GMCA GREATER MANCHESTER COMBINED AUTHORITY

Greater Manchester Integrated Care Partnership

NHS Greater Manchester
Integrated Care Partnership Board

Date: 29th November 2024

Subject: GM Urgent & Emergency Care (UEC) 4hr Standard of Care Performance

Report of: Colin Scales- NHS Greater Manchester Deputy Chief Executive

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PURPOSE OF REPORT:

Greater Manchester is one of the largest Integrated Care Systems (ICS) in England, serving a population of over 2.8million people, this positions GM as one of the most significant ICSs in terms of both population size and scope. GM is one of lowest performing ICSs in England for A&E wait times. This paper provides a comprehensive update to NHS GM Integrated Care Partnership Board on the circumstances surrounding this situation in Urgent Care including:

- Outlining the current performance against the two key performance recovery indicators in the 2-year UEC Recovery Plan
- Examining the key factors affecting UEC performance in Greater Manchester
- Highlighting the improvement work underway to address the under-performance against the recovery indicators.
- Advising on the next steps for UEC improvement within the context of wider public service reform.

RECOMMENDATIONS:

The NHS GM Integrated Care Partnership Board are requested to:

Note the performance of Greater Manchester against the UEC 4-hour standard of care, which is currently not being achieved.

Discuss the factors affecting GM's performance with reference to the improvement work which is already underway and the opportunities to leverage Live Well and collaboration between the Greater Manchester Integrated Care Board (GM ICB) and the Greater Manchester Combined Authority (GMCA).

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Executive Summary

Purpose of Report: This report provides a comprehensive update on the Urgent & Emergency Care (UEC) 4-hour Standard of Care Performance for NHS Greater Manchester (GM). It outlines the current performance, factors affecting UEC performance, improvement work underway, and the next steps for UEC improvement within the context of wider public service reform.

Key Points:

Performance Overview:

GM is one of the lowest-performing Integrated Care Systems (ICS) in England for A&E wait times.
The report sets out the current performance against the two key performance recovery indicators in the 2-year UEC Recovery Plan.

Factors Affecting Performance:

Demand and Complexity: GM has seen a significant increase in A&E attendances, particularly Type 1 cases, which require more comprehensive and immediate interventions.
Patient Flow: Challenges in patient flow, high bed occupancy, and delays in discharge contribute to the GM's current performance.
Workforce: Recruitment and retention challenges, along with high vacancy and turnover rates, impact the delivery of UEC services.
Population Health: GM has a higher proportion of residents with long-term conditions and mental health issues, leading to increased demand for urgent care.

Improvement Work:

Implementation of the 10 High Impact Initiatives (HII) from the UEC Recovery Plan, which include Same Day Emergency Care (SDEC), Frailty services, and Urgent Community Response (UCR).
Investment in UEC services, including additional hospital beds and ambulances, and the development of GM's major trauma centre.

Next Steps:

Strengthening the delivery of responsive services that meet physical health, mental health, and social care needs in neighbourhoods.

Focusing on prevention and early intervention to reduce the need for more intensive health and social care services later.

Recommendations: The NHS GM Integrated Care Partnership Board is requested to note the current performance, and the improvement work underway and consider the next steps for UEC improvement within the context of wider public service reform.

1. Introduction

Systems across the whole of the United Kingdom have seen challenges recovering Urgent and Emergency Care (UEC) performance since the COVID-19 pandemic. NHS England (NHSE) set out a 2-year UEC Recovery Plan spanning 2023/24 and 2024/25 with the aims of improving Accident and Emergency (A&E) performance with 78% of patients being admitted, transferred, or discharged within 4 hours by March 2025, and improving Category 2 ambulance response times relative to an average of 30 minutes across 2024/25.

GM is one of the lowest-performing Integrated Care Systems (ICS) in England for the Accident &Emergency (A&E) 4-hour standard of care. It is also one of the largest ICSs in England. It serves a population of over 2.8 million people, which is larger than the populations of Wales or Northern Ireland. This makes it one of the most significant ICSs in terms of population size and scope.

According to NHS Digital's A&E Activity Statistics (NHS Digital, 2023), ICS regions in urban and metropolitan areas report lower A&E performance due to higher patient inflow, greater density, and more complex cases. However, GM's performance remains below that of similar urban ICSs such as West Yorkshire Health and Care Partnership who in terms of serving a large & diverse population is similar to Greater Manchester, with comparable challenges in terms of healthcare demand and service integration.

This report sets out:

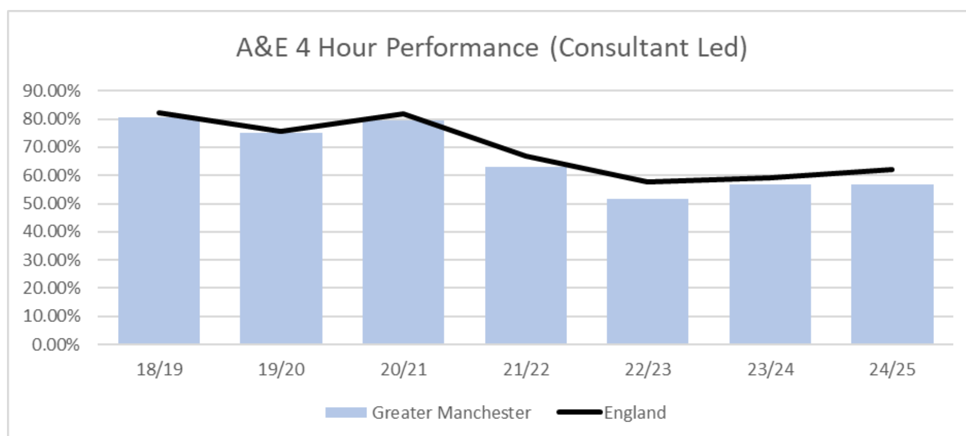
1. The current performance against the two key performance recovery indicators in the 2-year UEC Recovery Plan
2. The factors affecting UEC performance in GM.
3. Improvement work underway in GM to address the current non achievement of the UEC 4hr standard of care.
4. Next steps for UEC improvement in the context of wider public service reform

2. GM UEC Performance

A&E performance in England has consistently struggled to meet the national target of seeing, treating, discharging, or admitting 95% of patients within four hours (NHS England, 2023). This standard, introduced in 2004, remains a benchmark for the quality and efficiency of urgent care services across the country. Over the last decade, national performance has declined markedly, with most parts of the country, including GM, falling short of this standard.

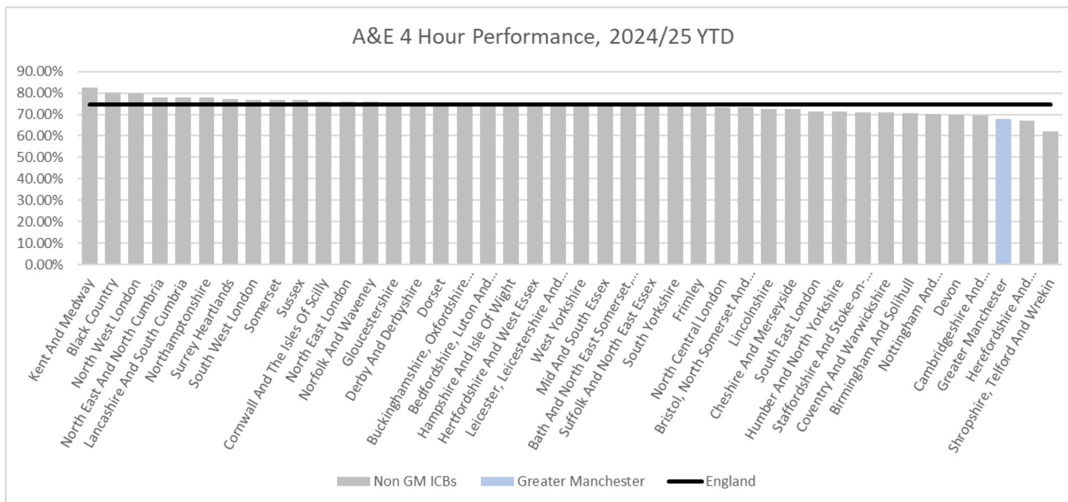
In GM, the A&E 4-hour standard of care has worsened significantly over the past decade. Analysis from NHS England shows that GM's compliance with the 4hr standard of care has decreased more sharply than in many other areas, particularly since the COVID-19 pandemic (NHS England, 2023). Between 2015 and 2023, GM's compliance fell by nearly 20 percentage points, compared to a national average decline of 15 percentage points. However, it should be noted that although this is across the GM area, there is variation between providers/sites. The consistent low performance suggests that local issues, beyond broader national trends, may be driving the low performance in GM.

The graph below illustrates GM's performance against the 4hr standard of care (all types) since 2017/18. As of 2024/25 year to date, NHS GM is 7.5% behind the rest of England, however this gap was as high as 10% in 2022/23, demonstrating improvement in the last 2 years to narrow this gap.



Graph 1 - GM's performance against the 4hr standard of care (all types

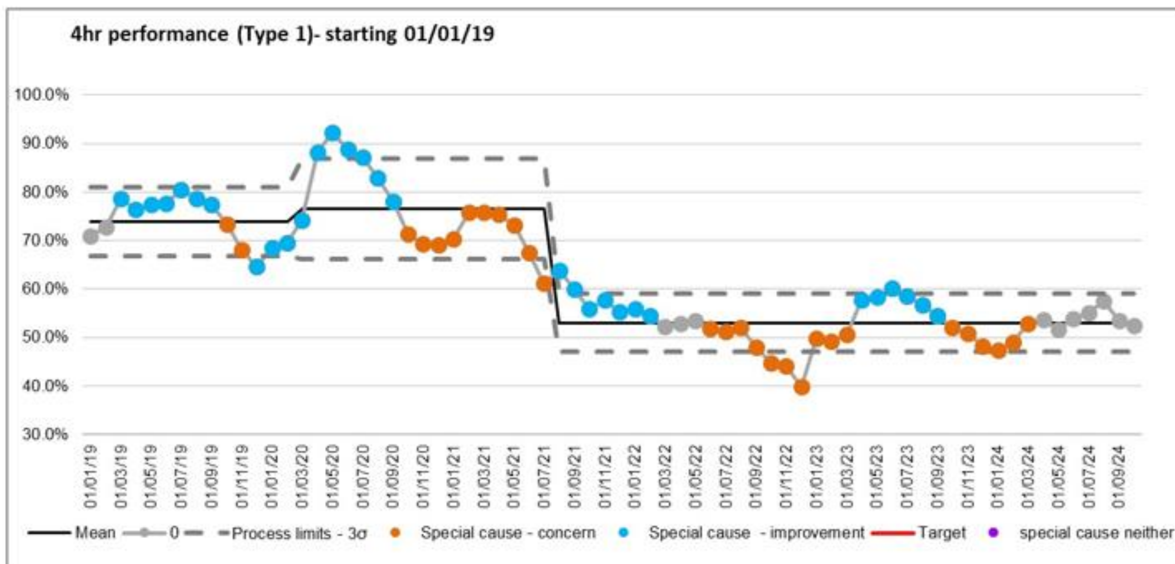
When benchmarked against other Integrated Care Boards (ICBs), NHS GM is ranked 40th out of 42 for the current year to date. This is shown in the graph below.



