise **collective investment in prevention**
 5. Maximise the **integration of employment support with wider social support** and enabling us to respond holistically to economic inactivity (and ill health)
 6. Unlock local capability to respond collectively to **priority cohorts** (Multiple Disadvantage, Economically inactive, young people, elderly/hospital discharge)
 7. Provide the opportunity and necessary local levers for local and national government to **formally work together** to deliver crosscutting government priorities at significantly greater pace
- As a core part of the proposal has been to explore recycling of benefits in a way that enables the recycling of system-wide savings into further prevention (with the benefits & savings being shared between GM and Government).

GMS Delivery plan

Alignment to Narrative and
GMS Priorities



Our seven workstreams

- | 1. | 2. | 3. | 4. | 5. | 6. | 7. |
|--|---|---|---|---|---|---|
| A healthy home for all | Safe and strong communities | A transport system for a global city region | A clear line of sight to high-quality jobs | Everyday support in every neighbourhood | A great place to do business: | Digitally connected places and people |
|  |  |  |  |  |  |  |

Greater Manchester Strategy 2025-35

Live Well



Our comprehensive model for integrated neighbourhood delivery to reform public services and establish a culture of prevention.

Comprising:

1. The Optimum Neighbourhood Model
2. Live Well Centres, Spaces and Offers
3. A Resilient VCFSE Eco-system
4. A Culture of Prevention

Prevention Demonstrator Portfolio

Confirming a portfolio of specific and agreed programmes of focus and delivery

Public Services Transformation & Prevention

'Multiple Disadvantage'

Preventative health & care

Economic Inactivity

Families and Youth



Prevention Demonstrator Outputs

GM and cross-Government accelerator, providing a replicable model to transform public service outcomes & spend
Comprising:

1. Delivery insight to optimise the Live Well Model
2. Evaluation Framework to connect interventions to impacts
3. Flexible/Integrated funding Model to enable transformation
4. Insight mechanisms for data linkage and sharing

Prevalence & GM Intelligence

The scale of the cardiovascular disease & diabetes issue in GM

- Prof Manisha Kumar, NHS Greater Manchester, Chief Medical Officer

Welcome to The GM Intelligence Hub

Introducing the GM Intelligence Hub: Unleash the power of data-driven insights for collaboration and healthcare future.

Our advanced health analytics platform consolidates patient/citizen centric data sources from a vast array of public services, providing a single and unified view to extract valuable insights. Informative and actionable visualisations empower health and care organisations to integrate, make informed decisions, stimulate meaningful dialogue, drive better care, and optimise health and wellbeing outcomes.

From population health management to health insights, our intuitive platform facilitates system working and drives meaningful discussions across the breadth of the Integrated Care Partnership.

Through this platform, you can connect with this transformative journey where analytics meets health and care, and together, we can build a healthier and sustainable future for the people of Greater Manchester.

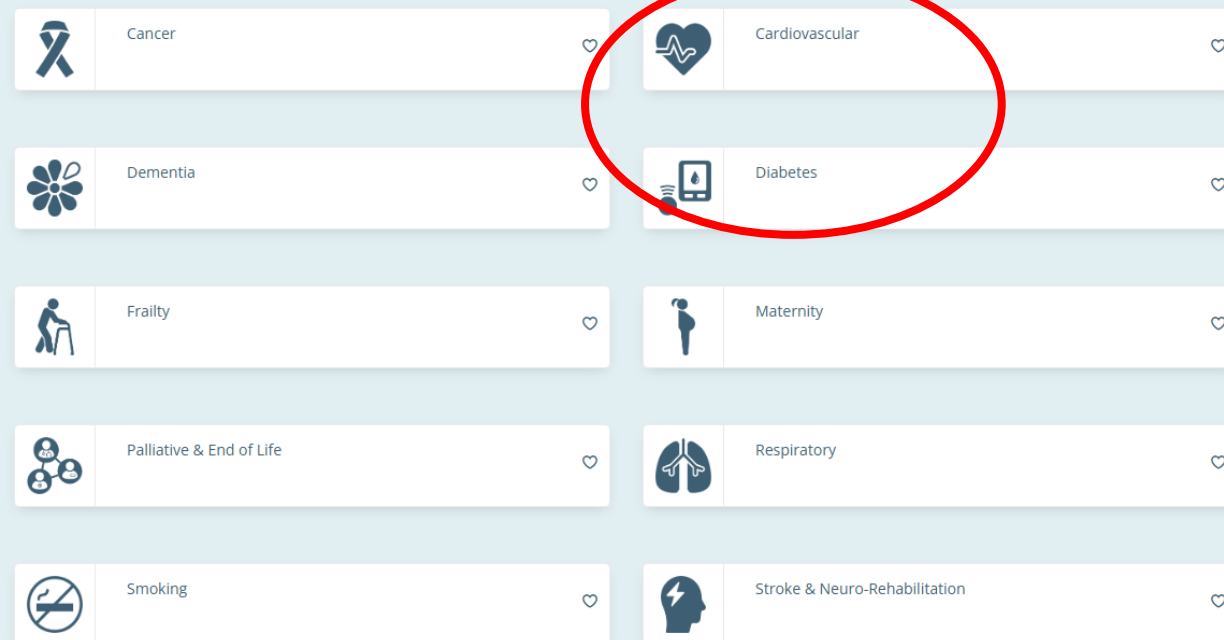
Dashboards include:

- CVD/Diabetes Single Prevention
- Diabetes
- Cardiovascular
- Other long-term conditions
- Programme theme views

Essential Links



- Near real-time data
- Custom views
- Data download
- Report builder
- Interactive controls
- Multiple filters
- Real-time updates
- Slide image exports

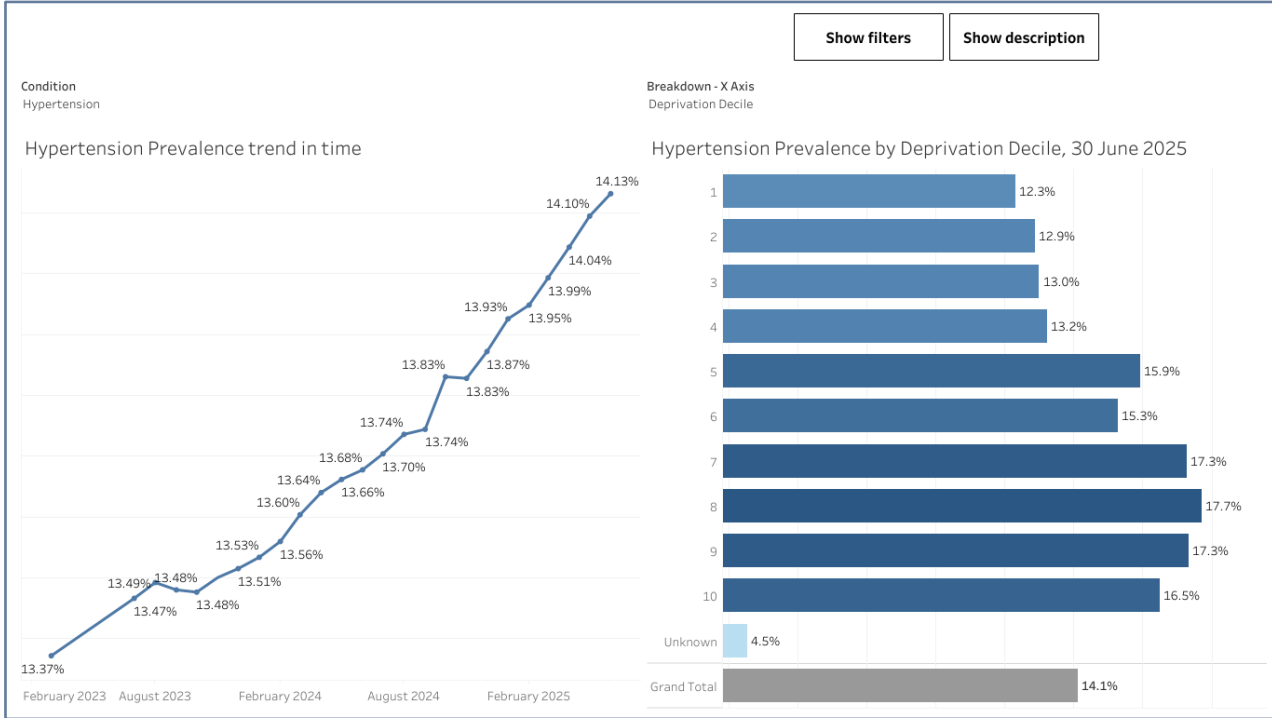
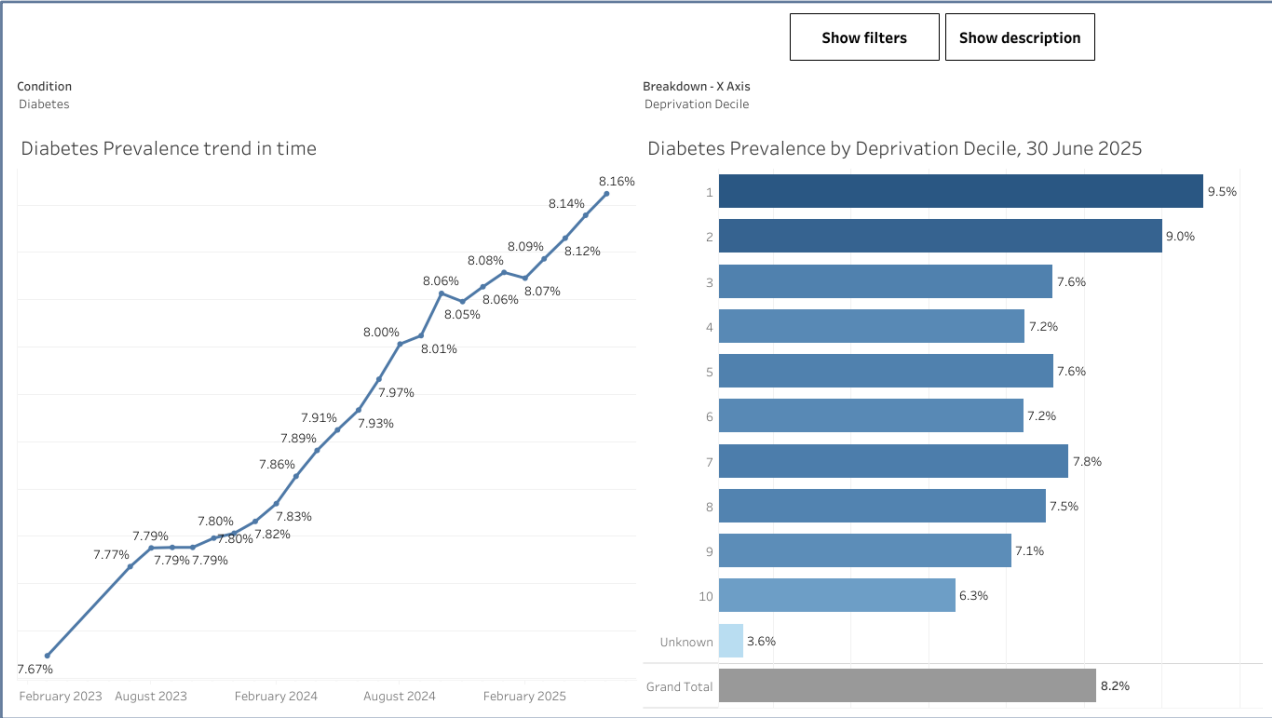


Diabetes and Hypertension in GM by IMD Decile



Greater Manchester

Diabetes worse in lower deprivation deciles – Hypertension worse in higher deciles



