SUMMARY OF REPORT:

This report provides a summary of the outputs from the GM UEC winter summit (the summit) held on the 14 February, including agreed next steps.

KEY MESSAGES:

The summit was convened in partnership with the regional NHSI and E team in response to the deterioration of performance against the 4 hour A&E standard during December and January. The summit was well attended by providers Chief Executives, CCG Accountable Officers, Local Authority Chief Executives and other senior system leaders. The aim of the summit was to develop an improved understanding of the challenges facing GM localities in comparison to other parts of the country, learn from success in GM and to identify the priority actions for the next 6 months to prepare better for next winter.

The key themes to emerge from the meeting were to:

- rapidly review whole system demand and capacity across the full UEC pathway for health and social care,
- continue with the transformation plans (but with a focus on improving consistency and scale of implementation and reducing variation),
- improve primary care engagement,
- implement a new range of community standards for primary and social care, with a greater focus on reducing delayed transfers of care attributable to social care,
• understand better why the ambulance non-transport rates are lower when compared to other parts of the country and;
• working together as a system to provide mutual aid.

PURPOSE OF REPORT:
The purpose of the report is to ensure the board are appraised of the summit discussions and actions that the whole system agreed to take forward.

RECOMMENDATIONS:
The Greater Manchester Health & Care Board is asked to:

• Note the content of this report and support the agreed actions from the summit

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1.0 INTRODUCTION

1.1. GMHSCP and the regional NHSI and E senior leadership teams agreed to convene a GM UEC Winter Summit on the 14 February this year. The summit was in response to deterioration in performance against the 4 hour A&E standard for the majority of localities in GM.

1.2. The summit was intended to build on the recent requirement for a number of GM localities to produce short term recovery plans to improve their non-elective performance by the end of March this year.

1.3. The aims of the summit were to:

- review the current pressures and performance in relation to UEC in GM, including the effectiveness of winter plans and transformational schemes,
- identify the root causes for the challenges we currently face and;
- collectively agree on priority actions and support required for the next 6 months to ensure improved preparation for next winter.

1.4. The summit was opened by Lord Peter Smith on behalf of GM and was well attended by provider chief executive officers, CCG accountable officers, local authority chief executives, senior medical and clinical leaders and other senior system leaders.

1.5. The summit provided an opportunity for the new NHSI and E North West Regional Director (Bill McCarthy) to meet with the GM system.

2.0 SUMMIT AGENDA

2.1. A significant part of the preparatory work for the summit was the production of locality data packs to enable a locality self-assessment process ahead of the summit. These packs included a number of new measures that provide a much wider view of the whole UEC pathway including the primary, community, acute and social care.

2.2. The data analysis provided an opportunity to compare GM systems with statistically comparable systems across the North of England and also a comparison of GM as a Sustainability and Transformation Partnership (STP) against other STPs nationally. The analysis highlighted that virtually every locality has a unique set of challenges that range from demand management
in the community through to hospital based patient flow or discharge and recovery.

2.3. Localities completed a full review of progress against the GM UEC Improvement and Transformation Plan (which will be maintained and refreshed monthly as part of the enhanced governance processes). In addition, each locality produced a Strength, Weaknesses, Opportunities and Threats (SWOT) analysis, which was used to inform discussions at the summit.

2.4. These materials have enabled localities to better understand what the key issues are within their areas and to sense check and adjust their improvement and transformation plans.

2.5. The summit also provided an opportunity to highlight some of the successes within GM:

- The Rochdale Intermediate Care Tier provides an integrated service supporting crisis response, discharges and transfer to assess, re-enablement and trusted assessor for care homes. In year one it achieved a reduction of 6% in non-elective admissions against a target of 3%.

- The Wigan Community Response Team provides a fully integrated response with access to a wide range of health and social care services, including community step up beds. This has resulted in a 10% reduction in ambulance attendances to the emergency department.

- 100% of GM’s residents can get routine or pre-booked appointments with their general practice seven days a week (up from 47% in 2016) and 100% of GP practices are part of a neighbourhood with 67 neighbourhoods now established across GM. Salford has put in place extended care teams (supporting care homes and home care). Anyone can refer into the service, so not solely reliant on GPs. These multidisciplinary teams are able to risk stratify patients.

2.6. Tameside and Glossop locality, who have continued to achieve over 90% performance against the four hour A&E standard, highlighted what they considered to be their critical success factors:

- Shared leadership, single commissioning function for CCG and Local Authority, one workforce and single version of the truth.

- Establishment of an Integrated Care Organisation with community, primary care and adult services.
• Use of digital technology to support care homes and urgent community responses with integrated care teams.

• An integrated model of care with individual neighbourhood priorities and social prescribing.

2.7. The summit also considered how GM can work better as a system to manage patient flow during periods of increased demand through improved use of the GM operational hub. Improved processes for managing cross-locality discharges and hospital repatriations in a more timely way were highlighted.

2.8. Improving the resilience and wellbeing of the workforce was also discussed with some best practice examples shared from within GM and across the country. Improving the use of the workforce across GM was also identified as an area where improvements could be made to overcome staff shortages and reduce the reliance on agency or locum workers.

3.0 SUMMIT OUTPUTS

3.1. Review of Whole System Capacity

3.1.1. There was a collective agreement that there needs to be a whole system demand and capacity review undertaken for each locality that includes all aspects of the UEC pathway including health and social care.

3.1.2. The review will take into account historic activity with an analysis by service or part of the UEC pathway, looking at average and peak demand per day. Projected growth will also be taken into account and tested based on changes to year on year growth and those set within the locality activity targets. A review of demand management schemes and other planned interventions that may shift demand from one service to another (including any required adjustments) will also be included.

