GREATER MANCHESTER HEALTH AND SOCIAL CARE
STRATEGIC PARTNERSHIP BOARD

Date: 31 March 2017
Subject: Urgent and Emergency Care Reform
Report of: Jon Rouse, Chief Officer, GMHSC Partnership

PURPOSE OF REPORT:

This purpose of this report is to set out proposals for reforms to the urgency and emergency system in Greater Manchester to improve performance and secure better outcomes for patients.

RECOMMENDATIONS:

The Strategic Partnership Board is asked to note the content of this paper to deliver a more consistent and coherent operating model for urgent and emergency care across Greater Manchester and approve the:

- Establishment of a single GM UEC Delivery Board and supporting structures which would replace the existing Urgent and Emergency Care Task Force and UEC Network.

- The UEC focus on the areas of work outlined in the paper (3.3 – 3.13)

- Development of a detailed delivery plan by April 2017

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1.0 INTRODUCTION

1.1. When Greater Manchester Health and Social Care Partnership received its devolved responsibilities in April last year, we knew that urgent and emergency care was going to be one of our most difficult challenges for a number of reasons:

- pressure of rising demand upon the system, including increasing numbers of frail elderly with multiple long term conditions;
- impact of the squeeze over several years on NHS acute and community capacity, including primary care;
- shortages in the UEC workforce, in both NHS and social care services;
- the impact of the reductions in availability of social care support for older people as a result of the cuts in central government funding for local government.

1.2. We could see from the data that there was a growing problem in terms of GM local systems being able to meet key performance measures including the four hour wait standard and delayed transfers of care. GM also has high levels of non-elective admissions compared to the rest of the country, suggesting weaknesses in our out-of-hospital provision.

1.3. Last summer the Partnership created an Urgent and Emergency Care Taskforce to take stock of the operation of the system across Greater Manchester and to determine the best way forward. It developed a work-plan and was able to instigate some short term measures, including identifying £5m of additional funding for capacity this winter, while recognising that fundamental changes would lie ahead.

1.4. Through the work of the Task Force we have identified that there are a number of strategic and operational factors that are potentially undermining the operation of the GM system, irrespective of the wider systemic impacts described at the top of the paper. Put bluntly, while our UEC system would be under pressure however well it was functioning, in reality there are a whole set of problems to address. It is therefore incumbent upon the Partnership, under the terms of devolution, to address these deficits and forge a different path forwards.

1.5. This report brings together our learning by offering a diagnosis of the main problems with the current system and proposing a package of reforms.

2.0 WHAT NEEDS TO CHANGE?

2.1. Overall, what we are striving for is a more consistent and coherent operating model for urgent and emergency care across Greater Manchester, working to a common set of standards, and that is readily understandable to the public in terms of the
decisions they make about their care needs. At the heart of the reformed model must be more reliable and flexible community–based provision that both prevents unnecessary A&E attendances and hospital admissions, and which enables safe and timely discharge from hospital.

2.2. To achieve this ambition, the following issues need to be addressed:

- **Confused relationship between Local Delivery (A&E) Boards and wider programmes:** There is a national UEC programme that is channelled through NHS Improvement and NHS England at national level. During the first phase it has worked through direct relationship with individual providers who have been grouped into clusters based on levels of performance/risk. The national programme has sourced and directed resources into individual Trusts. It has operated outwith the GM governance, meaning that at any one time local systems have been faced with several relationships – with our own Task Force, with the GM Urgent and Emergency Care Network (a mandatory national construct) and with NHS I/NHS E through the national programme. This is a recipe for duplication and confusion. The good news is that the national bodies have already decided that phases 2 and 3 of the national programme should be operated on a geographical footprint and this gives us an opportunity to rationalise and consolidate our efforts.

- **Separation of commissioning responsibilities:** Some of the fragmentation in commissioning is experienced at the local level and this should be addressed through the locality plans and some specific interventions, e.g. north east sector relationship with Pennine Acute. However, there are also issues at the GM level, most notably the fact that the commissioning of the Patient Transport Service (PTS) and 111 services were not devolved in the original agreement and are instead commissioned remotely from Blackpool CCG. This has made it difficult to commission an integrated urgent care model at the GM population level. There is also a general problem of commissioners being slow to respond to evidence, in terms of both what works and what doesn't work, in changing what and how they commission.