199,361 people (all ages, all diabetes types)
30-Jun-25; GM Diabetes Dashboard

426,507 people (all ages)
30-Jun-25; GM Cardiovascular Disease Dashboard

Hypertension prevalence by GM locality



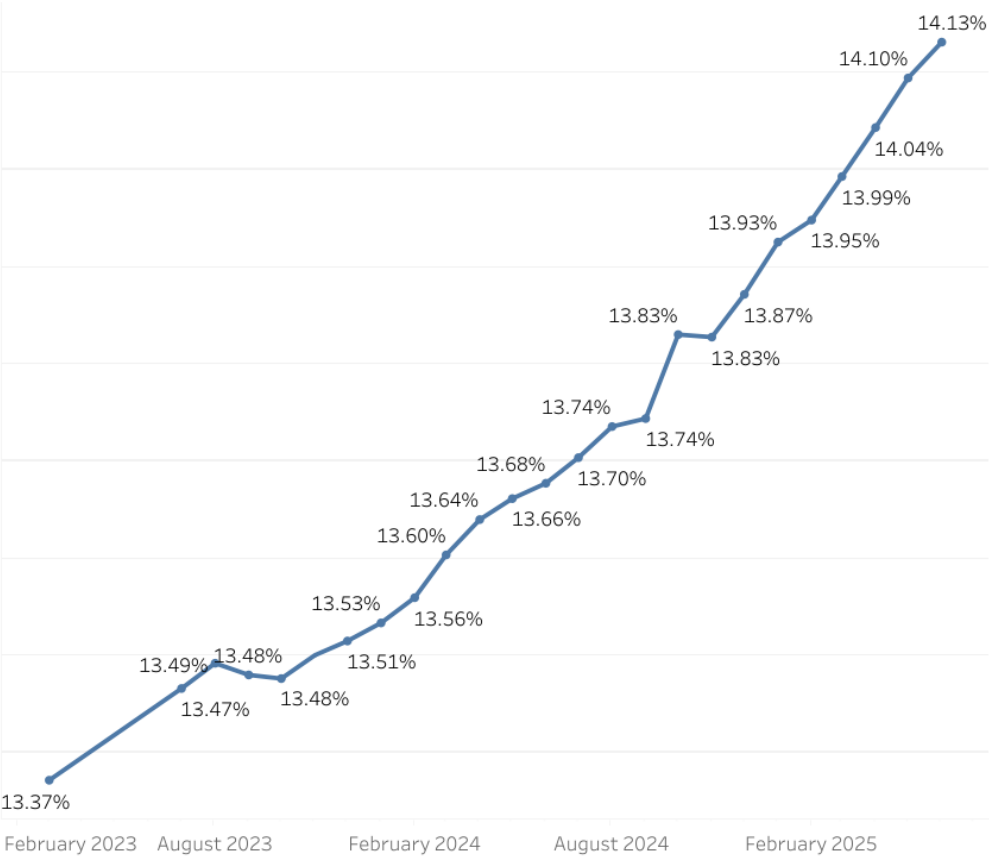
Greater Manchester

Show filters

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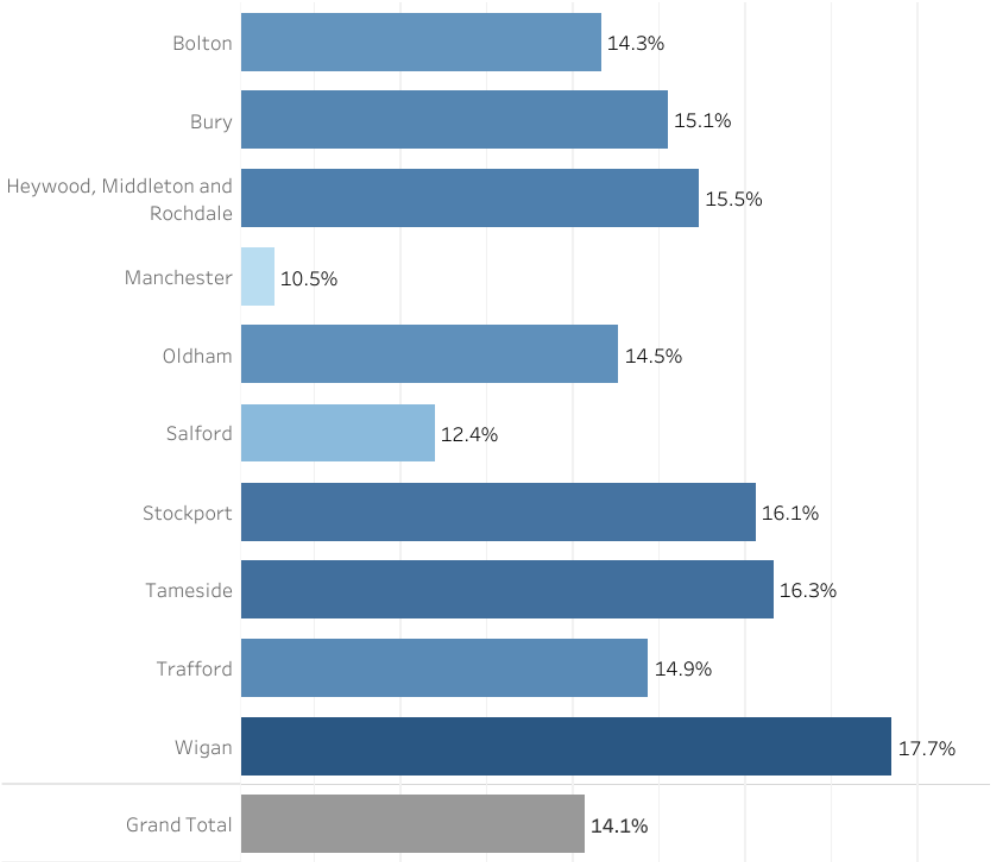
Condition
Hypertension

Hypertension Prevalence trend in time



Breakdown - X Axis
GM Locality

Hypertension Prevalence by GM Locality, 30 June 2025



Hypertension prevalence by GM ethnicity



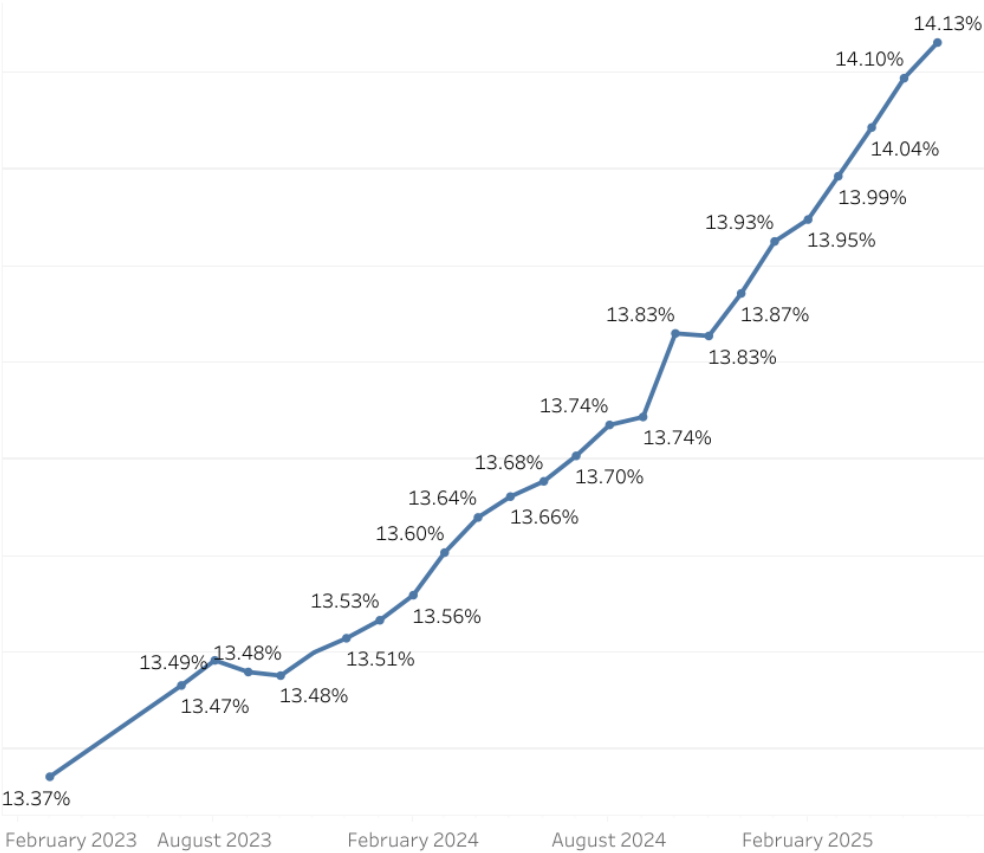
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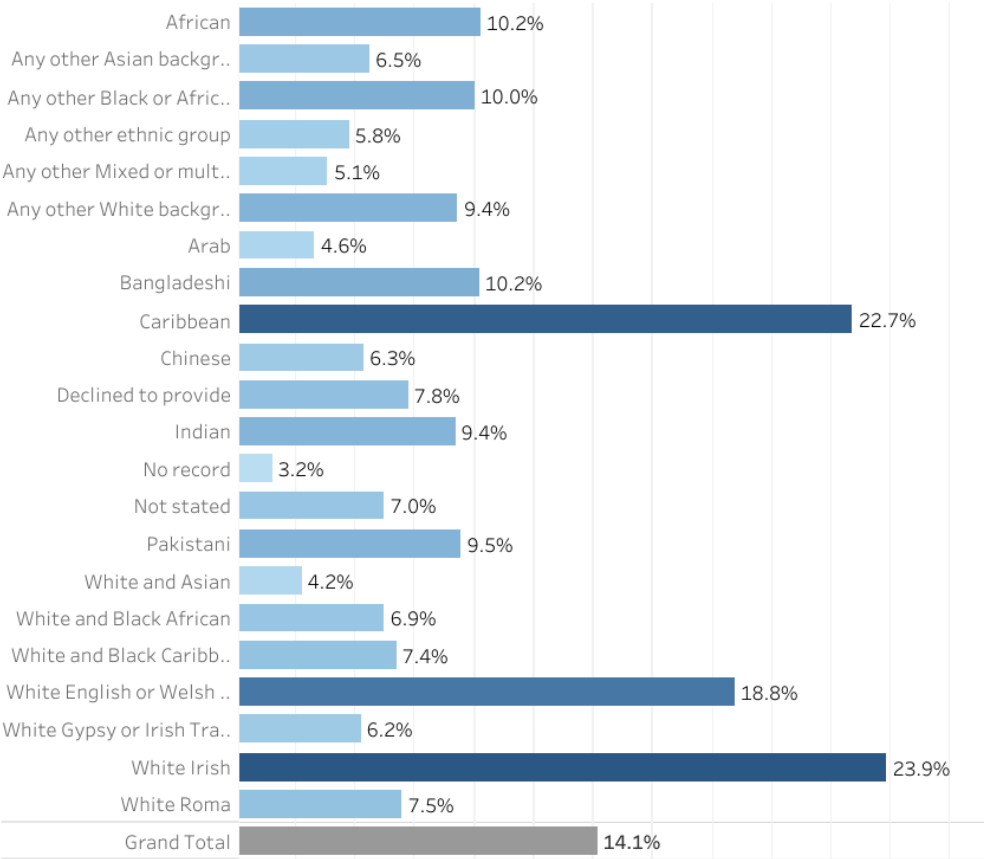
Condition
Hypertension

Hypertension Prevalence trend in time



Breakdown - X Axis
Ethnicity

Hypertension Prevalence by Ethnicity, 30 June 2025



Prevalence - Summary, trend in time and breakdown

Diabetes Age Category
All Patients

Diabetes Prevalence
All Types

Breakdown
GM Locality

Cover Sheet

Prevalence (Trend)

Prevalence (Variation)

8 Care Processes (Sum..

8 Care Processes (Brea..

Individual Care Process..