Graph 2 - GM 4hr Standard of Care Performance 2019-2024 (Type 1) comparison with ICBs

A&E activity types refer to the various categories of emergency care services provided in hospitals. These are classified into four main types: Type 1-4. Type 1 attendances refer to cases that require more comprehensive and immediate interventions, often placing a considerable demand on resources and personnel.

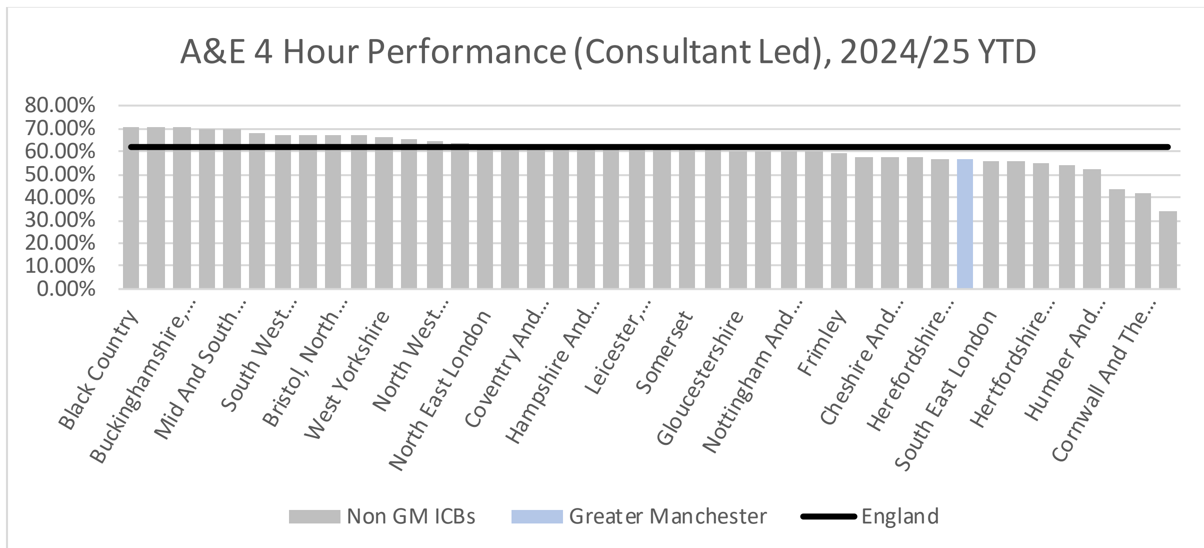
The table graph shows NHS GM Type 1 performance from 2019 to 2024. It shows the deterioration of performance since the Covid pandemic with the lowest performance coming in January 2022, approximately 40%, however since then you can see that performance has improved and NHS GM was at 60% in the summer of 2023 but dips again during the winter months.



Graph 3 – GM 4hr Standard of Care Performance 2019-2024 (Type 1)

When focusing on our Type 1 patients, who are the most acutely unwell, despite not achieving the 4hr standard of care, the situation for GM is better when compared to the ICBs than overall performance (all types).

The graph below shows that GM is 5% behind the rest of England. In terms of ranking among other ICBs, GM is currently 34th out of 42 for Type 1 activity.

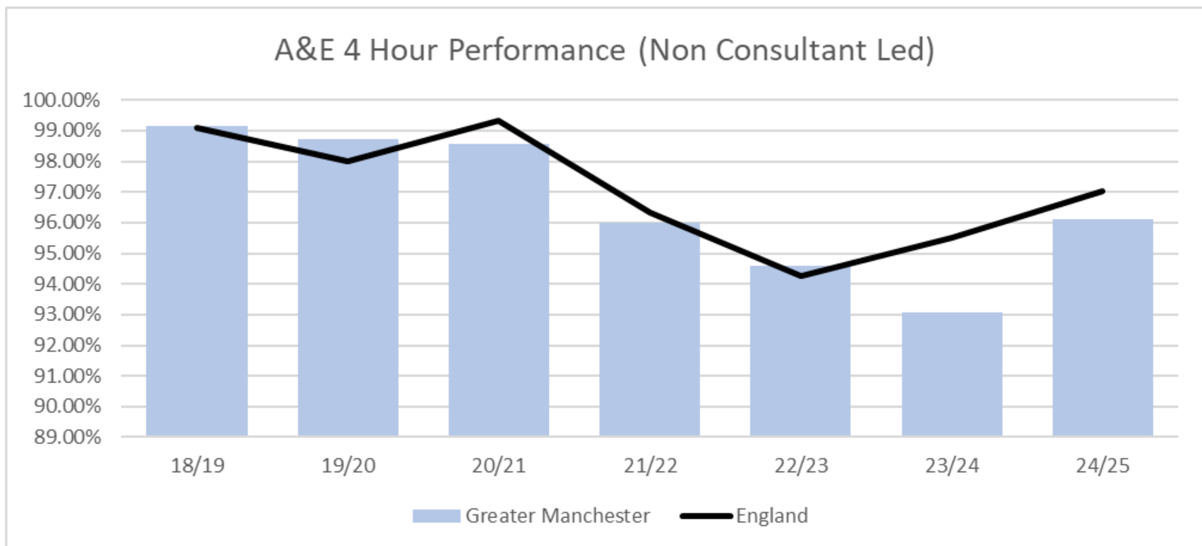


Graph 4 – GM 4hr Standard of Care Performance Year to Date 24/25 (Type 1)

A&E 4hr Performance Type 3 all ICBs

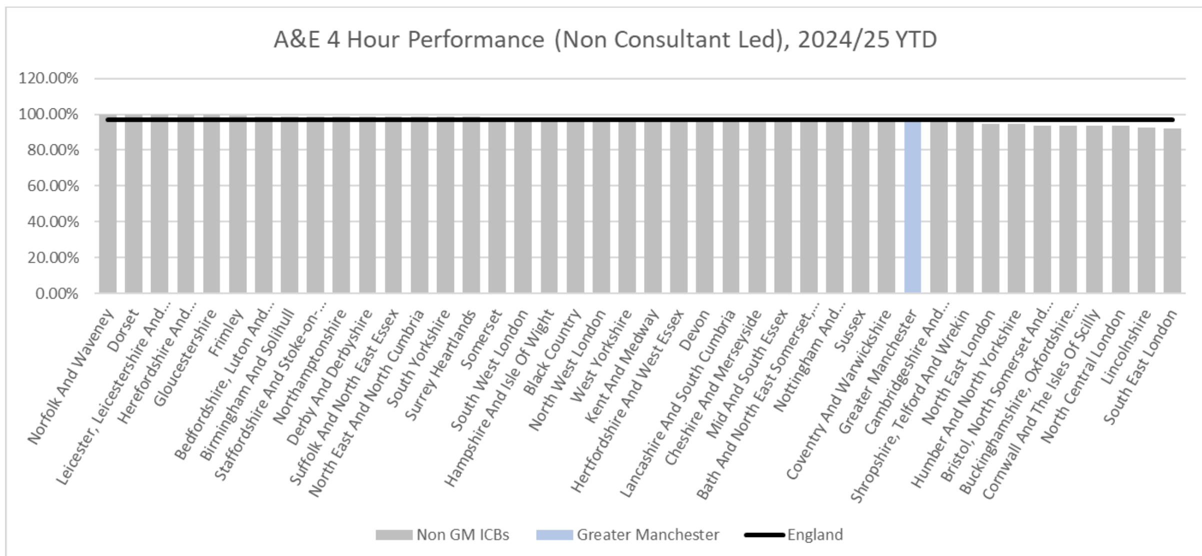
With regards to Type 3 services, they treat patients with conditions such as stomach aches, cuts and bruises, some fractures and lacerations, and infections or rashes. Type 3 services are usually GP-led and open at least 12 hours a day, every day. They can be located in the community or co-located with a major A&E department.

The graph below shows NHS GM Type 3 performance between 2019 and 2024 against the national England average. As you can see, we are below the average but have shown a good improvement in 24/25 when compared to 23/24.



Graph 5 – GM 4hr Standard of Care Performance 18/19-24/25 (Type 1)

If we compare ourselves to the other ICBs from type 3 performance only, you can see from the graph below NHS GM rank 32nd out of 42 performance and are at the national England average of 97%.



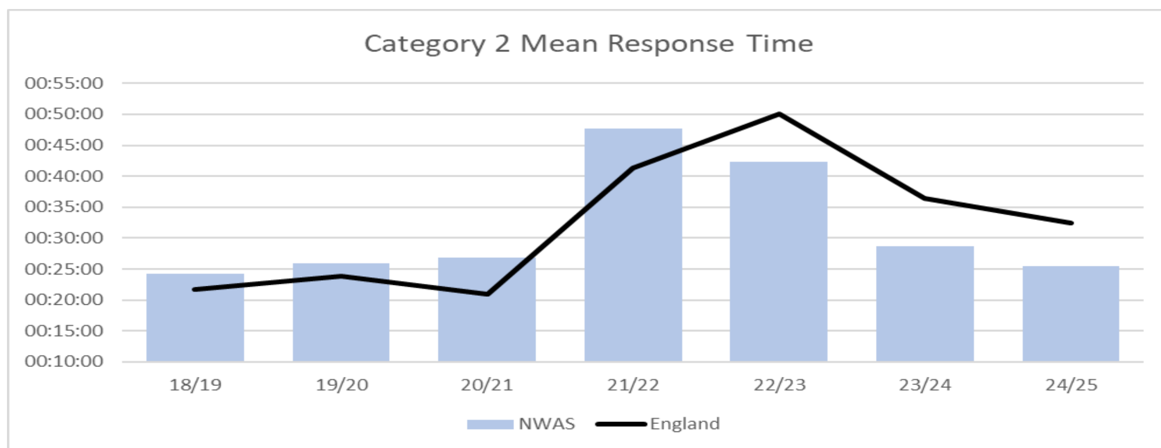
Graph 6 – GM 4hr Standard of Care Performance Year to Date 24/25 (Type 3)

Whilst GM's performance against the 4hr standard is challenged, as an ICS we are performing well against some other key metrics. Performing well in metrics beyond the 4hr standard of care is crucial for a comprehensive approach to patient care and overall healthcare quality. Additionally, focusing on a broader range of metrics encourages continuous improvement across all aspects of healthcare delivery. This balanced approach

ensures that healthcare systems are resilient, sustainable, and capable of meeting diverse patient needs.