- **Access to and use of data:** There are weaknesses in the way that data is accessed and used at the organisational, locality and GM level. Although we do have access to some useful predictive analytics from the GM Utilisation Unit, two of the Trusts have until recently not supplied data to, or utilised data from, this team, and arguably, only WWL are using the available data to its fullest extent to guide planning. Moreover, to the extent that data is used to guide system design and development, we tend to focus too heavily on symptomatic issues, e.g. numbers of GP and A&E attendances, at the expense of gaining a much more sophisticated view of the reasons for the underlying increases in demand for services.

- **Operational oversight and escalation processes:** Like most of the rest of the country, GM manages its urgent and emergency care system at a locality
level, driven by the operational requirements of individual hospitals. It relies heavily on escalation processes that seek to dampen down emerging problems, placing the onus back on the local system to resolve or at least manage them if at all possible. While this has some advantages in terms of ensuring local systems take first responsibility for the operation of their local system, it means that by the time issues are exposed at a GM level we are usually in some level of crisis requiring a ‘command’ response. The danger is that this reactive approach is becoming a normalised operational mode.

- **Workforce:** There is no joined up approach to the planning, recruitment and deployment of urgent and emergency care workforce in Greater Manchester. This means that while all systems are under strain, there is a disparity in access to key skills across the GM system, there is competition for key personnel and no co-ordinated approach to managing the agency/locum market.

- **Social care capacity:** Despite the introduction of the Care Act 2014 which places a statutory responsibility on local authorities to understand their capacity requirements and shape their market accordingly, we have found little evidence of GM local authorities having properly analysed their market, worked out the shortages and articulated a plan for addressing those shortages over time; even fewer have properly joined this up with their local workforce plan, their estate plans and their supported accommodation strategies.

- **Urgent care in the community:** There is significant variation between the local offers in Greater Manchester in terms of providing alternatives to A&E attendance and then admission. This includes differences in access to primary care streaming at the front door of the hospital, out-of-hours GP provision in the community, use of walk-in and urgent care centres etc. This needs systematic review locality by locality but our initial view would be that the commissioned provision in some of our localities is inadequate and in most localities, not properly integrated into a coherent system that can flex to meet different levels of demand on an agile basis. In too many areas providers are simply working to an assessment of average demand, rather than predictable but variable levels of demand.

- **Physical capacity:** There are three main issues here. The first is that, despite our overall direction of travel towards more care out-of-hospital, we suspect that one or two of our local systems may currently have inadequate non-elective acute and intermediate bed capacity. This needs urgent review. Second, some of our A&E departments have inadequate physical space. They were designed for numbers of attendances and an average level of acuity that has long been surpassed and they require re-provision or expansion. Under the banner of Healthier Together implementation this is an absolute priority for any available capital resourcing. And finally, there may be community estate requirements following from an assessment of out-of-hours provision. These
requirements should be addressed through the locality plans and subsequent GM prioritisation process, in terms of the delivery of integrated neighbourhood hubs, (including diagnostic provision.)

- **Information sharing:** Linked to our inadequate use of available data we are still also relatively immature in terms of access to data along the urgent and emergency care pathway which, if addressed, would give us a much better prospect of people being directed to the most appropriate care first time. One potential route to achieving better information access quickly is our Datawell system that enables safe access to data across NHS organisational systems and is looking to extend this to social care.

2.3. This is not an exhaustive list. One wider issue is that GM has to date not systematically adopted all known best practice from other parts of the country. Even against the core requirements of the national programme, some local systems have been slow to comply.

3.0 THE WAY FORWARD

3.1. What the preceding section demonstrates is that there is much that we can address that is within our own control, with the right levels of openness and collaboration, with the advantage of access to the Transformation Fund and hopefully, the Integrated Digital Fund and some capital resources, to help test new ways of working and make transitions. We are proposing the following package of reforms.

3.2. Governance

3.2.1. It is proposed that we create an Urgent and Emergency Care Board for Greater Manchester, incorporating the work of the Task Force, the network and the national programme. This would become a single portal for development of strategy, design and delivery of programmes and co-ordination of actions and interventions. The Board would be led at GM level by the Chief Officer, a provider CEO, LA CEO and Trust Medical Director as vice chairs and membership consisting of the chairs of the Local Delivery Boards, plus other senior local representation from local government, the primary care sector, the emergent Care Provider Forum, the Voluntary and Community Sector and NWAS. NHS I/NHS E regional office would also have a place on the Board.

3.2.2. Within GM, the Board would be accountable through the Performance and Delivery Board to the Strategic Partnership Board.

3.2.3. The existing Urgent and Emergency Care Task Force and the Network would be wound up in their current forms and the work subsumed into the Board. The Board would determine what sub-groups and learning networks it required. The Board will also need to review the current set of specialist urgent and emergency care
networks, e.g. stroke, and establish the best possible working relationship with them to maximise their contribution.