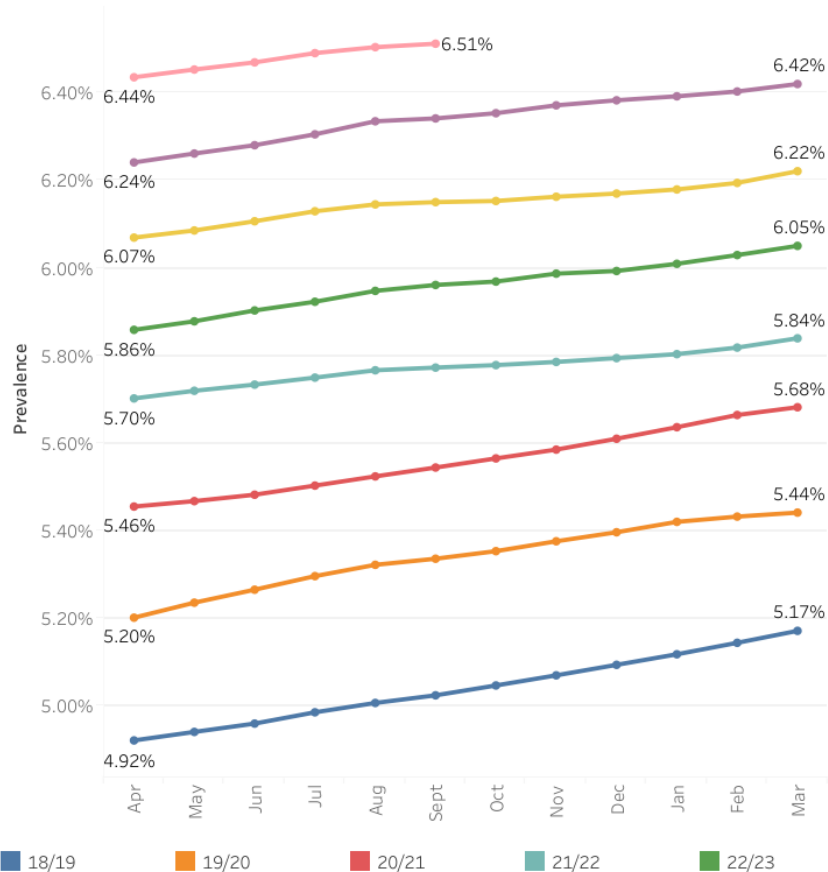
Treatment Targets

Structured Education

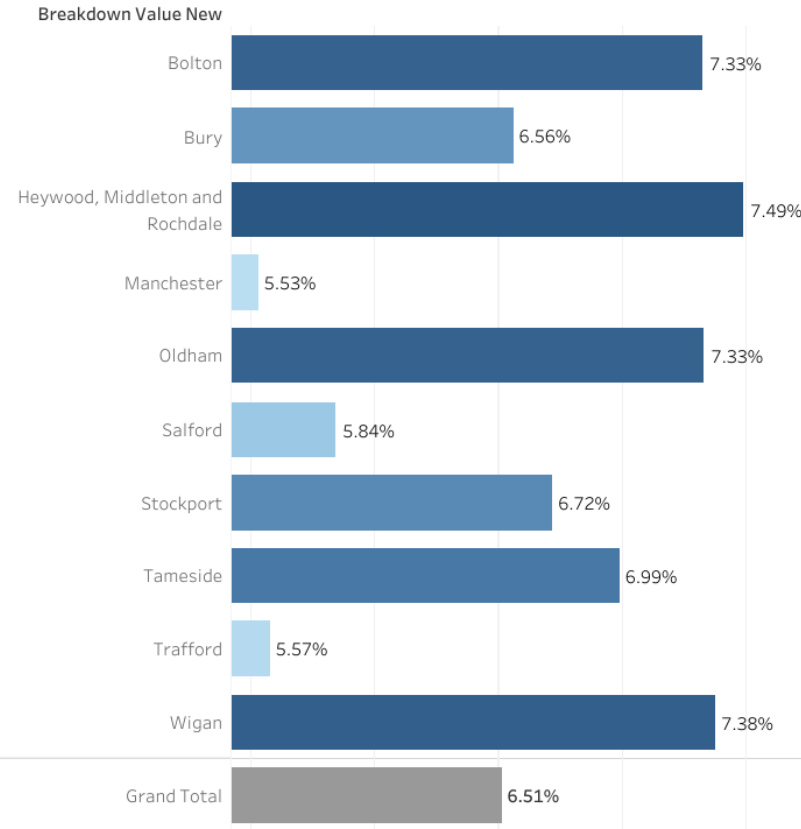
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All Types Prevalence trend in time (All Patients)



All Types Prevalence by GM Locality, 30 September 2025 (All Patients)



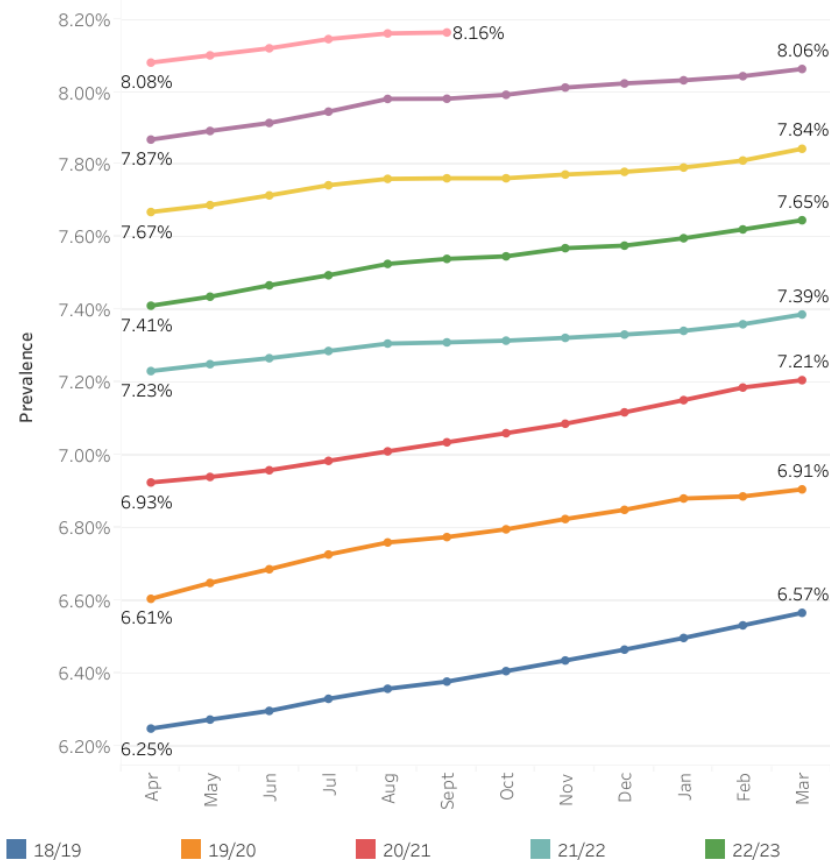
Prevalence - Summary, trend in time and breakdown

Diabetes Age Category
Age >= 17 (QOF)

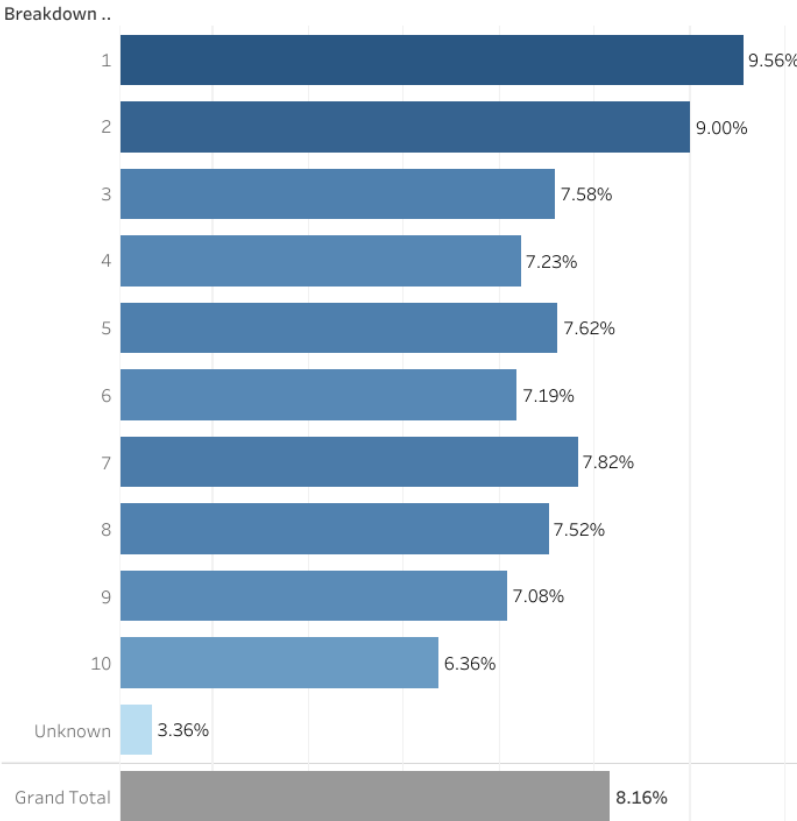
Diabetes Prevalence
All Types

Breakdown
Deprivation Decile

All Types Prevalence trend in time (Age >= 17 (QOF))



All Types Prevalence by Deprivation Decile, 30 September 2025 (Age >= 17 (QOF))



Cover Sheet

Prevalence (Trend)

Prevalence (Variation)

8 Care Processes (Sum..

8 Care Processes (Brea..

Individual Care Process..