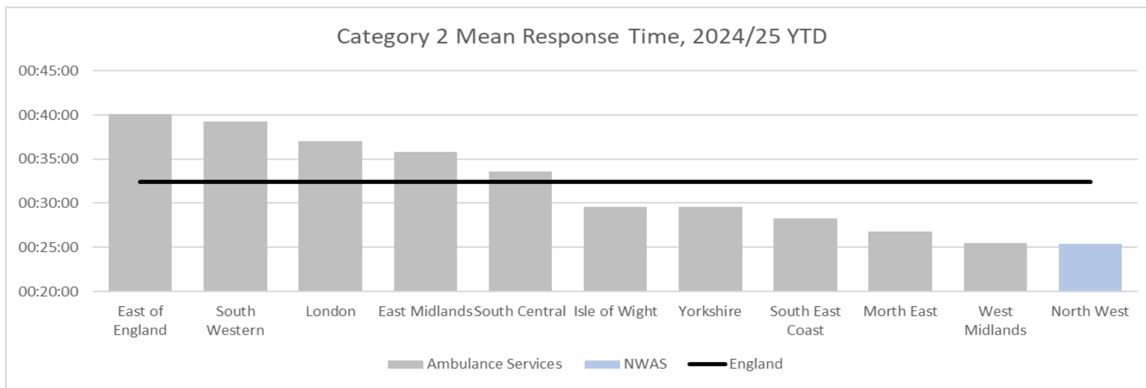
As part of the UEC recovery plan a key metric was to improve category 2 ambulance response times. A category 2 ambulance is for serious but non-life-threatening emergencies that require rapid assessment, urgent intervention, or immediate transport. Examples of conditions that may require a category 2 response include: heart attack, stroke, sepsis, and major burns.

The table below shows the mean response times for category tow ambulances for Northwest Ambulance Service (NWAS) since 18/19. You can see from the graph that since 22/23 NHS GM is performing well and average is s approximately 25 minutes, which is slightly better than the average for England, which stands at 32 minutes.



Graph 7 – GM Average Category 2 Ambulance Response Times 18/19-24/25

With regards to NHS GM 24/25 year to date performance the graph below shows that NWAS is the highest performing ambulance service in England when it comes to category two response times.



Graph 8 – GM Average Category 2 Ambulance Response Times Year to Date 24/25

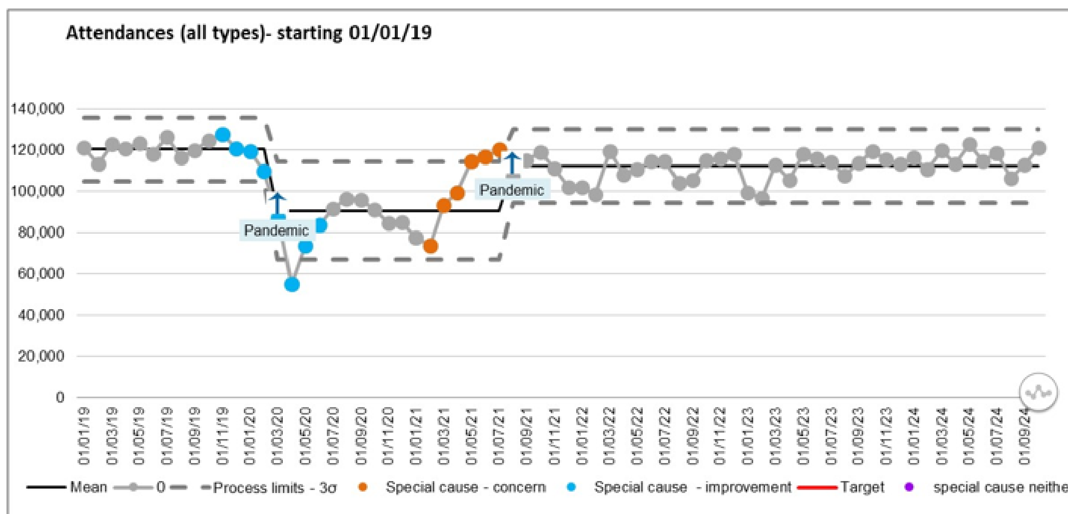
3. Unveiling the Causes: Key Factors Behind UEC Performance Challenges

The following section sets out key evidence and analysis into the factors which are impacting on GM's ability to meet the 4-hour standard of care.

3.1. The Changing Landscape of UEC Demand

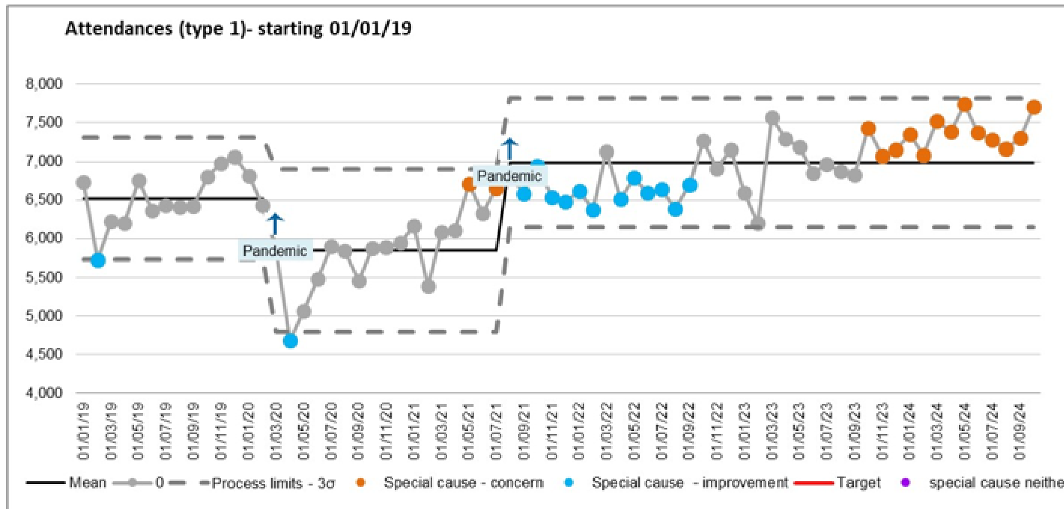
A&E departments nationally have been experiencing a rise in demand. GM saw a 15% increase in A&E attendance over the last decade, compared to a national average of around 10% (Public Health England, 2022). This increase is attributed to factors such as population growth, a rise in chronic illness rates, and challenges in access to healthcare.
In Greater Manchester total A&E attendances have remained relatively stable over the past 3 years. However, Type 1 demand has significantly increased, which shows a shift in where and how people seek health care.

The graph below shows NHS GM attendances (all types since 2019). This shows a stable position since the Covid 19 Pandemic



Graph 9 – GM A&E Attendances (all) 2019-2024

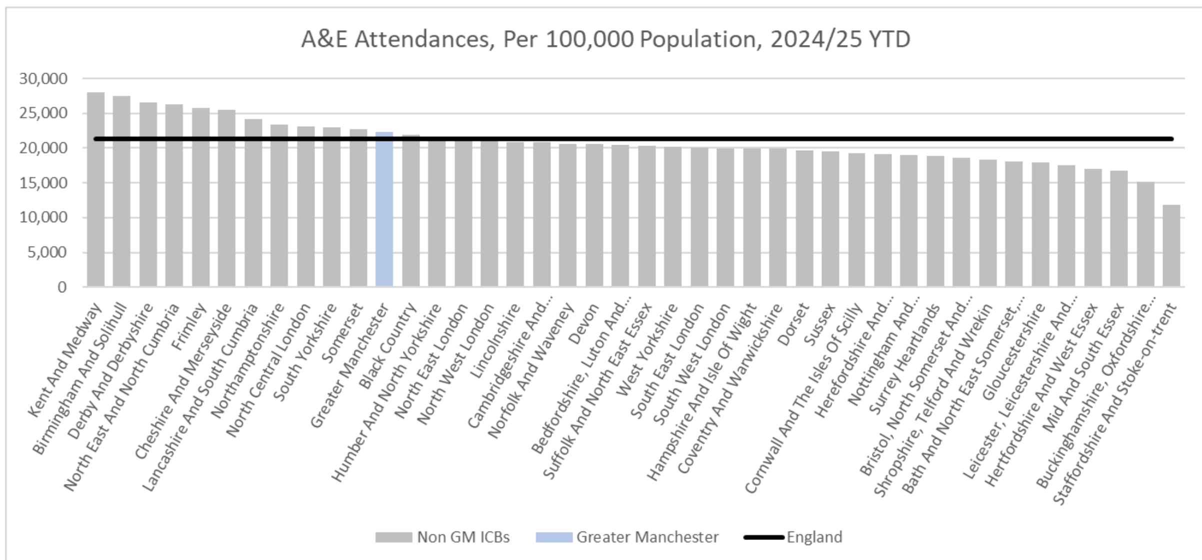
However, when we look at Type 1 attendances since 2019, the graph below shows a sustained increase which could be a contributing factor to NHS GM not currently achieving the 4hr standard of care target.



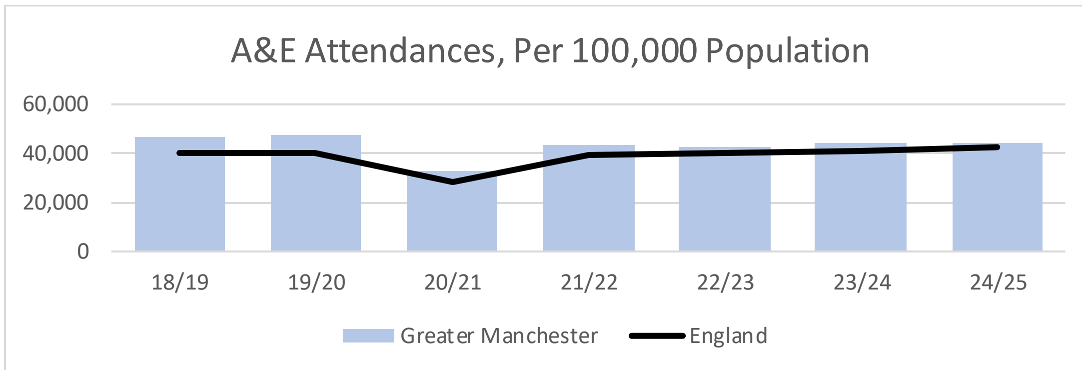
Graph 10 – GM A&E Attendances (type 1) 2019-2024

GM's performance as the second lowest in England highlights specific challenges that distinguish it from other ICS regions. For example, data from the Health Foundation shows that GM has a higher proportion of Type 1 A&E attendances than West Yorkshire, a similar sized and urban ICS, contributing to increased pressure on emergency departments (Health Foundation, 2023). In Q4 of 2022, approximately 80% of GM's A&E visits were Type 1, compared to 65% in West Yorkshire. This comparative discrepancy highlights the need for additional resources and specialised staff in GM's A&E facilities to meet the unique demands of its patient demographic.