3.1.3. A capacity baseline assessment will take into account staffing and bed availability as a principle measure of capacity but, will extend wider into other community-based health and social care services and consider actual productivity.

3.1.4. The review will compare demand and activity to identify services that are over/under capacity on average and peak days and what the system constraints may be. This will enable testing of assumptions and prioritisation of issues for each locality. Testing of scenarios and stress-testing of plans and the system will be undertaken.
3.1.5. The aim is to complete these reviews prior to the April 19 to enable operational plans to be adjusted for the next financial year.

3.2. **UEC Improvement & Transformation Plan – increase scale and pace**

3.2.1. There was clear agreement that the GM UEC Improvement & Transformation Plan was still valid and that localities needed to continue to progress delivery.

3.2.2. A large amount of effort has been put into developing new standards or models of care for services such as integrated urgent care or the acute management of frail patients, with some small scale testing.

3.2.3. However, it was recognised that changes needed to be implemented more consistently across localities and at greater pace and scale over the next six months.

3.2.4. The use of improved data analytics and measurement for improvement to identify and reduce variation in care and safety was also agreed as an action.

3.2.5. The GM UEC Improvement and Transformation Board will now meet formally on a monthly basis and a new operational oversight group will be established to ensure enhanced oversight of the improvement and transformation programme and wider operational issues.

3.3. **Primary Care**

3.3.1. While there have been significant improvements in primary care, the summit identified a need to further strengthen engagement with primary care in the delivery of the GM UEC Improvement and Transformation Plan and also in day to day operational management of patient flow – particularly during periods of increased demand and escalation. It was recognised that primary care have a critical role in supporting patients with urgent care needs and therefore need to be more connected with the wider system.

3.4. **Implement new standards for primary and social care**

3.4.1. Following the production and review of system data packs, it was agreed that we would rapidly implement an additional suite of measures and standards that would provide greater insight into how the wider UEC pathway was working across health and social care (which will include primary and community care services). The new measures will help us to assess how well locality schemes are working to safely keep people out of hospital (reducing demand) and how health and social care services are
working to reduce delays in discharge from hospital and to help as many people return to their usual place of residence following a hospital admission.

3.4.2. One particular area of focus will be to develop a better understanding of the reasons why the proportion of delayed transfers of care (DTOC) from hospital, that are attributable to social care, are higher in comparison to other parts of the country.

3.4.3. Part of this work will be to agree GM or locality-level ambitions to help drive improvements and to reduce the variation between localities or other parts of the country.

3.4.4. The first draft of these new measures and ambitions will be presented to the GM Partnership Executive Board at the end of March.

3.5. **Further analysis and improvement of ambulance non-transport rates**

3.5.1. The system-wide review of data and comparison against the North of England region has highlighted that the North West Ambulance Service has lower non-transport rates than other ambulance services. Further work will be undertaken to help us understand the reasons for this with a particular focus on why NWAS have lower transport rates to non-emergency departments (such as walk in centres or minor injury units) and where there are opportunities for improvement ahead of next winter.

3.6. **System working and mutual aid**

3.6.1. A further system workshop will be arranged during March/April and facilitated by the Emergency Care Improvement Support Team (ECIST) to identify how GM can work better as a system and utilise the GM Operational Hub better, with increased delegated authority to manage patient flow across the whole system during periods of increased demand. A new cross locality discharge and repatriation process will be implemented in early March to reduce delays and increase the number of patients discharged back to their usual place of residence.

4.0 **ADDITIONAL GM-WIDE ACTIONS**

4.1. GM is about to launch a three month test of a new single Clinical Assessment Service and Locality Integrated Urgent Care Services in eight localities.

4.2. These services will enable Greater Manchester to manage the lower acuity 111 and 999 calls much earlier in the call and will connect patients much
more quickly with local services. The test will deal with 85% of Category 3 and 4 ambulance calls. The calls will be pushed immediately following initial call categorisation to a single GM clinical assessment service. This service will complete a more detailed assessment of the patient's symptoms and needs; providing advice or re-directing them to an appropriate service such as primary care. Any calls requiring face to face assessment will be transferred to a locality Integrated Urgent Care Service, which will have access to a wide range of health and social care services. These services will be run by the GM OOH Alliance as a three month test of change commencing on the 5th March. This will be the first of its kind in the country.

4.3. Currently, the North West Ambulance Service achieve a non-conveyance rate of approximately 30% for the identified activity (circa 65k calls per year). GM aim to safely achieve a deflection rate of at least 50% to 60% through this test of change.

4.4. Providing the test of change is successful and safely reduces hospital conveyances, GMHSCP will work with localities to develop a sustainable model, which will continue to run, as a minimum, for the remainder of 19/20.

4.5. GMHSCP have purchased a web-based patient service finder. This will provide a much more user friendly service finder app for the public. The service finder will enable people to find a range of local services such as; pharmacy, GP appointment or walk in centre/urgent treatment centre and can be embedded in all health and local authority web pages across GM. It will also offer a direct link to NHS 111 online for patients who want to check their symptoms or are unsure of the service they require. The service is planned to be operational within the next two weeks. The service finder is fully customisable and enables the creation of a more bespoke Directory of Services (DoS), which includes a wider range of local authority and third sector/voluntary services. A health professional service finder is also included with added functionality which will be made freely available to all services across GM including the North West Ambulance Service.

5.0 RECOMMENDATIONS

5.1. The Greater Manchester Health & Care Board is asked to:

- Review and note the content of the report.