Treatment Targets

Structured Education

Show description

Show filter

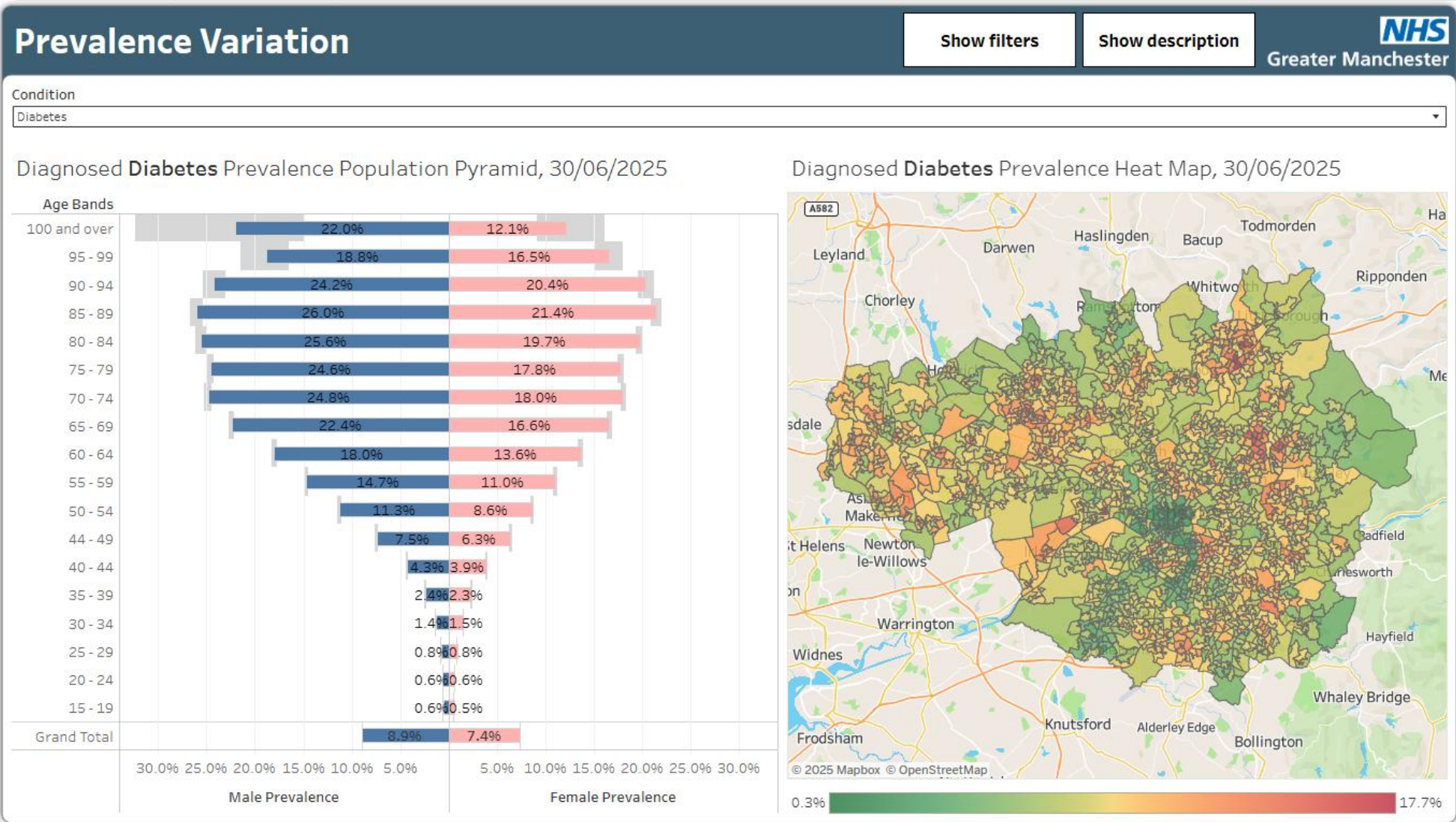
18/19

19/20

20/21

21/22

22/23



Addressing the Challenges:

A strategic approach to identifying and supporting patients at high risk or very high risk of cardiovascular disease and diabetes

- Matt Conroy, NHS Greater Manchester, Analytical Service Lead (Primary Care)

CVD Prevention & Diabetes: Our Four Strategic Pillars



Greater Manchester



SUPPORT SYSTEM LEADERSHIP



UNDERSTAND, MONITOR AND
TARGET UNWARRANTED
VARIATION



PUBLIC, PERSONAL AND
PROFESSIONAL ENGAGEMENT



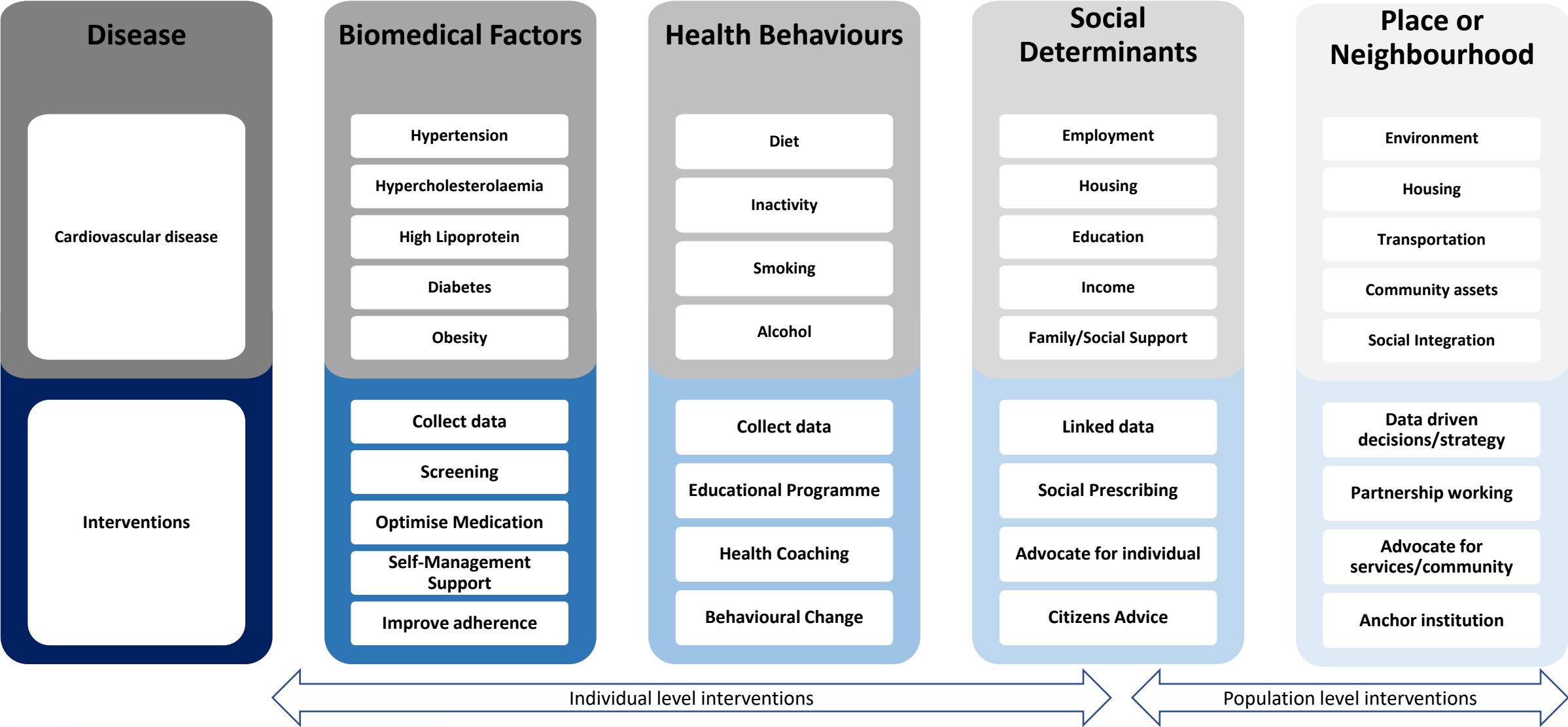
SUPPORT A SYSTEM-WIDE
RESPONSE

Access our CVD Strategy at: [Strategy.gmcvd.com](https://strategy.gmcvd.com)

GM individual Interventions & Population Health Approaches



Greater Manchester



Our aim:

To deliver PC transformation at an accelerated pace and at scale, via left shift of investment to unlock an increased and consistent investment into Primary Care, to support delivered of 3 Darzi shifts and to yield in year benefit to system pressures/costs.

Population Health Management Approach at Scale:

Risk Stratification of unmet need – defined as gaps in good care - using innovative digital tool CVNeed



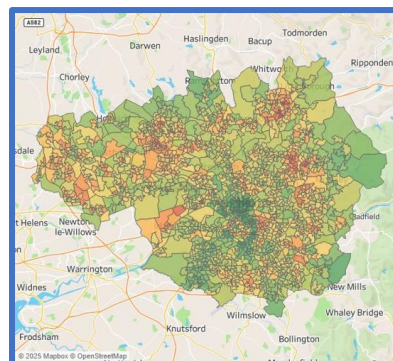
High-risk Long-term condition reviews:

2024/25, all 406 GM General Practices delivered CVD and Diabetes high risk reviews. Cohort identified via use of CVNeed Risk stratification tool to identify those who would benefit most from targeted clinical interventions.

For 2025/26, CVD and Diabetes continue, with CKD and respiratory reviews added in (using CVNeed and RespNeed)

Ambition for 2026/27, to launch a ‘whole person’ risk stratification tool, based on CVNeed – to include frailty, LTCs and mental health

This will inform a re-design of approach to LTC as part of General Practice Transformation at scale



Early Impact Data:

	Reduction in patients at high or very high risk
Atrial Fibrillation	4.5% (2,219 patients)
Diabetes	1.2% (841 patients)
Hypertension	0.9% (2,189 patients)
Secondary Prevention	3.3% (4,390 patients)
In total	1.6% (5,461)

- Reduction of -0.3% in **exception reporting in QOF**, in contrast to other QOF measures (+0.2% increase)
- Higher rate of improvement in Black, African and Caribbean, Black British ethnicity (2.8%) compared to White (1.6%)

Building on our Optometry Hypertension Case Finding Pilot:

- In 2024/25, NHS GM successfully rolled out an NHSE funded pilot for hypertension case finding in optometry care settings. Early outcomes demonstrate this is an effective model for case finding.
- It is delivered by Optical Practices with the support/management of Primary Eyecare Services and overseen by a cross-system leadership group.
- This pilot aimed to target up to approximately 6,800 individuals across selected pilot optometry sites, providing opportunistic BP and irregular pulse measurement for patients who were:
 - Over 40, and;
 - did not have a current hypertension diagnosis and;
 - had not have their blood pressure measured in the last 6 months
- Practice selection was via an enrolment process. All optometry practices across GM were invited to apply. Selected practices were prioritised to those located in the lower IMD deciles.



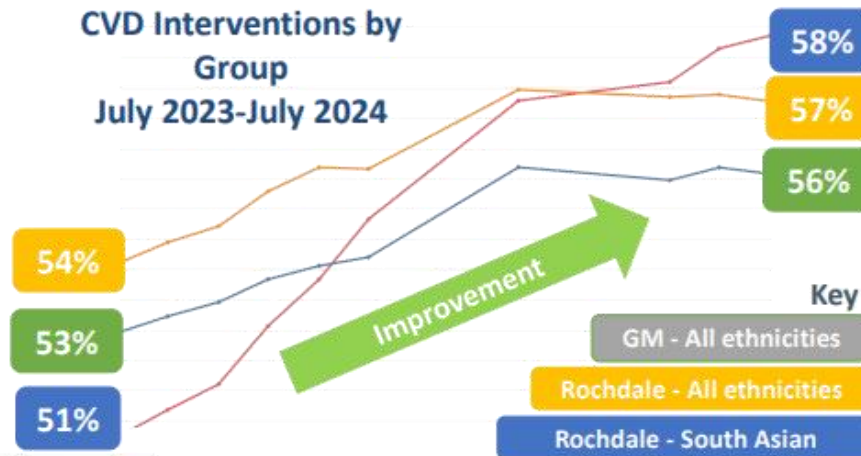
Cardiovascular Disease (CVD)

Community Engagement

Two CVD Community Fieldworkers (Living Well) have focussed on engaging residents from the South Asian community in Rochdale to address existing inequalities in primary care cholesterol (lipids) services. This was made possible by the System Transformation Funding from NHSE.



- 5,845 resources distributed
- 1,144 cholesterol & Blood Pressure chats
- 530 Blood Pressures taken
- 91 People referred to lifestyle interventions



Graph info: At the beginning of the project, the South Asian community had a lower percentage of cardiovascular disease (CVD) related interventions compared to Rochdale (all ethnicities) and Greater Manchester (GM) as a whole. However, by the end of the project in July 2024, there was a significant improvement across all three groups. Notably, the South Asian population showed the largest increase in intervention uptake. These interventions included blood pressure checks.