3.2.4. There would need to be agreement from the national bodies that they would work through the same governance within GM. In return, the Board would need to compliant with the requirements of the national programme unless a compelling case could be made as to why GM would benefit from a different approach. We have just received the letter from Simon Stevens and Jim Mackey (Appendix 5) that sets out the national; approach over the coming period, including expectations on local systems. Lyn Simpson will be the single NHS E/NHS I regional lead with responsibility for the interface with the GM devolved system. We have agreed that we will transact that relationship through both the Board and monthly bilateral meetings, with the level of intensity determined by our performance against both national standards and the terms of the devolution accountability agreement.

3.2.5. At the local level it is proposed that we keep the Local Delivery Boards, renamed as Local Urgent and Emergency Care Boards. There would be an opportunity to consider whether we have the right number covering the most sensible geographies in terms of an integrated system approach. We would also audit each, with support from the national team, to ensure they are compliant with known best practice. This is also an opportunity to explore the alignment and future proofing by using a Locality based approach that links into the Local Care Organisational planning.

3.2.6. Evidence from the rest of the country suggests that the best performing boards are relatively small, comprising the senior executives with ultimate accountability for the effective operation of the local system, working to a clear action plan that maps to the national standards, and working on a clear set of priorities that flow from a sharp analytical understanding of specific deficits in the local systems.

3.3. System development and support

3.3.1. The urgent and emergency care system is one of the weaker parts of the GM’s overall care system and yet we actually have relatively little dedicated resource committed to its oversight and development. We need a period of intensive focus led by an expert team to make the content of this report a reality. We therefore propose forming a joint team of 5-7 people between the Partnership team and NHS I to develop and then oversee a detailed change plan and to ensure the consistent roll-out of know best practice across the region. The Partnership element of this will need to be paid for from the Transformation Fund.

3.4. Data and analysis

3.4.1. Through the work of the Utilisation Unit we have relatively rich data on most of our urgent and emergency care system. The fact that UHSM and CMFT do not buy into this service is something of a barrier but we are working through ways to overcome
this problem, so that we can use and report data on a consistent basis. We are currently building an analytical tool that will enable us to have a daily insight into the position both at GM and local system level, and through the use of predictive modelling, plan forward. We will ensure that this tool is available to all local systems. We are also building an A&E workforce tool (see below) and through Salford, a primary care planning tool.

3.4.2. Where we are currently weak is with respect to social care data. We are awaiting the testing and then roll out of NHS England’s tool for monitoring care home capacity; City of Manchester will be one of the test sites. Beyond this, and under the auspices of the social care reform programme, we need to get a much better handle on market capacity in key areas – home care, nursing care, intermediate care.

3.4.3. More generally, we need to interrogate the quality of local systems, actively seeking feedback from patients and workforce, and ensuring learning from adverse incidents is openly shared across GM.

3.4.4. We will also want to review the bundle of performance metrics by which urgent and emergency care performance is judged. At present, strong emphasis is placed on the four hour wait standard, and not without reason, as there appears to be correlation with poor performance against this standard and higher hospital mortality. However, it is not the only important measure if we are to be able to assess system performance in the round. We await with interest possible changes at the national level in terms of indicator set but we would expect at GM level to define a set of metrics that better reflects the whole urgent care pathway, in and out of hospital. In particular, we need to use a much better breakdown of types of avoidable admission so that we can target resources at the right OOH pathways. We also need to focus on levels of bed availability.

3.4.5. All of this work will be built into our overall approach to provision of business intelligence, which will flow from the commissioning review.

3.5. Operational oversight

3.5.1. We propose that we change the operational model to some extent in Greater Manchester. We would like to experiment over at least a couple of years with the introduction of a small 24/7 365 day operational hub, co-located with NWAS, and with access to the best data, to work with local systems and across local systems proactively to help manage supply and demand. This would enable NWAS and hospitals more readily to flex provision but the plan would be to extend this into the relationship with out-of-hospital provision as well so that we are planning levels and types of diversionary capacity commensurate with predicted demand. Potentially, this would enable us to operate a much more agile system across 111, primary care, A&E and other urgent care provision. The hub would report through a single accountable person to the Urgent and Emergency Care Board.
3.5.2. If this proposal is agreed it would be funded through an allocation from the Transformation Fund with an expectation that if the concept works, (and it would need time to evolve in the light of experience), then it would be funded through the CCGs in the medium term.

3.5.3. We would also ensure that the development of the approach would be properly and independently evaluated and there may need to be a period of shadow running at the outset.