To understand whether the growth in A&E attendances in GM is a factor in the UEC low performance relative to other ICSs, we have analysed the data per 100,000 population. GM is in the top quartile for A&E attendances per 100,000 population in 2024/25 year to date (graph 11) and has been above the national average for attendances per 100,000 population since pre-pandemic (graph 12).



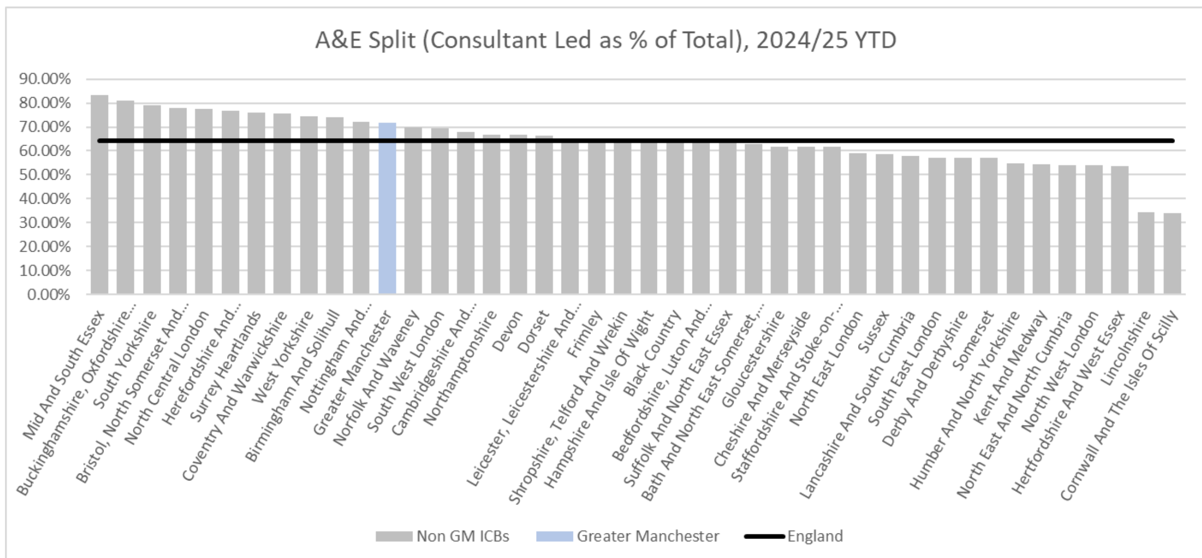
Graph 11 – GM A&E Attendances (all) per 100k population Year to Date 24/25



Graph 12 – GM A&E Attendances (all) per 100k population 2018/19-24/25

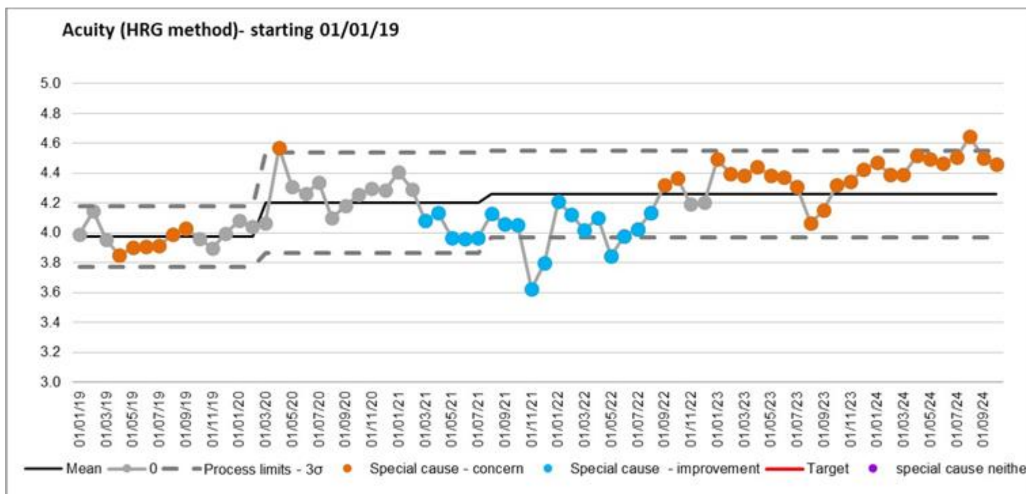
3.2 A Changing Picture in Acuity & Complexity

In GM we proportionally have more of A&E activity in type 1 emergency departments than the rest of England. 71.89% of A&E attendees so far in the 2024/25 year have presented at our emergency departments with Type 1 acuity. This positions us 12th out of 42 Integrated Care Boards (ICBs) in terms of this demand in our A&Es and this is shown in the graph below.



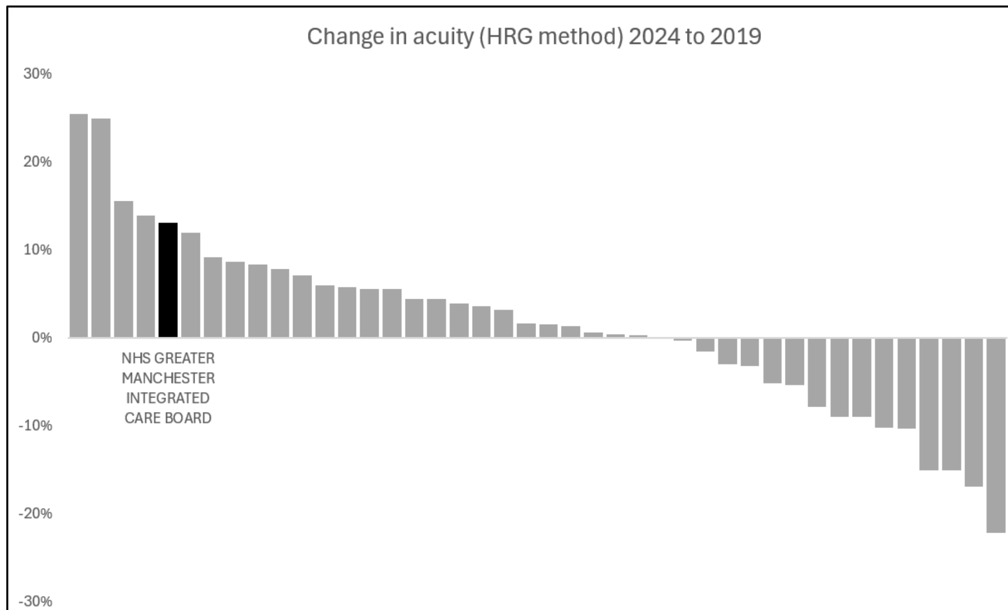
Graph 13 – A&E Type 1 as a percentage of total attendances for all ICBs 24/25 Year to Date

In GM this higher rate of attendance in type 1 A&Es is appropriate as there has seen a notable increase in patient acuity and complexity. When we use HRG (Healthcare Resource Group) codes we see that acuity has significantly increased, particularly over the past 12 months. This is evidenced in the graph below.



Graph 14 – GM Levels Acuity

Data also shows that the increase in GM has been much higher than the majority of England. The graph below shows that the acuity for GM has increased approximately 15% since 2019 and this is at 5th highest rate of the 42 ICBs.



Graph 15 – Historical Acuity ICBs

The poor health of the GM population is a linked factor in this picture of increasing acuity and complexity. More than half of the GM population live with one or more long term condition. Whilst 43.2% of GM's residents described their health as 'very good' in 2021, which was an improvement from 10 years previously, this is still below the national average (ONS, 2023). GM has a growing elderly population, with 623,982 people over the age of 60 years, which naturally leads to higher levels of co-morbidities and chronic conditions. Rates of chronic conditions such as cardiovascular disease and respiratory illnesses are higher in GM compared to other parts of England. This is partly due to higher levels of smoking and other lifestyle factors (Kings Fund 2024).

The pandemic has exacerbated existing health issues and introduced new challenges. The impact of COVID has been deeper and lasted longer on this already very vulnerable population, as well as the workforce, resulting in more individual complexities and an increase of previous unmet demand, many patients now present with more severe conditions due to delayed care during the pandemic. This together with a rise in acute activity across various services, including outpatient, elective, non-elective care, and A&E, has not only increased demand but also reflects the higher acuity and complexity of patients presenting in our UEC services, patients who require more lengthy assessments and diagnostics and potential admission leads to a higher number of breaches against the 4hr standard of care.

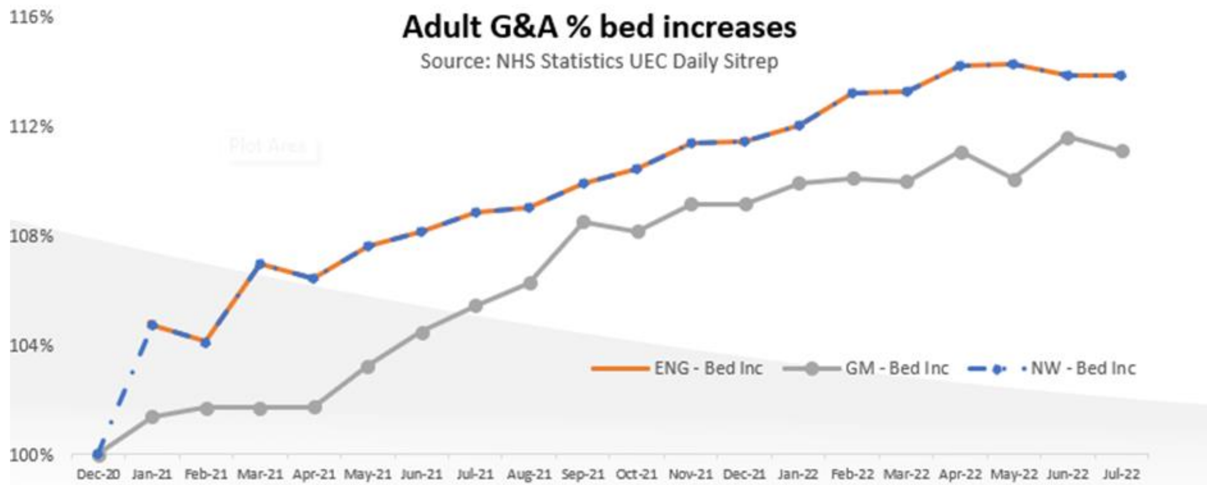
Mental health (MH) issues are also prevalent, with higher rates of depression and anxiety reported in GM compared to the national average. There is a growing recognition of the complexity of mental health needs in GM, with more patients requiring integrated care that addresses both physical and mental health. Patients attending A&E for self-harm should receive a comprehensive biopsychosocial assessment and appropriate care planning. However, assessments may be delayed if the patient is not fit for evaluation (e.g., intoxicated or not medically optimized), impacting the ability to meet the 4-hour target for treatment, discharge, or admission, with 59% of patients who attend A&E with a MH issue waiting over 4hrs.