507 Residents attended Focus Groups

Outcomes

- Increase in blood pressure & cholesterol checks
- Well controlled blood pressure and cholesterol management
- Overall Improvement for all residents
- Marked improvement in south Asian community
- Utilisation of medications to aid better management of blood pressure

Impact

- Reduced Cardiovascular Diseases
- Increased Life Expectancy
- Lower Healthcare Costs
- Enhanced Quality of Life



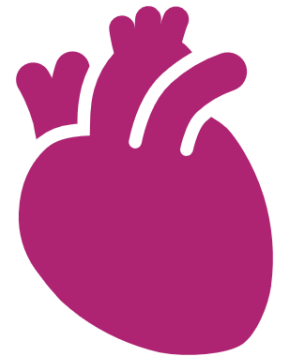
- The **CVNeed tool** has been developed in Greater Manchester. Using the GM Analytics and Data Science Platform, CVNeed identifies patients with unmet need to be prioritised – defined as gaps in good care in relation to cardiovascular disease – using routinely collected GP data.
- This prioritisation looks not only at disease diagnosis, but how well the condition(s) is / are managed. The CVNeed tool provides a CVNeed score that quantifies the current unmet need and the benefit in reducing this need.
- Using **CVNeed**, we can:
 - Address inequities in access, experience, and outcomes, prioritising underserved populations.
 - Enable population health management by delivering actionable insights at individual, practice, and population levels.
 - Provide a holistic framework for managing multiple long-term conditions (LTCs), recognising the overlap between conditions like diabetes, hypertension, and chronic kidney disease.

CVNeed was used to identify at risk cohorts



Hypertension	Atrial Fibrillation	Diabetes	Secondary Prevention of CVD (Coronary Heart Disease / Stroke / TIA / Peripheral Arterial Disease)
1 Clinic BP $\geq$ 180/120 mmHg (or home equivalent) CVNeed Score: 20	1a Not on Anticoagulant, Female and CHADS $\geq$ 2 CVNeed Score: 16	1 HbA1c $>$ 86 mmol/mol CVNeed Score: 24	1a No lipids ever CVNeed Score: 12
2 Clinic BP $\geq$ 160/110 mmHg (or home equivalent) CVNeed Score: 16	1b Not on Anticoagulant, Male and CHADS $\geq$ 1 CVNeed Score: 16	2a HbA1c $>$ 75 mmol/mol, mild or no frailty CVNeed Score: 20	1b No lipids in the last 12 months, sub-optimal non-HDL / LDL CVNeed Score: 12
3 No BP reading in the last 18 months CVNeed Score: 12	1c Not on Anticoagulant, Age $\geq$ 65 CVNeed Score: 16	2a HbA1c $>$ 75 mmol/mol, moderate or severe frailty CVNeed Score: 16	1c No lipids in the last 12 months, optimal non-HDL / LDL CVNeed Score: 8
	1d Not on Anticoagulant, No CHADS ever CVNeed Score: 16	3 No HbA1c reading in the last 18 months CVNeed Score: 12	2a Not on statin therapy and eligible CVNeed Score: 12
	2 On Anticoagulant and Antiplatelet CVNeed Score: 12		2b Statin declined or contraindicated, not on alternative lipid lowering therapy CVNeed Score: 12

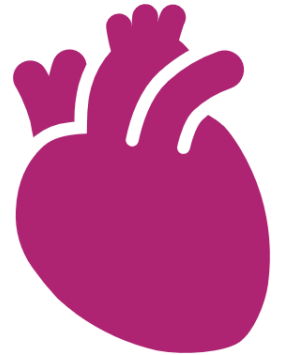
Authors: Matthew Conroy and Dr Aseem Mishra
Version 1.0
Last Updated: 22/01/2025



CVNeed –
Defining the
parameters of
‘Very High’ and
‘High’ need.

- ‘*Beyond Core Contract Review*’ (BeCCoR)
- Implementation developed through 10 x locality workshops
- Any patient in scope as of 31st March was eligible for an ‘enhanced review’:
 - BMI (obesity level)
 - Blood Pressure
 - HbA1c (glucose level)
 - Cholesterol
 - eGFR (kidney function)
 - Smoking Status
- The rationale behind the ‘*enhanced review*’ is that patients with single, uncontrolled CVD, may have other CVDs that are undiagnosed as part of standard practice
 - eg a high-risk hypertensive person is only incentivised to have blood pressure check every 12 months
- The GM ‘*enhanced review*’ did *not* allow for exception reporting (unlike QOF) as our data shows that patients with higher risk are also less likely to come forward for clinical care

BeCCoR represents significant investment in non-hospital care



- **Atrial Fibrillation:** 4.5% reduction in patients at very high or high prioritisation (2,219 patients)
- **Diabetes:** 1.2% reduction in patients at very high or high prioritisation (841 patients)
- **Hypertension:** 0.9% reduction in patients at very high or high prioritisation (2,189 patients)
- **Secondary Prevention:** 3.3% reduction in patients at very high or high prioritisation (4,390 patients)
- **In total** 1.6% reduction in patients in scope (5,461)
- Reduction in **exception reporting in QOF**: reduction of -0.3% in **exception reporting in QOF**, in contrast to other QOF measures (+0.2% increase)



Cohort	Median Systolic BP change	Number of Patients in Cohort
In scope, had BeCCoR review	-5	48 388
In scope, no BeCCoR review	-2	34 221
Not in scope	0	344,698

This shows the impact for an individual clinical parameter: the median change (improvement) in systolic blood pressure control was highest for those in the BeCCoR cohort who has a review undertaken, as compared to those in the cohort who did not have a review or those not in scope.

A median reduction of systolic by 5 is a significant clinical outcome.

-10mmhg = -17% RRR for MI's and -27% RRR for Stroke
(Ettehad et al, Lancet)

Cohort	Median HbA1c change (mmol/mol)	Number of Patients in Cohort
In scope, had BeCCoR review	-11	34,895
In scope, no BeCCoR review	-6	16,069
Not in scope	0	143,990

This shows the impact for an individual clinical parameter: the median change (improvement) in diabetes control was highest for those in the BeCCoR cohort who has a review undertaken, as compared to those in the cohort who did not have a review or those not in scope.

A median reduction of HbA1C by 11 is a highly significant clinical outcome.

-11mmol/mol hba1c = -14% RRR for MI's and 0% for Stroke
([UKPDS 35, BMJ](#))

Cohort	% treated with a statin (scheme start)	% treated with a statin (scheme end)	Change	Patients in Cohort
In scope, had BeCCoR review	59.8%	70.1%	+10.3%	30,139
In scope, no complete review	50.7%	55.6%	+4.9%	17,860
Not in scope	95.8%	93.6%	-2.2%	141,493

This shows the impact for an individual clinical parameter: the median change (improvement) in those on a statin to improve cholesterol/lipid control was highest for those in the BeCCoR cohort who has a review undertaken, as compared to those in the cohort who did not have a review or those not in scope.

An increase in people treated with a statin of 10.3% is a highly significant clinical outcome.

-1 mmol/L LDL-C = -22% RRR for MI's and -22% for Stroke
([CTT Collab, Lancet](#))

CVD conditions defined as Hypertension, Diabetes or CKD

Cohort	% (scheme start)	% (scheme end)	Change
In scope, had BeCCoR review	40.4%	44.2%	+3.8%
In scope, no BeCCoR review	23.8%	25.0%	+1.2%
Not in scope	30.8%	33.5%	+2.6%

This shows the impact of the scheme on identifying those who have more then one condition (of hypertension, diabetes or chronic kidney disease): this shows the highest increase in %age of patients in the BeCCoR grup who underwent a review. This demonstrates the success of this approach in also identifying undiagnosed but coexistent conditions.

The BeCCoR **risk cohorts correlate with service utilisation** across A+E attends; 111 and 999 calls; non-elective, elective, and outpatient activity

- This is across all service utilisation not just for CVD/Diabetes specific services
- CVD and Diabetes prevalence correlates with deprivation, and BeCCoR cohorts identify those with the most unmet clinical need
- Hence this analysis **suggests that the CVNeed risk stratification approach may also predict those at highest risk of increased service utilisation**
- This unlocks **potential system opportunities** to work differently around UEC, elective and neighbourhood reform

For the very high and high risk groups, **in-year improvement has been made to elective and non-elective admissions** for CVD as a result of BeCCoR scheme

- This is demonstrated on slides 20 and 22
- This may represent early evidence of further impact to be yielded in year 2 (2025/26) and beyond – recognising that it will take time for reduced unmet clinical need to translate into reduce service utilisation

BeCCoR high-risk reviews demonstrate shift from *Hospital to Community*



Greater Manchester

WHAT we did
(summary)

'Beyond Core Contract' reviews for high-risk long-term conditions patients

- Diabetes and CVD Prevention stated as key priorities in GM sustainability and prevention plans.
- Activity developed to identify high risk patients and prevent ED attendance and hospital admissions.
- ICB-wide quality standards negotiated through BeCCoR (Beyond Core Contract) programme.
- **Review high-risk long-term conditions patients for BP, HbA1C, cholesterol, BMI, eGFR & smoking status.**
- Incentivise primary care to carry out the reviews.
- Identify the high-risk cohort and communicate lists to GP practices.
- Set payment thresholds for partial and full payment of the incentive.
- Provide accessible near-real-time data access for stakeholders to track delivery.
- Evaluate the programme and communicate achievements.

HOW we did this

Effective & incentivised delivery through primary care across the ICB

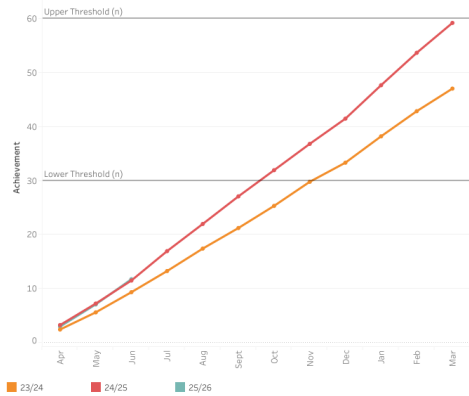
- CVDNeed tool developed to build scoring system to identify high-risk patient cohorts.
- GM-wide engagement with clinical and commissioning teams.
- Invest to save approach to build sustainability into long term system development.
- Central DII team identifying qualifying cohort in every GP practice in GM to communicate patient lists to all GM practices.
- Graduated incentivisation payments to GP practices for carrying out reviews.
- Practices strongly recommended to complete full long-term conditions/QOF reviews at the same time (eg for people with diabetes to include urinary ACR and foot check in addition to the minimum criteria).
- No exception reporting allowed.

So what? (impact of this on
patients/inequalities)

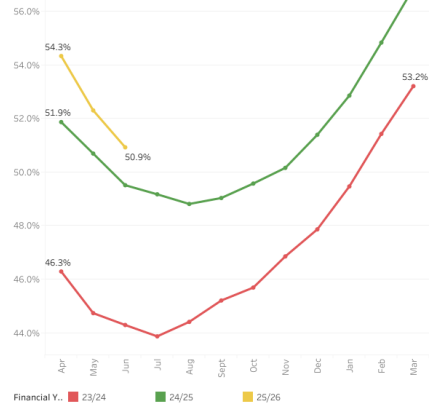
Left shift from 'hospital to community'

- **80% of blood pressure benefit - in primary prevention hypertensives** . Reducing cardiovascular events, attendance at ED and admissions to hospital.
- **BP optimisation – 78 MI and 144 strokes prevented.** (Based on a median SBP reduction of 5 mmHg for reviewed hypertensive patients. Relative-risk reductions from Ettehad et al., Lancet 2016.)
- **HbA1c control – 98 MI prevented.** (Based on a median HbA1c reduction of 11 mmol/mol (approx. 1%). Risk reduction from UKPDS 35, BMJ 2000.)
- **Increased anticoagulation for AF patients – 53 strokes prevented** . (Based on 2,221 high-risk AF patients newly anticoagulated; stroke risk reduced by 60%. Evidence from Hart et al., Ann Intern Med 2007.)
- **In total this equates to approximately – £6.7 million in system costs saved.** (Cost estimates derived from NICE guideline NG136 hypertension resource-impact report, using acute and follow-up NHS/social-care unit costs.)