3.5.4. It is recognised that we would still need reactive escalation procedures and protocols and we will need to keep this under ongoing review to ensure that they are as stream-lined and reliable as possible, involving only those parties who can genuinely make a difference in adverse circumstances.

3.5.5. More generally, we need a more rigorous approach to the definition and operation of common processes, so that there is much greater consistency of application of policy across GM.

3.6. Relationship with new models of care

3.6.1. Our plans for out-of-hospital care are of course critical to the success of any reform programme for urgent and emergency care. Ten times as many people are treated in primary care each day compared to our A&E departments. Our plans for the expansion of and better targeting of routine primary care will contribute to managing demand, as will the development of our Local Care Organisations, organised as networks of neighbourhood services at the 30-50,000 population level. In developing their LCOs each locality will also need to plan for an integrated local urgent care offer that blends out-of-hours primary care provision and access to other key services such as minor injuries and out-of-hospital diagnostics. Some localities may find it helpful to designate a super-hub where certain services can be concentrated, others may find it helpful to operate a more dispersed model. All areas will need to maintain up-to-date accessible on-line directories of community services, including granular information on when and how each of those services are available.

3.6.2. As a key contribution to this thinking, we are commissioning an immediate review of out-of-hours general practice across Greater Manchester, with a deep dive in each locality. This will consider the relationship with the wider urgent care offer and will make recommendations for changes and development.

3.6.3. We are also interested in developing a consistent approach to the urgent care response to people with the combination of co-morbidities and frailty, based on best practice. We are likely to use North Manchester as an intensive test-bed for the development of this sub-pathway.
3.6.4. We already have clear plans for the reorganisation of urgent and emergency care provision, including high risk and emergency surgery, under the Healthier Together programme. This is based on sectoral networks clustered around designated high acuity hubs. The clinical case for this programme remains as strong as at its inception and it is fully compatible with the wider package of reforms envisaged by this paper. The phasing of the implementation of the Healthier Together plan will be subject to final business case, resource availability and synthesis with the wider acute services strategy, to ensure optimum utilisation of estate and workforce.

3.6.5. Finally, we need to focus on delivery of the seven day hospital programme, supported also by a seven day ethos in the community. There is a repeat pattern in several of our local systems of delayed discharges building up over the weekend, putting unnecessary pressure on the whole system in the early part of each week. We have to smooth patient flow.

3.7. The right facilities

3.7.1. We have a good understanding of our A&E estate requirements and have included them as priorities within our overall estates programme. Many of these schemes also contribute to the implementation of our agreed care model under Healthier Together (see above.) Most of these improvements will require access to public service capital. While we have been able to support the relatively small scheme at Stepping Hill this year from within existing resources, most of the projects will require access to DH capital funding. We have submitted a list of our priorities accordingly with the benefit case. We await to see how the recent Budget announcements fit with our requirements.

3.7.2. However, it is not just about improving facilities at the front door of the hospital. We also need to ensure our community infrastructure is fit for purpose, to support both alternative urgent care provision but also timely discharge. As part of our estates strategy, we have mapped the known estates requirements across our neighbourhood hubs and are developing a capital finance strategy that can help support this programme. We will also need to facilitate the flow of private resources where this may be applicable, e.g. intermediate and nursing care requirements. And we continue to invest resources into the primary care estate as well.

3.7.3. Finally, there may be a case for targeted investment in specific diagnostic equipment to facilitate the move to a different integrated care model, e.g. to support radiography services.

3.8. Workforce

3.8.1. We are developing an overall Workforce Strategy for the health and care system in Greater Manchester that will incorporate the requirements of the urgency and emergency care system as a priority. This is underpinned by a Memorandum of
Understanding we have signed with partner bodies such as Health Education England. We will need to deal with the following:

- workforce planning: we need a much better understanding of our supply deficit both now and in the future; our new workforce planning tools and our relationship with Health Education England should help to address this

- changing roles: we need to work with professional bodies and others to ensure that role definitions are consistent with best practice, e.g. roll-out of the national SAFER programme.

