Greater Manchester Health and Care Board

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Date: 14 September 2018

Subject: Greater Manchester Urgent and Emergency Care Improvement and Transformation Plan

Report of: Steve Barnard, Head of Service Improvement UEC, GMHSCP

SUMMARY OF REPORT:

The report provides the board with an overview of the recently approved Greater Manchester Urgent and Emergency Care (UEC) Improvement and Transformation Plan. The report describes the next steps in terms of implementation and delivery of key deliverables for localities.

KEY MESSAGES:

A white paper on Urgent and Emergency Care reform was published by the Greater Manchester Health and Social Care Partnership in March 2017. This has provided a blueprint to engage further with localities and key stakeholder groups to design an improvement and transformation programme for the next two years.

The plan has been co-produced with over 130 stakeholders across Greater Manchester through a series of workshops. An early part of the design work was the identification of what we need to do consistently well to achieve our programme aims – our primary drivers. The four primary drivers identified were; Stay Well, Home First, Patient Flow and Discharge and Recovery.

The attached plan sets out a series of 'Wave 1' deliverables, which are to be achieved in advance of, or during, winter 2018. The remainder of the plan is described as 'Wave 2' activities, which will commence in Q4 of 2018 and through to 2019/20.

The plan has been reviewed and approved via the Locality Urgent and Emergency Care Boards and the Greater Manchester Urgent and Emergency Care Improvement and Transformation Board.

Finally, to complement the plan, a series of Greater Manchester ambitions have been developed and agreed with localities for the remainder of this financial year:

- For GM systems to focus on a targeted reduction of the stranded patient cohort (7 days plus length of stay) – achieving a GM system proportion of 40% stranded patients by the end of September 18 and 35% by the end of March 2019
- Achieving 33% of discharges by midday, 7 days per week by December 18
- Agreeing revised DTOC ambitions for 18/19

The plan and 18/19 ambitions will be central to our approach to preparing for and managing the winter period. Work is already underway with localities to ensure there is sufficient planning in place to deliver the correct levels of capacity in all parts of the UEC pathway.

PURPOSE OF REPORT:

The purpose of the report is to provide the board with an overview of the plan, the planned implementation process and associated programme governance. The report provides additional detail on the planned improvement and transformation activities within the plan.

RECOMMENDATIONS:

The Greater Manchester Health & Care Board is asked to:

- Note the content of this report

CONTACT OFFICERS:

Steve Barnard, Head of Service Improvement UEC, GMHSCP
stevebarnard@nhs.net

1.0 INTRODUCTION

1.1. The delivery of high quality urgent and emergency care services is a critical part of the Greater Manchester reform programme and remains an ongoing challenge due to; increases in demand for services, an ageing population with increasingly complex conditions and developing a workforce to for the future.

1.2. Equally, these challenges, alongside devolution, provide an opportunity for Greater Manchester to fundamentally re-think our approach to urgent and emergency care, with innovation at the heart of what we do; testing new models of care, utilising technology and systems working.

1.3. Our vision for Greater Manchester is:

"To work together to support people to stay well and to provide the highest quality urgent and emergency care that is; safe, coordinated and patient-centered.

Our services will be easy to access and understand. Patients will tell their story once, be treated with compassion and receive care as close to home as possible."

1.4. This is underpinned by four principle aims:

- We will develop and deliver GM standards of care, for the whole urgent and emergency care pathway, which fully meet the needs and rights of our population, in line with the NHS constitutional standards, best evidence and national guidance.

- We will provide an equitable and fully integrated urgent and emergency care service for patients with physical, mental health or social care needs, via localities across the whole of GM.

- We will harness technology, collaborative working and information sharing so that the population of GM will be able to access the right advice, care or support in the right place, first time.

- Year on year, we will reduce attendances to Emergency Departments and reduce the length of stay for those admitted to an acute hospital bed by enabling patients to self-care and recover through improved primary, community and social care services working together. This will be underpinned by a philosophy of 'home first' wherever safe and appropriate.

2.0 UEC IMPROVEMENT AND TRANSFORMATION PROGRAMME PLAN

2.1. The plan has been co-produced with over 130 stakeholders across Greater Manchester. An early part of the design work was the identification of what we need to do consistently well to achieve our programme aims – our primary drivers. The

four primary drivers identified were; Stay Well, Home First, Patient Flow and Discharge and Recovery.

2.2. The four primary drivers have been developed into the four principle work streams for the programme. For each work stream, we have an agreed Senior Responsible Office (SRO) from the wider Greater Manchester system. These SROs are senior system leaders from provider, commissioning and clinical roles associated with urgent and emergency care.

2.3. It is recognised in the development of the plan that, while there are four separate work streams, there is a significant overlap in terms of operation of the UEC pathway and how patients transition through. The programme structure and governance will ensure that the four work streams remain connected to ensure design and delivery of a fully integrated and seamless pathway of care.