% of high-risk patients receiving BeCCoR review



Diabetes '8 care processes' completion improving



Making things better:

Diabetes and CVD Prevention improvement work

- Prof Manisha Kumar, NHS Greater Manchester, Chief Medical Officer

- The **GM Secondary Prevention Lipid Medication Eligibility Pathway** has now been published on the GMMG website
- This pathway was developed through a task & finish group of GPs, lipidologists, and other CVD colleagues.
- Two additional pathways, **Primary Prevention** and **Statin Intolerance**, have been submitted to CEG and will be circulated for a 6-week consultation before being finalised.

GM SECONDARY PREVENTION LIPID MEDICATION ELIGIBILITY PATHWAY For established CVD including coronary heart disease, stroke/TIA, peripheral arterial disease	
STEP 1 OPTIMISE STATIN FIRST <i>Up to Atorvastatin 80mg OR Rosuvastatin 40mg* (or maximum tolerated dose)</i> • Optimise lifestyle measures • Ensure adherence to lipid-lowering medications • Use statin intolerance pathway if unable to tolerate any dose of statin	
STEP 2 Lipid therapy in addition to maximally tolerated statin based on LDL-C levels	
LDL-C Level (mmol/L)	Treatment Action
Persistently > 4.0 (single cv event)	Referral to lipid clinic for PCSK9 inhibitors
Persistently > 3.5 (multiple cv events)	
Persistently ≥ 2.6 - 3.5/4.0	Inclisiran
2.0 - 2.5	Ezetimibe 10mg Once Daily Consider ezetimibe if LDL-C remains > 1.4 after injectables
1.4 - 1.9	Consider Ezetimibe 10mg Once Daily
Criteria for referral to lipid clinic First exclude secondary causes: hypothyroidism, uncontrolled diabetes, excess alcohol and nephrotic syndrome	
Suspected Familial Hypercholesterolemia	Triglycerides (TG)
Any of • Total cholesterol ≥ 7.5 mmol/L • LDL-C ≥ 4.9 mmol/L	• ≥ 20 mmol/L once OR • ≥ 10 mmol/L twice (in absence of diabetes/alcohol)
Icosapent Ethyl can also be prescribed if, - Fasting TG 1.7-5.6 mmol/L & - LDL-C 1.04-2.60 mmol/L & - Taking Statin therapy <i>Green (specialist advice)</i>	
THE LOWER THE LDL-C, THE LOWER THE CV RISK - THERE IS NO LOWER LIMIT Initially review historical statin prescriptions and consider switching to recommended statins at the appropriate dose, unless there is a documented history of intolerance or adverse effects. *Use Rosuvastatin 20mg OD if on clopidogrel or of Asian origin • Bempedoic Acid is not recommended alongside statin therapy • Persistently raised = two levels above threshold taken at least 3 months apart • Repeat cholesterol and LFTs 6-8 weeks after initiation or change of statins • Use non-fasting samples for routine monitoring • If calculated LDL is unobtainable (triglycerides >4.5), repeat fasting	

Medications may require dose adjustment based on co-morbidities (e.g. renal/hepatic impairment), always check the BNF if uncertain. All medications must meet NICE criteria for initiation.

V1.5 1/06/25

Background

- GM submitted an Optometry bid with the aim to opportunistically screen and identify possible undiagnosed hypertension during routine optometry visits
- The pilot targets approximately 6,800 individuals across selected pilot optometry sites, providing opportunistic BP and irregular pulse measurement for patients who are:
 - Over 40, and;
 - do not have a current hypertension diagnosis and;
 - have not have their blood pressure measured in the last 6 months
- Focused on practices in the lower IMD deciles.
- Bid was successful and delivered by Optical Practices with the support/management of Primary Eyecare Services. Screening began in November 2024.

Practice locations and IMD deciles

CVD Greater Manchester



Decile 1	47
Decile 2	12
Decile 3	9
Decile 4	12
Decile 5	5
Decile 6	1
Decile 7	5

Decile 1	47 practices
Decile 1-2	59 practices
Deciles 1-3	68 practices
Deciles 1-4	80 practices
Deciles 1-5	85 practices
Deciles 1-6	86 practices
Deciles 1-7	91 practices

Pilot data (Nov 24 – Jun 25)

Outcome	Episodes	%
Discharge	2714	76.5%
Patient not eligible / unable to complete readings	8	0.3%
Refer routine - High BP (CP or GP)	745	21.0%
Refer routine - Low BP (no symptoms)	36	1.0%
Refer urgently - Irregular pulse (NHS111)	3	0.1%
Refer urgently - Very High BP (NHS111)	34	1.0%
Refer urgently - Very High BP (220/120+): Send to A&E	6	0.2%
Grand Total	3546	100%

Pilot Evaluation

- Pilot will finish in November 2025
- NHSE evaluation will be done by South West Innovation – data is due August 2025
- Greater Manchester evaluation:
 - ▶ Will include final data
 - ▶ “Closing the loop” data around hypertension diagnosis
 - ▶ Optometry Practice feedback
 - ▶ Patient feedback
 - ▶ Case studies

Tackling High Blood Pressure: IP Pathfinder



Greater Manchester

- 10 **Independent Prescribing Pathfinder** sites across Greater Manchester
- All prescribing is being done electronically using a nationally procured standalone system called 'Cleo Solo' and 9 out of 10 Pathfinder sites are using GMCR to access Patient Medical Records
- The Clinical models delivered across GM sites include Minor Illness, Respiratory and Hypertension
- The PharmOutcomes System is being used by Pathfinder Sites to record and report consultations for each clinical model
- Go-live dates for GM pharmacies varied from February 25-current. Hypertension consultations being rolled out from July 25.

GM Clinical Model

Hypertension

- Initiate treatment for patients identified through NHS BP Check Service
- Manage treatment for patients already diagnosed following GP referral through NHS BP Check Service
- Still in development

Gm Hypertension Consultation data from July 2025

Hypertension IP Consultations		Date ▼							
Pharmacy	▼	15/07/2025	21/07/2025	22/07/2025	23/07/2025	26/07/2025	30/07/2025	31/07/2025	Grand Total
Drugmart Pharmacy		1		1		1			3
Hollowood Chemists Limited (11 Mesnes Street Wigan)			1						1
Manley Pharmacy							1		1
Well (Branch: 224266 - Lees - Mellor Street)					1				1
Wilmslow Road Pharmacy (Branch: 223053 - Withington - Wilmslow Road)								1	1
Grand Total		1	1	1	1	1	1	1	7

- A total of 7 Hypertension IP Consultations were conducted in July
- More data to follow once dashboard is developed

- The Greater Manchester Hypertension Improvement Project (HeartBeat) targeted the 20 lowest-performing primary care practices to enhance hypertension management and reduce cardiovascular health inequalities.
- Due to constraints, 12 practices engaged, with 10 actively participating.
- The project demonstrated notable improvements through modest interventions, systematic Quality Improvement (QI) methods, and real-time monitoring using an online dashboard.

Outcomes

- Brooke Surgery improved BP control from 53% to 69% within a month.
- Enhanced patient engagement through direct outreach and structured recall systems.
- Efficient resource utilization with multidisciplinary team integration.
- Improved adherence to guidelines and protocols, reducing clinical variability.
- Real-time monitoring facilitated rapid iterative improvements and reduced administrative burden.
- Demonstrated feasibility of significant improvements without major workflow disruptions.

Financial/Efficiency Benefits:

- Reduced clinician workload through pharmacy technician clinics.
- Improved patient throughput and clinical efficiency.
- Potential cost savings through improved BP control, reducing long-term healthcare utilization.

Top tips

- Team Integration: Engage multidisciplinary teams early to ensure effective role distribution and ownership.
- Patient Engagement: Use targeted outreach and convenient booking methods to maximize patient response and participation.
- Real-Time Data: Implement user-friendly dashboards for continuous, real-time data collection to inform immediate adjustments and reduce administrative burdens.

GM Blood Pressure treated to target data

Size of the Prize - Greater Manchester Health and Social Care Partnership BP Optimisation to Prevent Heart Attacks and Strokes at Scale



% patients >18 years
with hypertension, blood
pressure treated to target

Baseline Mar-20
70.9%

47.4%
COVID impact 20/21

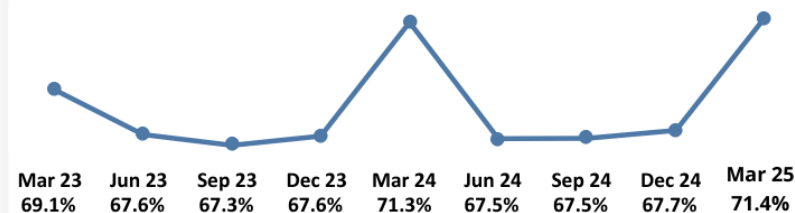
Mar-25
71.4%

75%
15,880
additional patients

80%
37,937
additional patients

85%
59,994
additional patients

In year variation



Ambition 1		Ambition 2		Ambition 3	
Potential cardiovascular events and deaths prevented in 3 years ¹ and estimated savings ^{2 3}					
95	heart attacks	228	heart attacks	360	heart attacks
£0.7M	saved	£1.7M	saved	£2.7M	saved
142	strokes	340	strokes	537	strokes
£2.0M	saved	£4.7M	saved	£7.5M	saved
76	deaths	182	deaths	288	deaths