Delays often occur when mental health (MH) patients require a Mental Health Act (MHA) assessment following the initial liaison assessment. Coordinating and completing this process can take several hours, frequently resulting in breaches of the 4-hour standard of care. Additionally, national pressures on MH beds lead to longer waits for a bed in A&E, which impacts both space and staff availability for further assessments.

3.3 Problems with Patient Flow

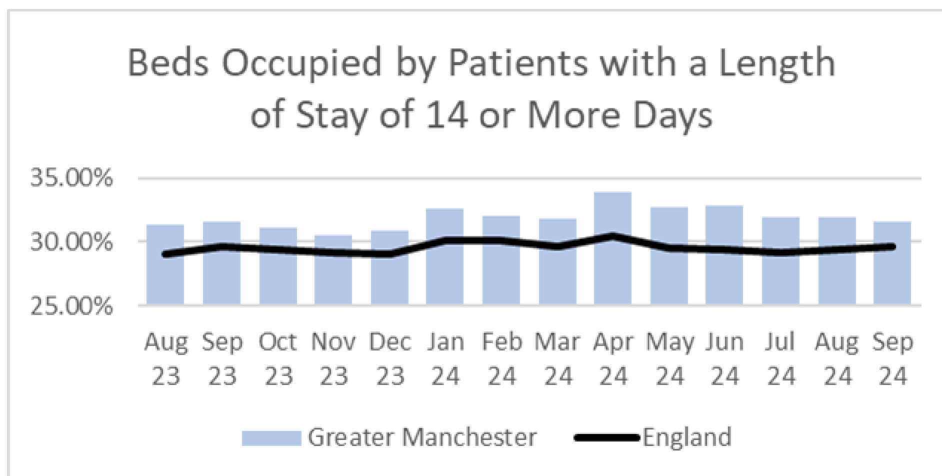
Achieving good patient flow is essential for delivering safe and timely care and meeting the 4-hour standard. Efficient patient flow ensures patients are seen, treated, and either admitted or discharged promptly, reducing A&E congestion, and improving hospital handover and 4-hour performance.

While there have been significant improvements in the urgent and emergency care (UEC) services for Greater Manchester residents, changes in the acute care offer have also occurred. To maintain patient flow, the system requires a sufficient number of acute beds. However, as shown in the graph below, since 2020, GM has increased its bed base at a slower rate than the England average, despite similar growth in bed occupancy and rising demand throughout the system.

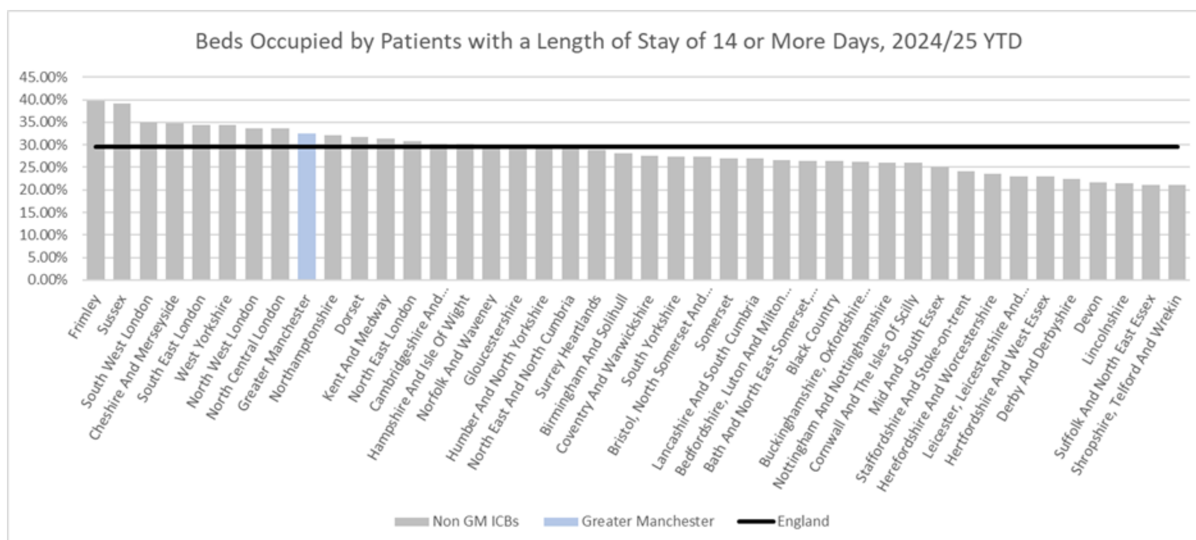


Graph 16 - GM Adult G&A Percentage bed increases

Patient flow is also reliant on timely discharge. Delays in patient discharge are partly due to increased complexity and co-morbidity, requiring longer stays in hospital before discharge can occur. The graph below (graph 17) shows that GM is significantly above the national average in terms of Length of Stay (LoS) of 14days or more and is 9th out of 42 ICBs (Graph 18) for the same metric, illustrating the increased complexity or patients which impact on the flow through the acute system.



Graph 17 - GM Beds Occupied by patients with a LoS >14days.



Graph 18 – GM Beds Occupied by patients with a LoS >14days compared to other ICBs.

Patient flow is significantly impacted by the number of patients with No Criteria to Reside (NCTR). Since January 2022, Greater Manchester has seen a sharp increase in NCTR, driven by recording mechanisms and reduced flexibility in discharging patients post-pandemic. This challenge has persisted, with the region currently 6.9% behind its target as of November 2024. High NCTR numbers contribute to high bed occupancy, disrupting patient flow and adding pressure on A&E departments.

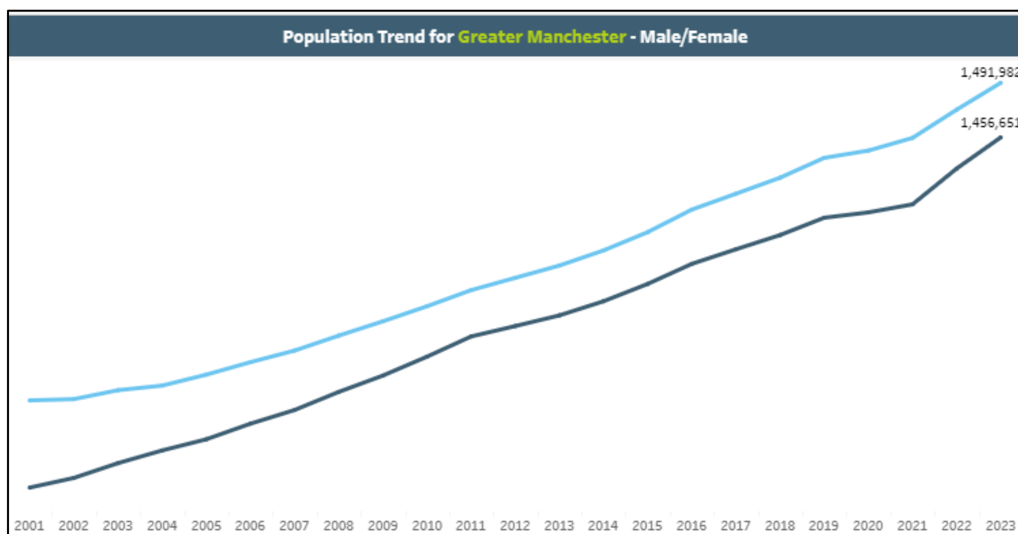
Adult Social Care (ASC) in GM accounts for over a third of local authority spending and supports around 50,000 individuals, including those with disabilities, illnesses, and unwaged carers. Each week, ASC facilitates the discharge of 500 people, primarily through home-based rehabilitation (pathway 1) and short-term beds (pathway 2). The 'home first' approach helps 80% of emergency hospital admissions return to their original homes, promoting independent living. However, the ASC provider market is fragile, with many providers exiting due to financial pressures, including recent wage and insurance cost increases. This fragility impacts patient flow, as available ASC beds may not always be suitable for discharge needs, leading to delays and higher bed occupancy in hospitals.

In GM focussed pieces of work are being undertaken to reduce the numbers of patients in hospital beds that are medically fit for discharge but remain on the NCTR (No Criteria to Reside) list. This included NCTR Sprint, GM Super Multi-agency Discharge Events (MaDE), Weekly Discharge and Flow meetings for mutual aid support.

3.4 Population Density and Growth in Greater Manchester

GM is one of the most densely populated metropolitan areas in the United Kingdom, with approximately 2.8 million residents (ONS, 2023) and around 3.3 million registered with a GP in GM. Over the past ten years, the population in GM has increased by 7%, due to urbanisation, internal migration, and international immigration (ONS, 2023). This is a 6.3% higher growth rate than across England and Wales over the same period (GMICP 2023). This rate of growth and the high density and urbanised nature of GM contribute to a heightened demand for healthcare services, particularly in emergency care, where a denser population correlates with higher A&E utilisation rates.

The graph below shows the population trend for Greater Manchester as you can see from 2020 there has been a steeper increase.