- recruitment (and retention): we will need a GM-wide approach to recruitment to ‘hard-to-fill’ positions that is based on a compelling GM offer including ability to combine specialisms, use of the best of our employer brands, realistic use of rotations across sites, training and research opportunities. This will also incorporate the potential for international recruitment as exemplified by the pioneering programme between WWL, Edge Hill University and HEE

- new workforce models: there is evidence from elsewhere in the country that different combinations of workforce can help to mitigate some of the shortages in key staff groups; we need to learn from the best of these alternative models and apply them to our own local systems. For example, we need to make best use of the emergency care consultant workforce, including making better use of in-reach from other specialist consultants

- cross-sectoral partnerships: if we are to achieve the quality and capacity of intermediate and high acuity out-of-hospital care we require, it is unlikely that we will be able to rely entirely on the private care sector; we will need to nurture new public private partnership opportunities, between LCOs/acute trusts and care providers

- cross-border partnerships: the principle of a one system approach will need to extend to mutual aid with respect to workforce. We have seen the recent example of Salford Royal working with Trafford commissioners to facilitate health contribution to homecare provision for complex cases

- growing our own: our wider ambitions under the workforce strategy to develop more career pathway opportunities through lower grade jobs across health and care can also support our urgent and emergency care system, for example, with respect to homecare provision, Patient Transport Service (PTS) and telephony services.

3.8.2. However, perhaps most importantly, we will need to engage strongly with the relevant workforce to ensure that they have had chance to feed in to the detail of any system changes and feel an ownership for the changes we want to make. We also need to find ways of giving teams more control over their own environment and recognising their work and achievements.
3.9. Community care reform

3.9.1. The principal constraint on our urgent and emergency care system at this time is delayed discharges. There are multiple reasons for this, some of which, such as poor flow management, have to be addressed in our hospitals. However, a key problem is lack of community capacity of the right quality. It is not the task of this report to repeat the social care reform package that was approved by the Partnership Board in February but it is right to state that the reform of urgent and emergency care is heavily reliant on the successful implementation of those previous proposals, as is the parallel work to review the quality and administration of continuing health care (CHC). Key needs are:

- understanding and addressing gaps in intermediate and high acuity nursing home capacity (including high end dementia care) to enable both adequate step-up and step-down provision.
- the consistent roll-out of intensive primary care support to care homes
- a much more consistent approach to the commissioning of homecare support, including minimum contractual standards and new models
- a zero tolerance approach to delayed discharges and the harm they cause to patients
- common approach to how we deal with provider failure so that we lose beds from the system for the minimum period possible
- common approach to interpretation of national policies, e.g. ensuring that adherence to regulatory requirements does not become an exercise in unnecessary risk aversion, e.g. admitting someone with a complex care package to a particular facility.

3.9.2. To this end we need to learn from best practice models such as Glasgow where they have achieved an 80% reduction DTOCs in the last few years through targeted investment and strict management of contracts.

3.9.3. We should be mindful with respect to the budget announcement that is likely that one or two of the GM local authorities with very high DTOCs will be subject to some form of special intervention with respect to DTOCs as a condition of receiving the additional social care resources.

3.10. Patient assessment and transport

3.10.1. In February to Board agreed to GM taking responsibility for commissioning NWAS services for the GM population and from 1 April, the management of the relevant contacts will pass across to our CCGs, with Bury acting as the lead commissioner. NWAS have already pioneered a number of innovative services to help reduce
numbers of unnecessary conveyances to A&E and we are confident in our ability to collaborate with them (and wider blue light services) to bring about further innovation, some of which is described in the section below.

3.10.2. With respect to assessment services we need to ensure to ensure a single consistent model across Greater Manchester designed to ensure that all patients are referred to the right care, if required. We will want to review the way that NHS111 works in Greater Manchester, including looking at other practice models such as North East England where they make more use of clinical assessment, seemingly with a positive impact in avoiding unnecessary trips to A&E. We will also want to ensure that we maximise the opportunity for direct booking of out-of-hospital services from patient assessment services such as 111.

3.10.3. With respect to the ambulance service, our immediate priorities will be to develop strategies to reduce turnaround times, further to reduce unnecessary conveyances to A&E, and to ensure more consistency in response times, particularly to the most urgent calls. We will want to look at best practice from other parts of the country, such as the CQC 'outstanding' rated West Midlands service which makes greater use of higher graded paramedics within its workforce. However, this is not a one way street. We also need to look at how we can support the ambulance service to do a better job. Areas we will be looking at are:

- improving pathway design for mental health patients and other people with broader needs (e.g. alcohol) that could be better treated elsewhere
- optimising opportunities for combining workforce responses (e.g. paramedics and ANPs)

3.11. Specific cohorts

3.11.1. Understandably, at this time, an urgency emergency care reform programme is going to focus on the greatest volumes, and that means the frail elderly. But that isn’t sufficient and we need incorporate sub-programmes with respect to the following groups as a minimum:

- mental health crisis care : which is built into our mental health strategy as an early priority, and we are making good progress on all age plans
- children : too many of our children and young people, in an emergency are having to be taken out of area. We need to ensure that we have adequate bed capacity in the right places with the right workforce. This will be addressed in part through our paediatrics workstream under theme 3 – standardisation and consolidation of acute care. However, we also need effective deflection plans for this cohort within each of our localities, including out-of-hours
• people with learning disabilities and complex behaviours: we are working hard to bring home people who have been stuck in Assessment and Treatment hospitals; a real danger for us is that these individual and others get readmitted in a crisis because there isn’t an effective crisis response; we need to address this risk more comprehensively in our wider learning disabilities strategy

• homeless – this group - rough sleepers, sofa surfers and those in temporary accommodation – are both more vulnerable in terms of requiring urgent case but also less likely to be registered with a GP and to access alternatives to A&E

• substance misusers: we need to review our acute provision for these cohorts, and ensure that the provision we do have, for example, the RADAR service, is being used appropriately and effectively

• frequent flyers: we have a group of other individuals who attend A&E heavily, often due to chaotic lifestyles; these individuals require a case management approach within the community, often in partnership with the voluntary sector

3.12. Consistent application of best practice

3.12.1. We are expecting the publication in April/May of a national delivery plan by NHS England/NHS Improvement, which will include a refreshed set of requirements with respect to urgent and emergency care. While under the terms of devolution we potentially have the ability to negotiate on new requirements, our previous experience under the national programme is that the requirements tend to be sensible and evidence-based. At the same time, we are in a position where our local urgent care systems have not fully implemented the requirements of the national standard under the first phase of the national programme. This is disappointing, particularly in areas such as ‘discharge to assess’.

3.12.2. We have to get better at consistently applying best practice across Greater Manchester. One of the key early tasks of the new system development team will be to define some clear minimum standards for local systems. We would then propose to condition the release of further resources, e.g. capital, winter monies, based on the adoption of these standards. They are likely to cover areas such as:

• demand management
• provision and use of data
• role of community pharmacy
• GP streaming at the front door of our hospitals
• full roll-out of SAFER model
• truly integrated discharge teams within hospitals
• comprehensive use of ‘discharge to assess’ model

• consistent use of protocols on patient choice on discharge

• working across GM on consistent winter messaging campaigns

3.12.3 We also have an opportunity under the devolution deal of looking at different ways to incentivise higher performance, using different pricing and payment models.

3.12.4 We will also need a clearer approach to quality assurance, particularly with respect to key measures such as the elimination of 12 hour waits, referral to treatment times, and stranded patients.

3.13. The offer to the GM population

3.13.1. The whole of this package needs to be translated into a ‘deal’ with the GM population. At the heart of this is the move to as quickly as possible to a consistent core offer that needs to include:

• minimum primary care offer, including access to a bookable GP appointment within their neighbourhood cluster and trustworthy access to emergency dentist and pharmacy services

• trusted 111 service which will get them to the right care within the right length of time

• trustworthy urgent care infrastructure in the community that the primary care community and NWAS know that they can access when they need it

• development of single website and app that will tell them what care is available in real time, and will allow them to book urgent appointments

• access to specific support and advice for carers

• confidence that care home residents will get the same level of out-of-hospital service as the rest of the population

3.13.2. In return, we will have reasonable expectations of the population itself:

• to make use of available alternatives to A&E

• if you call an ambulance and you don’t need to go to A&E, alternative provision will be made for you

• if you turn up at A&E but you don’t need A&E services, you will be diverted to alternative provision, probably a GP
• abuse of the system may have consequences, as you are denying care to people who really need it.

4.0 CONCLUSION AND NEXT STEPS

4.1. Urgent and emergency care is the spine of our health and care system and a litmus test of its overall functionality. We cannot say that we have integrated urgent and emergency care system in Greater Manchester until we have a properly integrated model of urgent and emergency care that public and professionals understand and rely on. Under devolution, we have inherited a model of care that is fragmented and over-stretched. We cannot solve this entirely ourselves, for example, deficits in resources and the inadequacies of the national workforce planning system. But what this report demonstrates is that there is much we could do to redesign an improved system that over time could lead to much better patient experience and outcomes.

4.2. If there is agreement to the approach described in this report then we would carry out rapid engagement across the system on the development of a detailed delivery plan, with a timetable for implementation from May onwards.

5.0 RECOMMENDATIONS

5.1. The Strategic Partnership Board are asked to note the content of this paper to deliver a more consistent and coherent operating model for urgent and emergency care across Greater Manchester and approve the:

• Establishment of a single GM UEC Delivery Board and supporting structures which would replace the existing Urgent and Emergency Care Task Force and UEC Network.