References

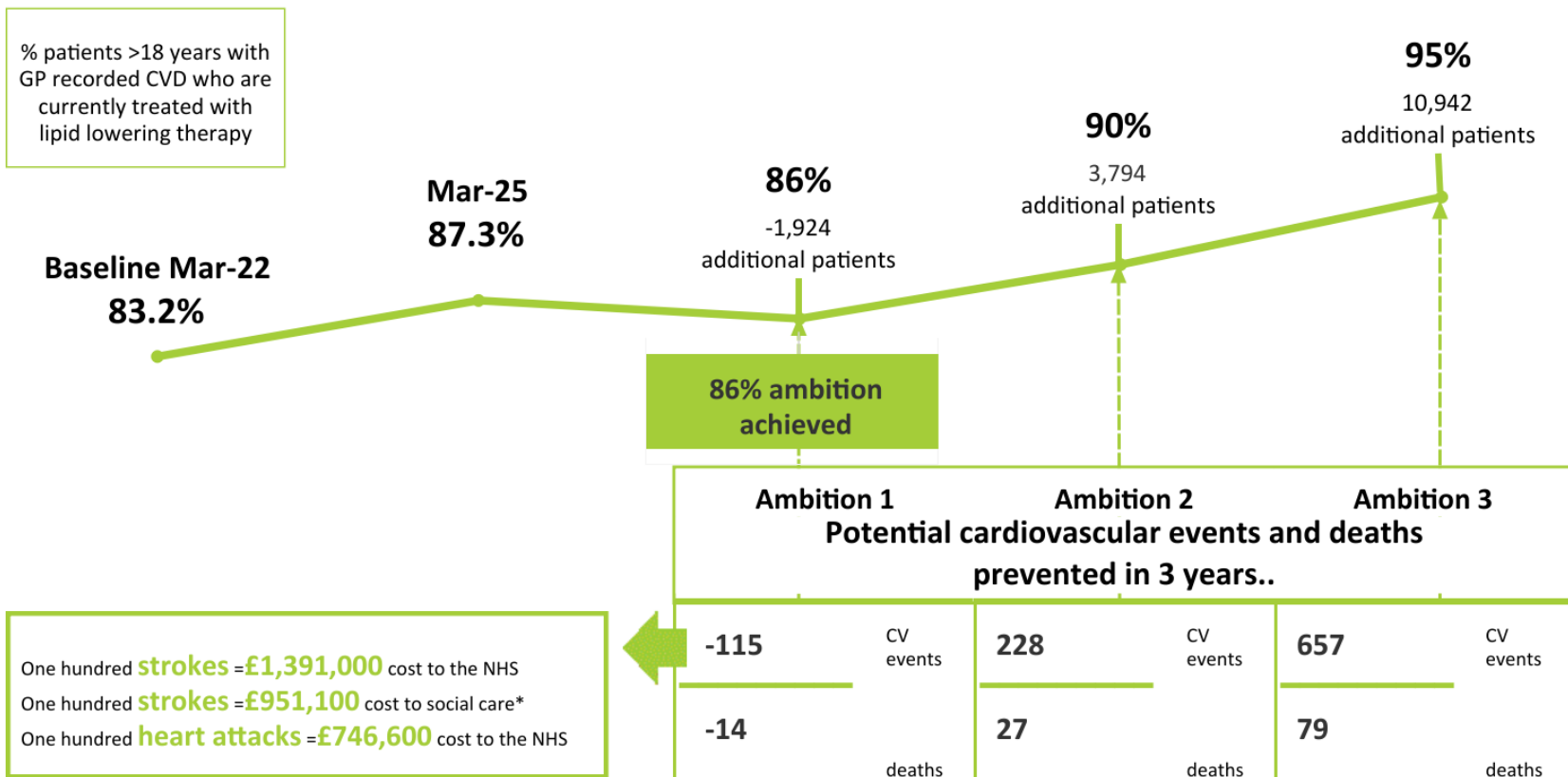
- Public Health England and NHS England 2017 Size of the Prize
- Royal College of Physicians (2016). Sentinel Stroke National Audit Programme. Cost and Cost-effectiveness analysis.
- Kerr, M (2012). Chronic Kidney disease in England: The human and financial cost

Modelling

Data source: CVDPrevent. Briefing note: [CVDPrevent online methodology annex v1 December 2022](#)
Potential events calculated with NNT (theNNT.com). For blood pressure, anti-hypertensive medicines for five years to prevent death, heart attacks, and strokes: 1 in 100 for heart attack, 1 in 67 for stroke.

Size of the Prize - Greater Manchester ICB

Cholesterol Optimisation to Prevent Heart Attacks and Strokes at Scale



References

1. Collin et al. (2016), Interpretation of the evidence for the efficacy and safety of statin therapy, *The Lancet*, 388, 2532-2561. DOI: [https://doi.org/10.1016/S0140-6736\(16\)31357-5](https://doi.org/10.1016/S0140-6736(16)31357-5)
2. Royal College of Physicians (2016). Sentinel Stroke National Audit Programme. Cost and Cost-effectiveness analysis.
3. Kerr, M (2012). Chronic Kidney disease in England: The human and financial cost

Modelling

Data source: CVDPrevent. Briefing note: [CVDPrevent online methodology annex v1 December 2022](#)

Potential events calculated with NNT (Collins, 2016). For patients with known CVD, lipid lowering medicines for five years to prevent cardiovascular events and death: 1 in 10 for cardiovascular events, 1 in 83 for mortality.

* Stroke costs to social care are given for the 1st year following stroke only.

GM NHS Health Check data



Greater Manchester

Area ▲▼	Recent Trend	Count ▲▼	Value ▲▼		95% Lower CI	95% Upper CI
England	–	4,736,485	29.6		29.6	29.6
Greater Manchester local authorities	–	304,394	40.5*		40.3	40.6
Bolton	–	56,945	73.7		73.4	74.0
Rochdale	–	29,295	52.6		52.2	53.0
Salford	–	29,051	44.4		44.1	44.8
Trafford	–	30,823	44.0		43.6	44.4
Wigan	–	36,302	43.4		43.0	43.7
Oldham	–	22,376	34.4		34.1	34.8
Bury	–	19,062	34.4		34.0	34.8
Stockport	–	27,076	31.3		31.0	31.6
Manchester	–	38,296	30.1		29.8	30.4
Tameside	–	15,168	22.9		22.6	23.2

Source: OHID, based on NHS Health Check Programme data

Trend - Multiple Measures

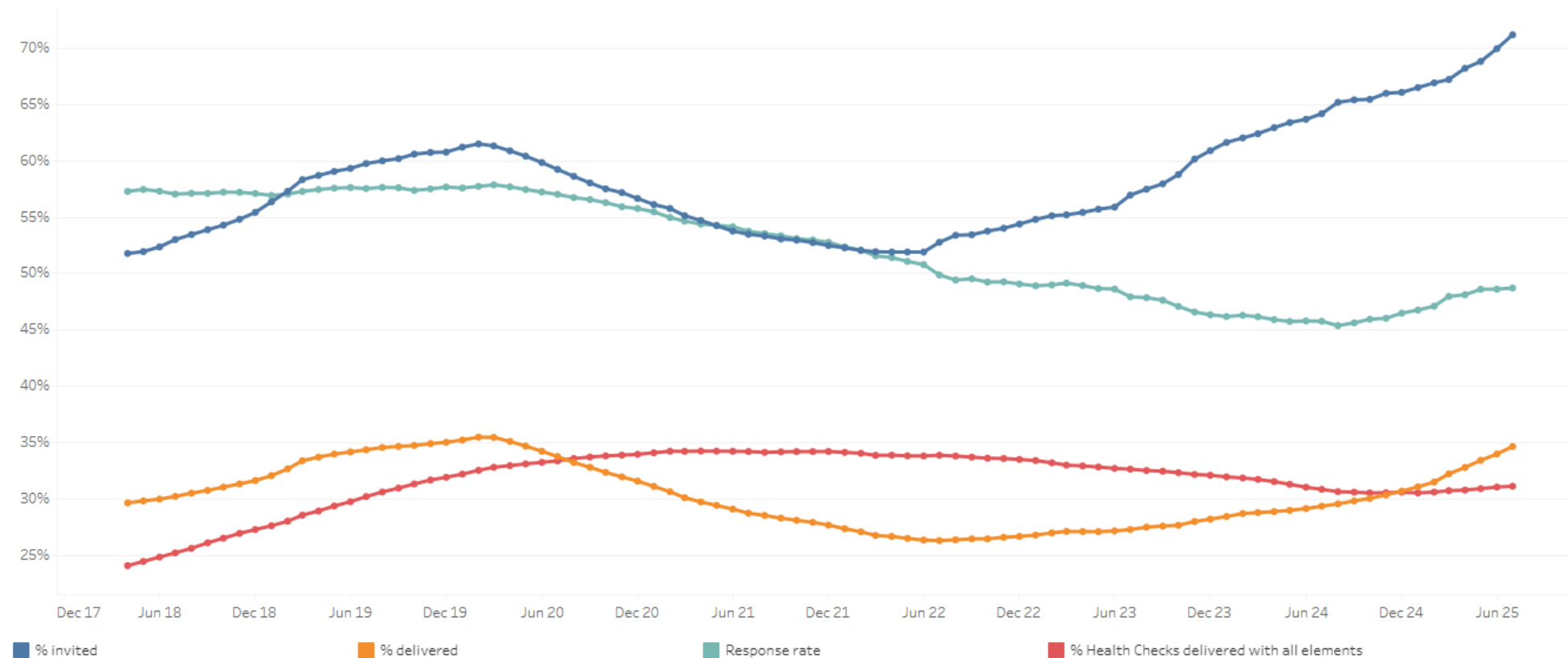


Greater Manchester

GM Locality: (All) PCN Name: (All) Practice: (All) Reporting period: Last 5 years Health check delivery by: Either practice or third party

Health checks in the Last 5 years

It is possible for the response rate to be greater than 100% due to the timing of invitations and responses. Not all practices code invitations for NHS Health Checks, only delivery.



The GM Health Check Working Group is involved in on-going discussions around the gap between invitations and response rate. Strategies to improve this gap and delivery are being considered. Last meeting was 2nd September.

The Impact of Our Work:

Addressing inequalities and improving patients' lives

- Ewan Jones, NHS Greater Manchester, Senior Programme Manager (LTC)

REDUCING HEALTHCARE INEQUALITIES



CORE20

The most deprived **20%** of the national population as identified by the Index of Multiple Deprivation



The **Core20PLUS5** approach is designed to support Integrated Care Systems to drive targeted action in healthcare inequalities improvement

Target population

PLUS

ICS-chosen population groups experiencing poorer-than-average health access, experience and/or outcomes, who may not be captured within the Core20 alone and would benefit from a tailored healthcare approach e.g. inclusion health groups



CORE20 PLUS 5

Key clinical areas of health inequalities

1



MATERNITY

ensuring continuity of care for women from Black, Asian and minority ethnic communities and from the most deprived groups

2



SEVERE MENTAL ILLNESS (SMI)

ensure annual Physical Health Checks for people with SMI to at least, nationally set targets

3



CHRONIC RESPIRATORY DISEASE

a clear focus on Chronic Obstructive Pulmonary Disease (COPD), driving up uptake of Covid, Flu and Pneumonia vaccines to reduce infective exacerbations and emergency hospital admissions due to those exacerbations