Graph 19 - Population trend for Greater Manchester

3.5 Greater Manchester's Demographics and Health Inequalities

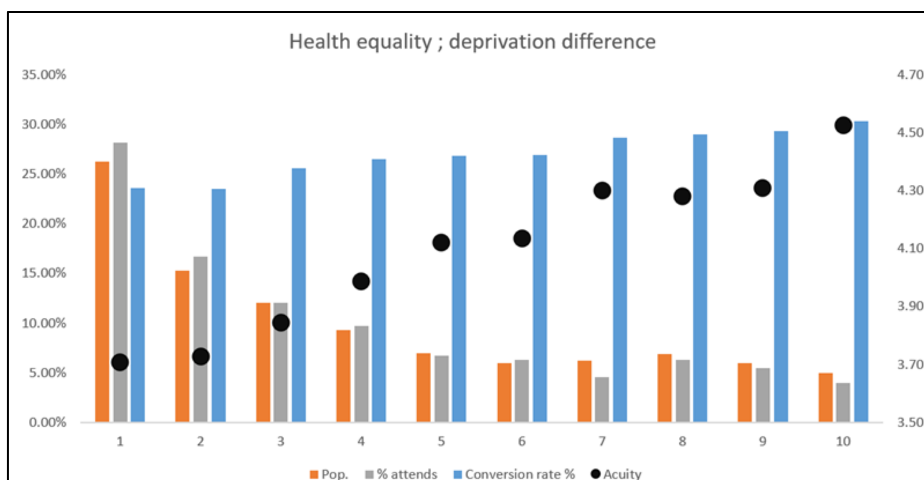
The demographics of GM reveal disparities that impact A&E attendance and strain emergency services.

Poverty is the single biggest driver of ill health, and the relationship is bi-directional: Poverty causes il health, and ill health causes poverty. GM is a disproportionately deprived area within England compared to the other ICSs, having the third highest percentage of the most deprived areas in England. 1.1 million of GM residents live in the most deprived 10% of areas in the UK.

Deprivation and associated poor health outcomes lead to increased demand for urgent care, as individuals in lower-income areas are more likely to suffer from chronic conditions, mental health issues, and acute illnesses.

A study by the Health Foundation found that deprived areas, like GM, report A&E attendance rates up to 30% higher than affluent areas, directly impacting GM's A&E capacity (Health Foundation, 2021).

The effects of deprivation on A&E attendances in GM can be seen in the data below (graph 19). The graph shows that for patients attending any of the type 1 A&Es across GM we can see that patients from a more deprived area attend more frequently but for, potentially, conditions which have could have been seen in an alternative setting. As an example, the proportion of the population that are in the most deprived decile is 26.1% but they represent 28.5% of all type 1 attendances. However, their conversion rate to admission is the lowest (23.2%) and their acuity is also the lowest at 3.71.



Graph 20 - GM Population, A&E attendances, admissions, and acuity by deprivation decile

3.6 Impact of Health Service Availability and Access in Greater Manchester

The 4-hour standard of care performance in GM is impacted by current challenges in access to other services.

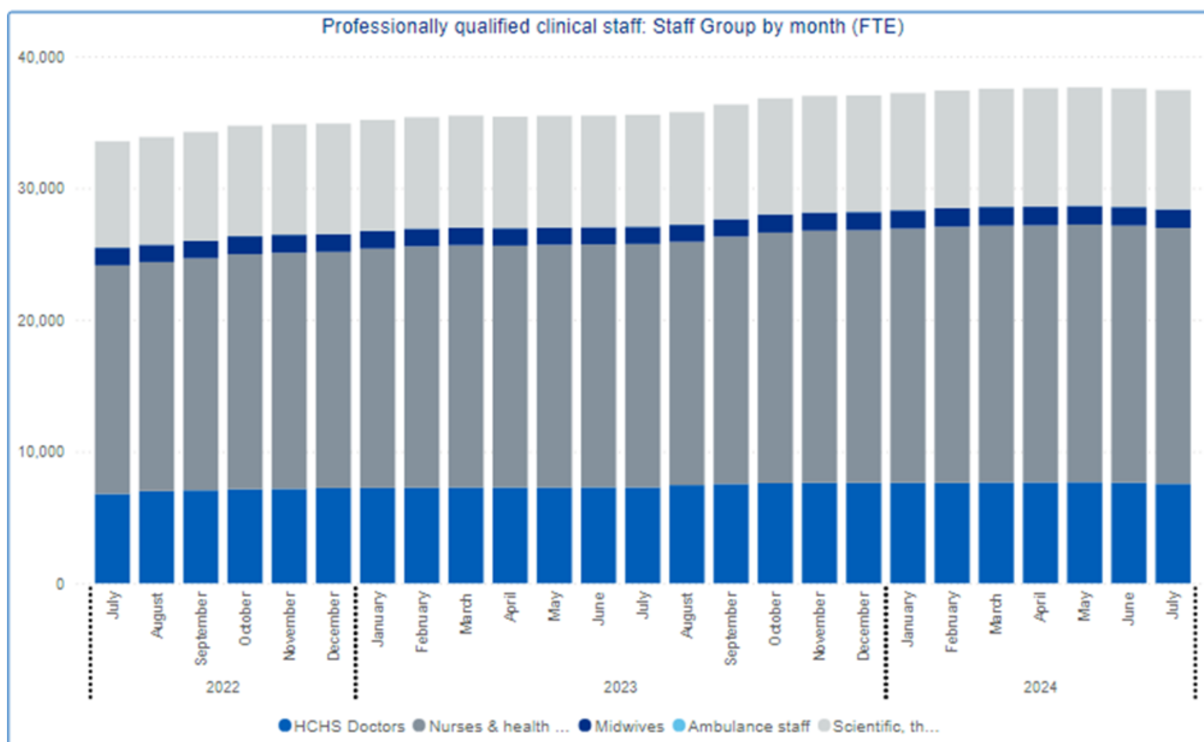
The number of people in GM waiting for planned treatment in secondary care increased over the past decade and was particularly exacerbated by the COVID-19 pandemic. Patients who face long waits for elective procedures often turn to other services such as primary care and A&Es when their conditions worsen, contributing to higher demand in A&E (GMICP Joint Forward Plan).

Access, or limited access, has been linked to a shift in patient reliance from GP services to A&E departments, placing added strain on emergency resources (King's Fund, 2022) According to the 2023 NHS GP Patient Survey, 28% of patients in Greater Manchester reported difficulty in securing a GP appointment. This is slightly higher compared to the national average, where 26.5% of patients across England reported similar difficulties.

3.7 Workforce Impact on UEC Delivery

NHS staff have faced immense pressures in recent years especially during the pandemic. The Covid pandemic showed the remarkable flexibility of our staff to step into new roles, but it has also led to fatigue. While leaver rates reduced at the height of the pandemic, we are now seeing rates rise with vacancy rates at 11.8% across the NHS nationally. Demand for NHS staff is likely to continue to exceed supply over the coming years without any action.

Since the pandemic the overall NHS workforce, when looking at professionally qualified clinical staff in post across the system (including Doctors, Nurses, Health Visitors, Midwives, Ambulance Staff and Scientific, therapeutic, and technical staff), has increased in the GM system. This is shown in the graph below.



Graph 21 - GM Workforce, professionally qualified clinical staff in post.

Equally we have seen an increase of 11.4% in the UEC workforce profile in GM from August 2023- to August 2024, with 3,362 people working in the sector.

Data also shows that in comparison GM has the second highest workforce in terms of Whole Time Equivalent (WTE) per 100,000 weighted population and when compared to the England average GM has 17.9% more workforce WTE per 100,00 population in the UEC sector. (Table 1).

GM and ICS Peer Comparison Table				
ICS Breakdown	Aug-24 WTE	Weighted Patient Population	WTE per 100,000 Population	Patients per WTE
Birmingham and Solihull	949.6	1,627,267	58.4	1,714
Black Country	1,164.3	1,371,392	84.9	1,178
Cheshire and Merseyside	2,461.5	3,063,453	80.3	1,245
Greater Manchester	**2,999.3**	**3,376,872**	**88.8**	**1,126**
South Yorkshire	1,406.3	1,552,987	90.6	1,104
West Yorkshire	1,676.3	2,666,706	62.9	1,591
ICS Totals	**10,657.2**	**13,658,677**	**78.0**	**1,282**
England	**46,779.8**	**62,154,630**	**75.3**	**1,329**

Table 1 - GM / Peers and North-West UEC Workforce by Weighted Population

However, when we look at the UEC workforce of GM in relation to the level of activity and acuity we find that our A&E departments do not have enough clinical workforce to meet the demand, with most A&E departments understaffed (SEDIT Metrics, August 2024). Furthermore, despite workforce increases, GM faces a 7% NHS vacancy rate, 6% sickness rate, and 14% staff turnover rate (GMICP 2022-25). The Adult Social Care sector experiences even higher turnover at 31%. Recruitment and retention are particularly challenging especially given the lack of parity in pay and conditions compared to the NHS (GMIPC 2022-25). However, as we continue to develop integrated provisions, particularly through new blended and hybrid roles and transforming services, we should see a positive impact over time.

A 2024 Emergency Medicine Journal article highlighted a crisis in staff retention in emergency medicine, partly due to concerns over working conditions and practices. NHS providers in GM have long reported challenges in recruiting and retaining staff with the necessary specialist skills for UEC services.

3.8 Public Opinions on UEC Performance

Whilst public confidence in A&Es is falling according to Healthwatch engagement, feedback on people's experience is varied, with some reporting extremely positive experiences. However, engagement undertaken since 2021 regularly shows that more people report difficult experiences than positive ones. In December 2021, we undertook engagement in all A&Es across Greater Manchester, exploring people's decision making and service usage. This was supplemented with an online survey.

In total, over 2,000 people took part in the engagement. The feedback from this told us that most people who attend A&E (70%) have contacted, or tried to contact, another service before attending A&E. The majority had contacted their GP practice (27%) or NHS 111 (22% over the phone, and 6% online), and 5% had called 999 for an ambulance. For the people who had contacted a GP practice, some had been unable to get an appointment, and some had been sent to A&E by their GP.

Many of the people who had gone to A&E (78%) felt that their attendance had been inappropriate. However, there was a notable minority that felt that they did not need A&E, but it was the only option available to them, either because no other service was open, because they could not get an appointment elsewhere, or that NHS 111 had been too cautious.

This feedback that NHS 111 is sometimes too risk adverse is consistent and comes out across wider, more recent engagement too. When asked about 111, less than 50% of people report a positive experience, with the concern that this puts people off using the service, especially if they have a pre-conception that 111 will send them to A&E anyway. Engagement has shown that whilst the majority of people are aware of 111, they do not always understand the wider services that they offer, including, for example, booking out of hour GP appointments.

Feedback on ambulances has remained consistent from 2021 to this year too. There is regular feedback that waits for ambulances are too long, with concerns that people are being advised to make their own way to hospital, or being sent a taxi instead of an ambulance, even for severe asthma attacks. These concerns were exasperated by the fact that when people drove themselves or a family member, there then were difficulties parking that added to the stress and anxiety.

When asked about urgent care, there is a consistent view from people that if people could get help more easily and for longer hours in the community from either GP, specialist services, or pharmacies, they would use those instead.