• The UEC focus on the areas of work outlined in the paper (3.3 – 3.13)

• Development of a detailed delivery plan by April 2017

6.0 APPENDICES

• 1) Data Picture for GM
  o a. Trend performance over last two years on attendances,
  o b. Performance against the 4 hour A&E Standard over last two years
  o c. Non-elective (emergency) admissions over last two years
  o d. Delayed discharges of care over last two years
  o e. Bed days per 1000 population – Q1 data 2016-17

• 2) Urgent and Emergency Care – Reformed Governance Structure
• 3) Urgent and Emergency Care Board – Terms of Reference and Proposed Membership

• 4) State of implementation against national guidance across local systems
  o A&E Improvement Plan

• 5) Letter from Simon Stevens and Jim Mackey
APPENDIX ONE: DATA PICTURE FOR GM

a. Trend performance over last two years on attendances

![GM A&E Attendances (All Types)](image)

b. Performance against the 4 hour A&E Standard over last two years

![GM A&E Performance (All Types) vs. Standard](image)
c. Non-elective (emergency) admissions over last two years,
d. Delayed discharges of care over last two years

% of Greater Manchester Acute Trust Beds Occupied by Delayed Patients from April 2015 to January 2017

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e. Bed days per 1000 population – Q1 data 2016-17

Bed days per 1000 population
APPENDIX TWO: URGENT AND EMERGENCY CARE – REFORMED GOVERNANCE STRUCTURE

- HSCP Perf & Delivery Board
- GM UEC Delivery Board
- UEC Hub 24/7/365
  - HubTeam (6-8)
- UEC Transformation
  - UEC Transformation Team (4-6)
- Locality UEC Delivery Boards
- Themed sub-groups: workforce / comms
APPENDIX THREE: URGENT AND EMERGENCY CARE BOARD – TERMS OF REFERENCE AND PROPOSED MEMBERSHIP

GREATER MANCHESTER URGENT & EMERGENCY CARE (UEC) DELIVERY BOARD

TERMS OF REFERENCE

1. Purpose

The GM UEC Programme Board is led and supported by the GM Health & Social Care Partnership, NHS England and NHS Improvement. Its key purpose is to provide joint oversight of the GM Urgent and Emergency Care and Accident & Emergency Improvement programmes, ensuring an aligned approach and maintaining required progress against national requirements and agreed metrics that span both programmes.

The Board will act as a focal point for inter-agency collaboration around urgent and emergency care and A&E improvement, ensuring effective coordination and communication through aligned programme management arrangements and Greater Manchester wide structures. It will feed into and draw upon the place based planning of the emerging Local Care Organisations ensuring that GM maintains a direction of travel that builds a resilient and effective health & social care offer to all residents.

The work of the Board will be undertaken through the GM UEC governance structure set out in Appendix Two. This includes establishing sub-groups as necessary, e.g. UEC workforce, UEC Communications and UEC Hub, each with its own terms of reference.

To secure the timely delivery of required improvements at scale, the Board will develop a strategic view of programme requirements and priorities and ensure that available resources are utilised in an effective manner.

The Board will also assess strategic opportunities to support LCOs in developing transformational plans encompassing A&E and urgent and emergency care.

2. Membership

The Board is made up as follows:

- GM HSCP Chief Officer (Chair)
- Local Government Director Adult Social Care
- Local Government CEO (Vice-chair)
- GM Provider CEO (Vice-chair)
- GM Provider Director Operations
- GM Provider / NWAS Medical Director (vice-chair)
- NWAS CEO
- Mental Health Provider CEO
- Chairs of Local UEC Delivery Boards
- GM LMC Chair
- GM LPC Chair
- ECIP GM Lead
• GM Voluntary Sector Representative
• Care Provider Forum Chair
• NHS Improvement Delivery and Improvement Director Greater Manchester and Lancashire
• NHS Improvement/NHS England Regional Representative

Additional officers and representatives from health & social care organisations within GM may be co-opted to join the group as appropriate.

The group will be serviced and supported by GM HSCP Urgent & Emergency Care team

Members of the Board are expected to attend meetings wherever possible.

However, a member of the Board may nominate a suitably senior member of their team to deputise on their behalf where necessary.

3. Chair

The Board will be chaired by the GM HSCP Chief Officer.

4. Frequency of meetings

The Board will meet on a monthly basis with meeting dates to be agreed in advance in accordance with business requirements.

5. Quorum

The quorum necessary for the transaction of business shall be ten members, including a nominated Chair and representatives from GM providers and local A&E Delivery Boards.