4



EARLY CANCER DIAGNOSIS

75% of cases diagnosed at stage 1 or 2 by 2028

5



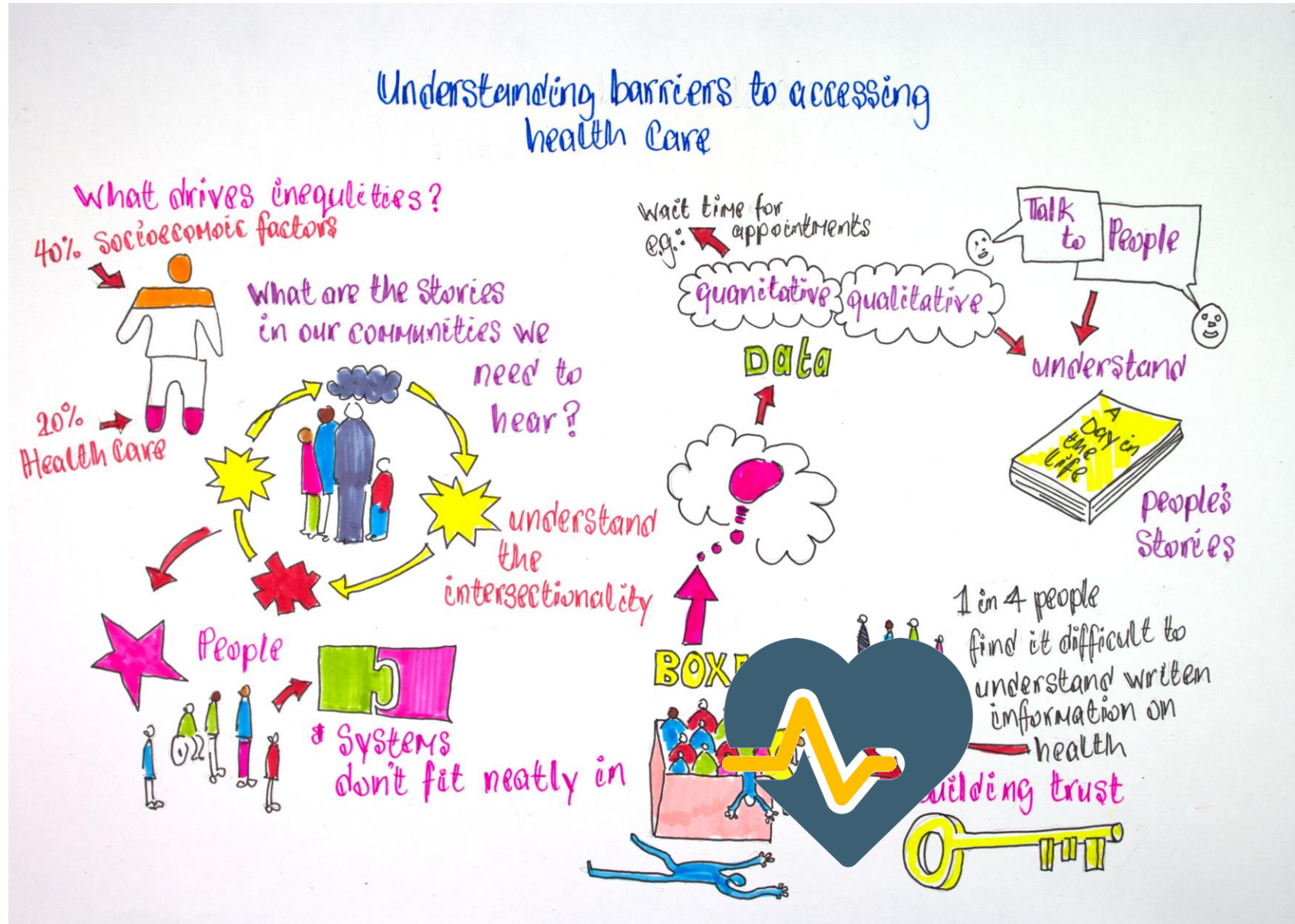
HYPERTENSION CASE-FINDING

and optimal management and lipid optimal management



SMOKING CESSATION

positively impacts all 5 key clinical areas



Healthier You the Diabetes Prevention Programme

John's Story



Retired truck driver, from Rochdale, lost 5 stone on the Healthier You Programme, proving you're never too old to make positive changes to your health.

"For quite some time I thought about my declining health, so I embraced the opportunity to join Healthier You wholeheartedly. I wanted to make sure if anything happened to someone in my family, I could be there for them."

As well as the changes to his weight, he saw his blood glucose level, which should be under 42, drop from 46 to 37.

- **John's tips for reducing your risk of diabetes:**
- Make it fun
- Replace unhealthy food with healthy foods you enjoy
- Do what you can - if you can't get around easy, try exercises in bed and around the house
- Create a daily routine – perhaps get up early and start your exercises after breakfast
- Join Healthier You – encourage each other
- Persevere – don't worry, your health will improve if you keep at it
- Make it sustainable - continue with your changes once the programme ends.

Type 2 Diabetes Path to Remission Programme

Sarah's Story

Sarah from Wigan was diagnosed in 2023 and felt overwhelmed with all the unfamiliar paperwork and medical information on type 2 diabetes.

With the support of her nurse, she joined the Path to Remission Programme choosing the virtual option to suit her mobility needs.

By August 2024 she had completed the programme, lost 40% of her starting body weight, and her blood glucose is down to a healthier level.

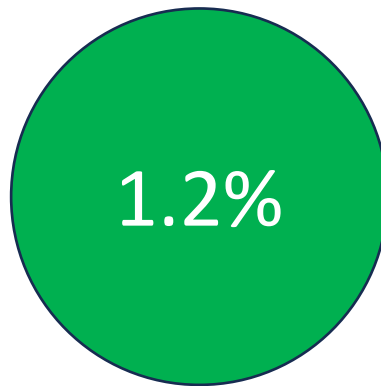
Most importantly she achieved diabetes remission.

'Having a community to share ideas with made all the difference'



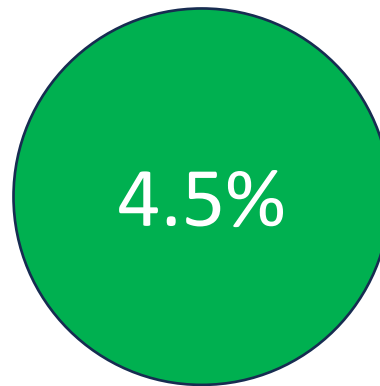
Reduction in patients at very high or high prioritisation

Diabetes



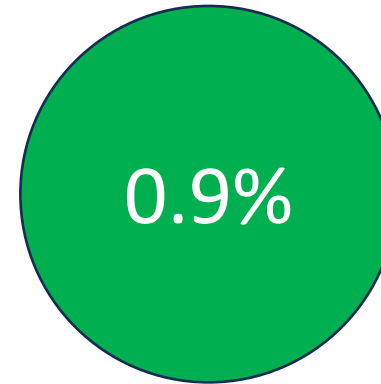
841 patients

Atrial Fibrillation



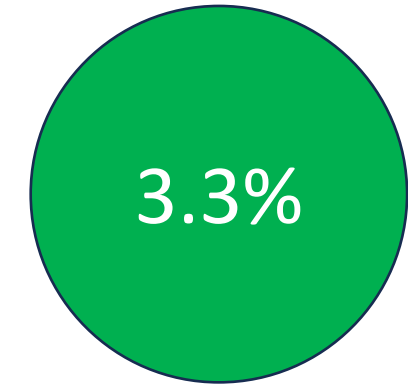
2,219 patients

Hypertension



2,189 patients

Secondary Prevention

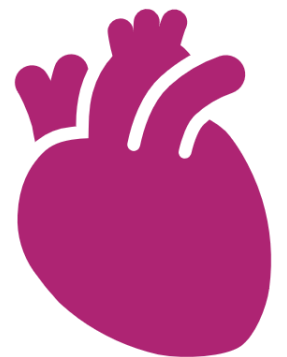


4,390 patients

In total **1.6%** reduction in patients in scope (5,461 patients)

and

Reduction in **exception reporting in QOF**: reduction of **-0.3%** in **exception reporting in QOF**, in contrast to other QOF measures (**+0.2%** increase)



Impact: Reduction in People at High Risk



Greater Manchester

Cohort	HYPERTENSION Median Systolic BP change mmHg	LIPIDS % change in those treated with a statin	DIABETES Median HbA1c change mmol/mol	% of patients identified with multiple CVD conditions (defined as Hypertension, Diabetes or CKD)
In scope & had BeCCoR review	-5 48,388 patients	+10.3% 30,139 patients	-11 34,895 patients	+3.8%
In scope & NO BeCCoR review	-2 34,221 patients	+4.9% 17,860 patients	-6 16,069 patients	+1.2%
Not in scope	0 344,698 patients	-2.2% 141,493 patients	0 143,990 patients	+2.6%

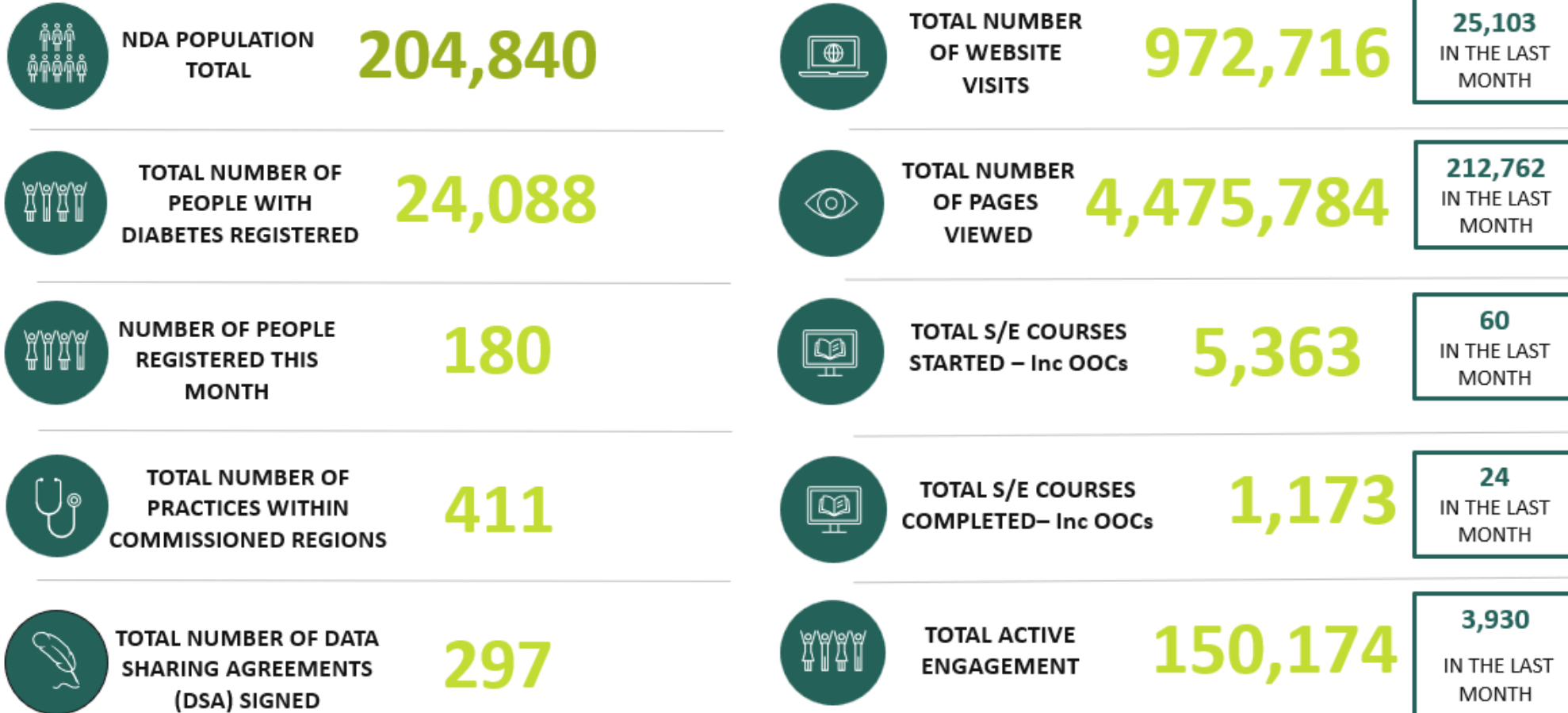
- Continuous glucose monitoring (CGM):
 - Continuously tracks glucose levels in real-time.
 - Data is sent to a receiver or smartphone.
 - Alerts for high/low glucose levels.
- Hybrid closed loops:
 - Links CGM to an insulin pump.
 - Digital controller/algorithm.
 - Automated dose adjustment/correction.
- Benefits:
 - Helps prevent hypoglycaemia and hyperglycaemia.
 - Reduces need for finger-prick tests.
 - Improves glycaemic control.
 - Enhanced quality of life.



Impact: *MyWay Diabetes* Patient Data Access, Self-Management

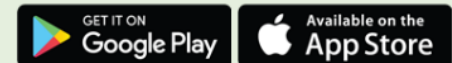


Greater Manchester



Download the
MyWay Diabetes App!

1. Go to the Google Play or App Store
2. Search for 'MyWay Diabetes' → 



Questions & discussion