Feedback about discharge also comes up regularly when discussing urgent care. This includes people being discharged too early before they are either physically or mentally ready, with a perception that this is due to hospitals needing their beds back. Patient experiences include people going to A&E because their package of care was not ready, or their support networks are not strong enough, leading to an exacerbation of their condition and an emergency readmittance.

4.0 Summarising the Causes; The Top 3 Factors

This detailed analysis demonstrates that GM is facing several key factors that contribute to its challenges in achieving the 4hr standard of care in A&E departments which are different to those facing other ICSs:

The most significant issue is the combination of **increased demand and increasing complexity of need.** GM has experienced a notable rise in A&E attendances, particularly Type 1 cases, which require more comprehensive and immediate interventions. Additionally, there has been a rise in patient acuity and complexity, driven by health inequalities, an aging population, and higher rates of chronic conditions and mental health issues.

Connected to this, is **difficulty for our population to receive urgent and emergency care in the right place, at the right time.** Patient flow through GM's hospitals is challenged, with a high number of patients who no longer need acute hospital care remaining in beds due to discharge delays, contributing to high bed occupancy and consequential delays in seeing people quickly within A&E. Access to primary care, mental health care and elective care is a critical factor. Despite improvements in availability of these services, the cycle of high demand and complexity into all parts of the health and care system is felt in UEC services.

Public perception and experience of A&E services are declining, with concerns about long waiting times and the appropriateness of care received. This feedback highlights the need for improvements in patient experience and service delivery. People describe a complex system, where it is not easy to receive the help that they need.

These factors collectively contribute to GM's challenges in meeting the 4-hour standard of care in A&E departments, highlighting the need for targeted interventions and strategic improvements. Addressing these issues requires a coordinated effort across the health and care system, including increased investment, better workforce support, improved data management, and innovative care models.

5.0 Improving UEC in Greater Manchester: Successes and Developments

The Urgent and Emergency Care (UEC) Recovery Plan is a two-year action plan published in January 2023 by NHS England to improve the quality and access of urgent and emergency care services. The plan is supported by a £1 billion national improvement package and a £200 million ambulance fund.

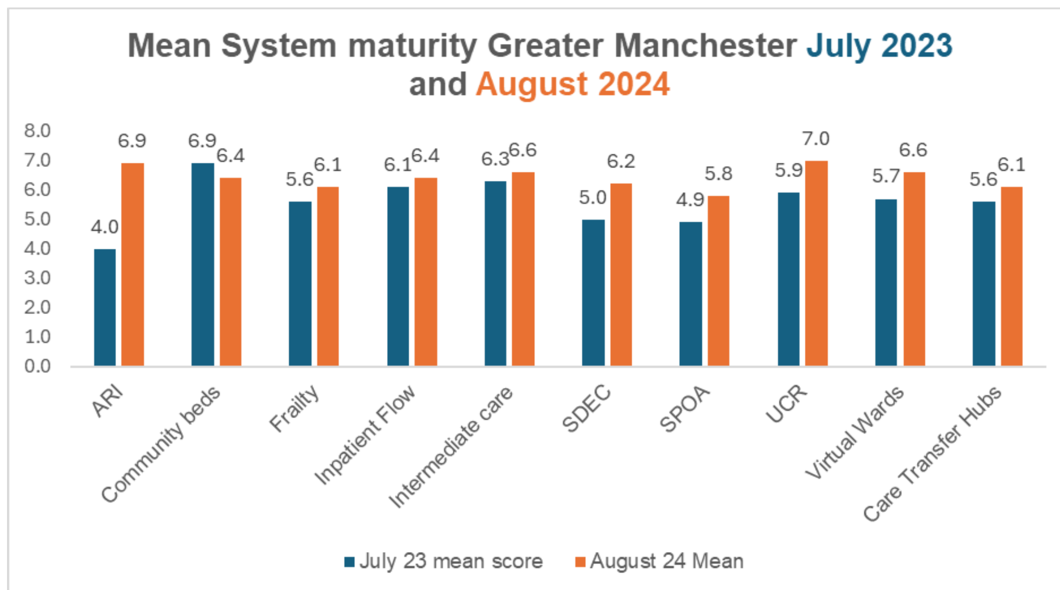
NHSE have applied a tiered approach to the support it provides to ICSs based on their performance against the 4hr standard of care, and GM has been placed in Tier 1 as they are not achieving the metric, meaning that it receives intense support from the Emergency Care Improvement Support Team (ECIST).

To support the recovery of UEC services there are 10 high impact initiatives (HII) that evidence shows will enable systems to make progress in improving quality, experience, and timeliness of service delivery. The HIIs are:

1. **Same Day Emergency Care (SDEC)**
2. **Frailty**
3. **Inpatient flow and length of stay (acute)**
4. **Community bed productivity and flow**
5. **Care Transfer Hubs**
6. **Intermediate care demand and capacity**
7. **Hospital at Home/Virtual Wards**
8. **Urgent community response**
9. **Single point of access**
10. **Acute Respiratory Infection Hubs**

Together with the ICB our locality systems have worked toward the implementation of these initiatives and have been regularly assessed to ensure that progress continues and to understand our successes and areas for continued development. Our achievements are

assessed using a matrix scoring system and GM has shown improvement over the past 18 months with all initiatives scoring as progressing to mature levels.



Graph 22 - GM HII Maturity July 23 v August 24

Key:
0-3 is classified as Early Maturity
3-5 is classifies as progressing Maturity.
6-7 is classified as Maturity.
8 is classified as Benchmarkable.

5.1 The Current Greater Manchester UEC Offer

Over the past decade, the UEC service offer in GM has broadened beyond the core services offered in A&Es and in primary care. This has been in response to the challenges outlined above relating to increased demand and complexity. These developments have been aimed at creating alternatives to A&Es that can treat people more effectively for their level of need. GM ICS have developed a set of common standards of UEC service delivery which each of the 10 localities are expected to achieve:

5.1.1 GM Hospital @ Home (Virtual Ward) Standards

By the end of 2024, Greater Manchester aims to have 936 virtual beds as part of the GM Hospital @ Home (Virtual Ward) programme. Between May 2023 and 2024, there were 36,154 patient admissions to these virtual ward beds, with an average bed occupancy rate of 68%. The University of Manchester's ARC team is conducting a comprehensive review of the programme to assess its effectiveness and outcomes.

5.1.2 2hr Hour Urgent Community Response (UCR)

All 10 localities in Greater Manchester have a 2-hour Urgent Community Response (UCR) service, aiming to respond to 70% of referrals within 2 hours. In August 2024, 89% of UCR referrals met this target. The UEC Recovery Plan has driven a 122% increase in UCR referrals from February 2023 to July 2024, with 37% of referrals coming from the ambulance service, helping to avoid A&E visits. Approximately 84% of discharged patients remained in their usual residence. However, the service is predominantly used by patients identified as 'white,' indicating lower utilisation by minority groups.

5.2.3 Same Day Emergency Care (SDEC)

The long-term plan aims to enhance system maturity for direct referrals to secondary care, reducing A&E demand. Prioritizing access to Same Day Emergency Care (SDEC) is crucial, though further improvements are needed for clinician referrals. Access varies across England, with Greater Manchester having SDEC in all acute hospitals. Efforts are underway to map SDEC provision by locality and improve NHS 111 and ambulance access. A key challenge is the complex referral criteria, which the plan aims to standardize across the Integrated Care Board (ICB) to ensure equal referral opportunities for clinicians.

5.2.4 Urgent Treatment Centres (UTCs)

Introduced in 2017, Urgent Treatment Centres (UTCs) provide urgent medical help for non-life-threatening emergencies. The 2023 Delivery Plan for recovering urgent and emergency care services expects UTCs to increasingly serve as the front door of Emergency Departments (ED), allowing emergency medicine specialists to focus on higher acuity cases. Greater Manchester currently has 10 accredited UTCs, with 3 more working towards accreditation.

5.2.5 Front Door Streaming

The 2022 to 2023 NHS planning guidance emphasizes the need for structured streaming between Urgent Treatment Centres (UTCs) and A&E departments. It mandates that A&E departments have pathways to refer clinically stable patients to community-based alternatives or appropriate on-site specialties, ideally 24/7, but at least 12 hours a day, 7 days a week. This ensures patients receive timely care from the right professionals, reducing congestion and demand in A&E departments.

5.2.6 Primary Care Access

Access to Primary Care is a priority for Greater Manchester's 2.8 million citizens and has been nationally emphasized in the Primary Care Access Recovery Plan (May 2023). Greater

Manchester has pledged to ensure same-day urgent access to General Practice when clinically warranted, eliminate the '8am rush' with improved telephony infrastructure and NHS App usage, and support PCNs. Additionally, they aim to improve NHS dentistry access through a Dental Quality scheme, ensure Community Eye Care service access in optometry, and enhance pharmacy services to reduce health inequalities. Over the past six months, GM GPs have seen a 5% increase in patient visits compared to the same period last year.

5.2.7 NHS111

NHS 111 is a free, non-emergency service in the UK designed to reduce pressure on emergency departments by providing quick healthcare advice. It directs only 12.5% of calls to A&E and resolves 12.8% with no further action. The primary recommendation for 37.8% of calls is to contact Primary Care. In Greater Manchester, call volumes have declined since the introduction of NHS 111 online in December 2017.

5.2.8 GM Clinical Assessment Service (CAS)

The Greater Manchester Clinical Assessment Service (GM CAS) significantly enhances system capacity by intervening in patient care earlier, supporting the urgent and emergency care (UEC) system, particularly 999 and Emergency Departments (ED), by redirecting activity to lower acuity care or self-care. While the savings are not directly cashable, they help mitigate extreme and growing demand. In 2023/24, GM CAS handled an average of 6,050 cases per month, and LCAS handled 6,214 cases per month. The service successfully closes over 50% of 999 calls without needing an ambulance, freeing up more ambulance hours daily.

5.3 Investment in Improving GM UEC Services

UEC services in GM are funded through a range of different contracts with provider organisations including the standard NHS contract and distinct funds for certain contracts or service developments.

The UEC Discharge and Capacity fund is a distinct funding stream that is targeted at achieving the HIIs set out in the UEC Recovery Plan. The main objectives include increasing capacity by funding additional hospital beds and ambulances to handle the rising pressures on hospitals. Another goal is to speed up the discharge process for patients who are medically fit to leave, thereby freeing up beds for new patients. Expanding community services, such as virtual wards and urgent community response teams, aims to reduce unnecessary hospital admissions. Additionally, the funding focuses on growing and

supporting the NHS workforce to ensure there are enough staff to meet the increased demand.