A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in, or exercisable, by the Board.

6. Notice of Meetings

Meetings of the Board, other than those regularly scheduled as above, shall be summoned by the secretariat of the Committee at the request of the Chief Officer of GM HSCP.

Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda of items to be discussed and any supporting papers, shall be circulated to each member of the Committee and any other person required to attend, no later than 5 working days before the date of the meeting.

7. Notes of Meetings

The secretariat will record a note the proceedings and decisions of all meetings of the Board, including recording the names of those present and in attendance. Notes of meetings, including agreed actions, will be circulated promptly to all members of the Board.

8. Key responsibilities

The Board will:
• Coordinate and support the successful delivery of both the GM UEC and A&E Improvement programmes;
• Enable joint oversight of planning and progress across different organisations and sectors and ensure that this takes account of differing perspectives. This includes oversight of Local A&E Delivery Boards;
• Ensure strategic and operational alignment between the programmes in the context of STPs, ensuring overall coherence, clarity of purpose and appropriate pace;
• Enlist expertise as required from across services, organisations and sectors to support ongoing work where this is required including STPs;
• Review and provide oversight of emerging risks to delivery of required improvements at a GM level;
• Ensure that available resources are utilised effectively and efficiently across both programmes including avoiding duplication and recognising opportunities for collaboration across the programmes.
### APPENDIX FOUR: STATE OF IMPLEMENTATION OF THE A&E IMPROVEMENT PLAN ACROSS LOCAL SYSTEMS

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Statement of good practice</th>
<th>Red</th>
<th>Amber</th>
<th>Green</th>
<th>Blue</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. ED Streaming</strong></td>
<td>All major specialties have a consultant immediately available on the telephone to provide advice &amp; streaming for ED &amp; primary care</td>
<td>0</td>
<td>5</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>There is a primary care stream available (if activity levels justify it) with the capacity to meet the true patient demand</td>
<td>1</td>
<td>4</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Patients presenting with mental health illness are assessed, managed, discharged or admitted within the ED standard</td>
<td>0</td>
<td>8</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>There is an ambulatory emergency care service available for 12 hours per day, 7 days per week which manages at least 25% of the emergency take</td>
<td>0</td>
<td>6</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>There is an acute frailty service available 12 hours per day, 7 days per week which treats all eligible patients</td>
<td>1</td>
<td>6</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Community and intermediate care services respond to requests for patient support within 2 hours</td>
<td>0</td>
<td>3</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>SAFER patient flow bundle implemented on assessment and medical wards as a bare minimum, to improve patient flow</td>
<td>0</td>
<td>2</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td><strong>4. Improved flow</strong></td>
<td>What percentage of the base wards on each acute site has SAFER in place?</td>
<td>(2) 0-10%</td>
<td>(2) 40-50</td>
<td>(2) 60-70</td>
<td>(5) 90-100</td>
</tr>
<tr>
<td></td>
<td>The use of the red and green day approach has been considered</td>
<td>0</td>
<td>1</td>
<td>8</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>A baseline assessment of the effective use of EDDs and Clinical Criteria for Discharge has been carried out</td>
<td>0</td>
<td>4</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Ward round checklists are in use in all wards in the acute hospital/s</td>
<td>0</td>
<td>3</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td><strong>5. Improved discharge processes</strong></td>
<td>Systems are in place to review the reasons for any inpatient stay that exceeds six days</td>
<td>0</td>
<td>4</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>A ‘home first: discharge to assess’ pathway is in operation across all appropriate hospital wards</td>
<td>0</td>
<td>5</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Trusted assessor arrangements are in place with social care and independent care sector providers</td>
<td>0</td>
<td>6</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>At least 90% of continuing healthcare screenings and assessments are conducted outside of acute settings</td>
<td>0</td>
<td>7</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>A standard operating procedure for supporting patients’ choice at discharge is in use, which reflects the new national guidance</td>
<td>1</td>
<td>4</td>
<td>3</td>
<td>3</td>
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<td></td>
<td>There is a responsible director in the trust who will monitor the DToC situation daily and report regularly to the board on this specific issue</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>9</td>
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<tr>
<td></td>
<td>Related to the above, there is a named senior individual in every CCG and SSD who will be the single point of contact for the nominated trust exec.</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>8</td>
</tr>
</tbody>
</table>

**11 acute trust sites in GM**

- **Blue** = Scheme already in place/alternative in place
- **Green** = actions in place and on track for initiative to be implemented within rapid implementation guidance timeframes
- **Amber** = in plans, but risks associated with delivery
- **Red** = no evidence of existing implementation or in system plans.