For 2024/25, the Discharge fund increased, with an additional £9.5 million allocated to GM NHS organisations and a further £13 million distributed across GM's 10 Local Authorities as part of the Spending Review. These funds were allocated to each locality based on the relative needs' formula.

Investment has also been made this year in our infrastructure to deliver UEC services in GM. £174 million of GM's capital allocation has been assigned to improving A&E departments in three localities and to the development of GM's major trauma centre.

6.0 Moving Ahead to support UEC Progress

GM's population need and deserve UEC services which can meet their needs in a timely and effective way, now and into the future. Despite good progress with the High Impact Initiatives as set out in the national UEC Recovery Plan, GM is not seeing the benefits in a comparable way to other ICSs.

Given the challenges of increasing demand and increasing complexity that have been identified as having impact in GM in a disproportionate way to that seen in other ICSs, a focus purely on improving UEC services in isolation of wider public service reform is unlikely to be enough to deliver the recovery required.

There is opportunity to harness the benefits of devolution and mature models of integration in GM to specifically focus on recovery of UEC. Opportunities include:

Strengthening the delivery of responsive services that meet physical health, mental health, and social care needs of GM people in their neighbourhoods. Live Well is GM's commitment to everyday support in every neighbourhood, changing how we work with communities and in public services to grow opportunities for everyone to Live Well. Barriers have existed to how far and how fast we can progress our neighbourhood model which need to be addressed to maximise the potential to meet people's urgent need in community, reserving A&Es for people needing emergency care.

Wrapping personalised care around people with the highest intensity of needs. Health Inequalities experienced by people in GM result in a cycle of high intensity use of UEC

services and deteriorating health. Ensuring our neighbourhoods have the capacity and flexibility to provide intensive and personalised support to our most under-served populations will be a critical success factor on reducing this cycle and improving health outcomes.

Preventing our younger generation from developing ill-health which requires UEC service delivered care in the future. With increasing demand and increasing complexity of need seen in UEC services in GM, combined with growing population size, it is evident that there is opportunity to leverage GM's foundations on prevention to benefit UEC recovery. Prevention involves early intervention and prevention to reduce the need for more intensive health and social care services later. It includes various health promotion activities designed to encourage healthier lifestyles and prevent illness. By engaging with communities, we can address the root causes of health issues and promote sustainable health improvements.

The continued partnership between the GM ICB and GMCA will be key to success, enhanced integration of health and social care services will ensure a seamless patient experience and better health outcomes. Collaborative efforts will enable more efficient use of resources, reducing duplication and ensuring that investments are targeted where they are most needed. Joint initiatives can focus on workforce development, ensuring that staff are well-trained and supported to meet the demands of UEC services and strengthening community-based services through collaboration will help manage patient flow and reduce pressure on A&E departments.

7.0 Conclusion

In conclusion, the challenges faced by Greater Manchester's UEC services are multifaceted and deeply rooted in the region's unique demographic and health profile. The significant increase in demand, particularly for Type 1 emergency services, coupled with a rise in patient acuity and complexity, has placed immense pressure on the system. This has been exacerbated by the COVID-19 pandemic, which has led to a backlog of care and an increase in the severity of conditions presented. The analysis highlights the need for a targeted approach that addresses the specific needs of the GM population, particularly in terms of health inequalities and the provision of integrated care that encompasses both physical and mental health.

Moving forward, it is clear that a holistic approach is required to improve UEC performance in GM. This includes not only focusing on the immediate pressures within A&E departments but also addressing the broader determinants of health and well-being. By strengthening

community-based services, improving patient flow through the system, and investing in the workforce, GM can work towards achieving the 4-hour standard of care. Additionally, strong collaboration between GM ICB and GMCA will support the development a more resilient and responsive healthcare system that addresses the specific needs of the Greater Manchester population, ensuring a concerted effort across the health and care system, with a focus on prevention, early intervention, and the delivery of personalized care to those with the highest needs.

Through these measures, GM can aim to provide a UEC service that is timely, effective, and equitable for all our residents.

8.0 Glossary of Terms

A Type 1 Accident & Emergency (A&E) department refers to an emergency department (ED) that provides 24-hour, consultant-led care to patients with serious or life-threatening injuries or conditions. In the UK, the National Health Service (NHS) categorizes A&E departments into different types based on the level of service they provide.

- Type 1 A&E: These departments are hospital-based and offer comprehensive emergency care for a wide range of conditions, including major trauma, heart attacks, strokes, and other critical medical situations. A consultant-led team is always available to oversee patient care.
- Type 2 A&E: These are smaller units, typically offering emergency care but with less comprehensive services than Type 1 and may not have full-time consultants available.
- Type 3 A&E: These are "minor injury units" that provide treatment for less severe conditions, like cuts, sprains, and minor illnesses, but they do not handle life-threatening cases.

A&E All-Type 4-Hour Performance: The percentage of patients who are admitted, transferred, or discharged within 4 hours of arrival at the emergency department.

A&E All-Type Attendances: The total number of patients attending the emergency department.

Acute Respiratory Hubs: Specialized centres designed to provide rapid assessment and treatment for patients with acute respiratory conditions.

Admission Avoidance: Strategies and services aimed at preventing unnecessary hospital admissions, particularly for vulnerable populations.

ASC Pathways:

- **Reablement**: A short-term service designed to help people regain independence and confidence after an illness or hospital stay.
- **Extra Care**: Housing designed with the needs of older people in mind, offering varying levels of care and support on-site.
- **Technology Enabled Care (TEC)**: The use of technology to support and enhance the delivery of care services, such as telecare and telehealth.
- **Pathway 1**: A discharge pathway where individuals are discharged home with rehabilitation support.
- **Pathway 2**: A discharge pathway where individuals are discharged into short-term beds for rehabilitation before returning home.
- **Pathway 3**: A discharge pathway for individuals who require longer-term care in a residential or nursing home setting.

Blended Roles: Positions that combine responsibilities from different areas of care, such as health and social care, to provide more integrated support.

Care Transfer Hubs (CTH): Coordinating centres that manage the discharge of patients with complex needs, ensuring they receive appropriate post-discharge care.

Category 2 Ambulance Response Times: This category includes emergency calls for serious conditions such as stroke or chest pain. The target response time is an average of 18 minutes.

Community Bed Productivity and Flow: Like inpatient flow, focusing on community settings to improve care and discharge processes.

Discharge to Assess (D2A): A model where patients are discharged from the hospital to their own home or another community setting to have their long-term care needs assessed.

Frailty: Enhancing acute frailty service provision by improving recognition and referrals to avoid unnecessary admissions.

G&A Bed Occupancy: The percentage of general and acute beds that are occupied.

Health Based Place of Safety (HBPoS): A designated space where individuals detained under Sections 135 or 136 of the Mental Health Act 1983 can be safely managed while undergoing an appropriate mental health assessment.

Healthcare Resource Group (HRG): are standard groupings of clinically similar treatments that use comparable levels of healthcare resources. Within the English National Health Service (NHS), HRGs are designed to help organizations understand their activity in terms of the types of patients they care for and the treatments they undertake. For example, different knee-related procedures that require similar levels of resources may all be assigned to one HRG.

Home First: An approach that prioritizes discharging patients from the hospital to their own homes as soon as they are medically fit, with the necessary support in place.

Hybrid Roles: Roles that involve a mix of in-person and remote work, often utilizing technology to deliver care and support.

ICS (Integrated Care System): A partnership of organizations that come together to plan and deliver joined-up health and care services to improve the health of their local population.

Inpatient Flow and Length of Stay (Acute): Implementing efficiencies and advancing discharge processes to reduce inpatient care variation and length of stay for key pathways and conditions.

Intermediate Care (IMC): Services that provide short-term support to help patients recover and regain independence after a hospital stay or to avoid unnecessary hospital admissions.

Intermediate Care Demand and Capacity: Improving demand and capacity planning for intermediate care, including community rehabilitation, through better data use.

Length of Stay (LoS): The duration a patient spends in a hospital from admission to discharge. It is a key metric for hospital efficiency and patient care quality.

Mean Ambulance Handover Time: The average time taken to transfer a patient from an ambulance to the care of the emergency department.

Multi Agency Discharge Event (MADE): Events that bring together various health and social care professionals to improve patient flow, unblock delays, and streamline discharge processes.

No Criteria to Reside (NCTR): A status indicating that a patient no longer needs to stay in a hospital bed based on clinical criteria.

OPEL (Operational Pressures Escalation Levels): A framework used to assess and manage the operational pressures within acute hospitals, ensuring a consistent and systematic approach to escalation.

- **OPEL 1**: Indicates that the system is operating within normal parameters, with demand being met by available resources.
- **OPEL 2**: Signifies that the system is starting to show signs of pressure. Focused actions are required to mitigate the need for further escalation.
- **OPEL 3**: Reflects significant pressure on the system, with patient flow being compromised. Urgent actions are needed across the system, and external support may be required.
- **OPEL 4**: Represents extreme pressure, where the system is unable to deliver comprehensive care. Decisive actions are necessary to recover capacity and ensure patient safety, often requiring extensive external support.

Same Day Emergency Care (SDEC): A model of care where patients are assessed, diagnosed, and treated on the same day without being admitted to a hospital bed.

Single Point of Access (SPoA): A system that provides a single point of contact for urgent and emergency care services, streamlining access and referrals to appropriate care.

The Evidence-Based Treatment Pathway clock (EBTP): A standard used in the NHS to measure response times for mental health crises. It ensures that individuals experiencing a mental health crisis receive timely and appropriate care.

- **Within 1 hour**: A response from a liaison mental health service should be provided within one hour of the service being contacted.
- **Within 4 hours**: An appropriate response or outcome should be in place within four hours of arriving at an emergency department or being referred from a ward.

Tier 1 and Emergency Care Improvement Support Team (ECIST): Teams that provide expert support and guidance to improve emergency care services and patient flow within the NHS.

Urgent Community Response (UCR): Services that provide urgent care within two hours to prevent hospital admissions, often involving a multidisciplinary team to support patients in their homes.

Urgent Treatment Centres (UTC): Facilities providing urgent medical help for non-life-threatening conditions. They are open at least 12 hours a day and can handle minor injuries and illnesses.

VCSE (Voluntary, Community, and Social Enterprise): This term encompasses a wide range of organisations that operate for the benefit of society, including:

- **Voluntary organisations**: Groups that rely on volunteers to carry out their activities.
- **Community organisations**: Local groups that address specific community needs.
- **Social enterprises**: Businesses that aim to generate profit while also achieving social, environmental, or community goals.

Virtual Wards (VW): Services that provide hospital-level care at home for patients with complex needs, aiming to prevent hospital admissions and support early discharge.

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