2.4. The outputs across all of the work streams have been reviewed and considered with a view to interdependencies, themes and specific deliverables. In total, nineteen specific service improvements have been identified, grouped into work stream areas which will be underpinned by enabling work streams such as workforce, systems operations, digital interoperability-innovations and communications. The enabling work streams will run for the full duration of the programme until March 2020.

2.5. The attached plan sets out a series of 'Wave 1' deliverables, which are to be achieved in advance of, or during, winter 2018. The reminder of the plan is described as 'Wave 2' activities, which will commence in Q4 of 2018 and through to 2019/20.

2.6. The high level project plans are living documents and, as such, are under ongoing review and adaptation.

2.7. The plan describes the governance and oversight processes that will be in place to monitor and review progress.

3.0 GREATER MANCHESTER UEC PLANNING GUIDANCE 18/19

3.1. The GM Urgent and Emergency Improvement and Transformation Board (UECITB) met on the 20th July and approved UEC planning guidance for localities to implement and progress during the remainder of 2018/19.

3.2. In June, NHSI&E set out the latest planning guidance for UEC during the remainder of 18/19. A central element of the planning guidance is focussed on reducing bed occupancy to levels when the 4 hour standard was last achieved, the principal driver for this being a 25% reduction (in number) of super-stranded patients (patients with a length of stay of 21 days or more) by December 2018 (compared to 17/18 baseline). Under the terms of devolution, GM has the ability to develop its own planning guidance for localities.

3.3. Whilst the national programme is focused on the super-stranded patient cohort as the key driver to reduce bed occupancy, GMHSCP has already embarked on a broader programme of work to reduce bed occupancy, by asking systems to focus on reducing the proportion of stranded patients (a length of stay of 7 days or more) as part of the quarter one improvement plan, which includes the super-stranded cohort of patients.

3.4. This focus on stranded patients during quarter one helped the vast majority of GM systems to reduce significantly the number of both their stranded and super-stranded patients, which contributed to better patient safety, better patient experience and improved 4 hour performance.

3.5. Research shows that reduced length of stay improves patient outcomes, therefore, the GM UECITB has approved the following ambitions for the remainder of this year:

- That Greater Manchester achieves 40% stranded patients (7 days plus), as a system aggregate, by the end of September 2018 and 35% by the end of March 2019.

- Achieving 33% of discharges by midday 7 days per week by December 18 (it is widely acknowledged that earlier discharges enable the earlier of transfer of patients from emergency departments and acute assessment areas, which promotes good patient flow early in the day).

- Revised DTOC ambitions for 18/19 to achieve a GM aggregate of less than 200 DTOC beds per day (based on agreed Integrated Better Care Fund targets.

4.0 OVERSIGHT AND GOVERNANCE

4.1. The Greater Manchester UEC Improvement and Transformation Board is now fully established and meets every two months. One of its core functions is to monitor progress against the agreed plan and to evaluate the impact of the changes through a structured reporting and measurement process.

4.2. The Locality UEC Delivery Boards meet monthly and are responsible for monitoring progress against the plan at a locality level.

4.3. Localities have recently completed a baseline assessment against the Wave 1 deliverables within the plan, which will be reviewed as the next Greater Manchester UEC Improvement and Transformation Board.

4.4. A Greater Manchester UEC Board Development session is being held on the 14th September to help localities explore; the characteristics and behaviours of a high performing UEC governance structure and how localities will work together and support each other during periods of increased demand to maintain good patient flow.

4.5. The Greater Manchester UEC Professional Clinical Advisory Group held its inaugural meeting in July. The membership is representative of professional groups and clinical staff (including social care). The group will be responsible for the design of clinical pathways or models of care, including the development of GM UEC clinical standards. The group will also be responsible for reviewing the UEC pathway quality and safety.

5.0 RECOMMENDATIONS

The Greater Manchester Health & Care Board is asked to:

- Note the content of this report and attached plan

GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

URGENT AND EMERGENCY CARE IMPROVEMENT PROGRAMME

2018 – 2020 PROGRAMME DELIVERY PLAN

'A GUIDE FOR TRANSFORMATION AND IMPROVEMENT'

Final version

Contents

Version Control

Version	Description	Date	By	Comments
0.1	**Document Creation**	**4th July 2018**	**E. Price**	
0.2	**UEC Team meeting feedback**	**9th July 2018**	**UEC team**	**Full plan review**
0.3	**Driver diagram updates**	**10th July 2018**	**I. Moses**	**Application of tasks**
0.4	**Driver diagram updates**	**10th July 2018**	**T. Emery**	**Application of tasks**
0.5	**Driver diagram updates**	**10th July 2018**	**C. Kelsey**	**Application of tasks**
0.6	**UEC Team Meeting review**	**16th July 2018**	**E. Price**	**Review of time line and deliverables**
0.7	**Plan update**	**18th July 2018**	**S. Barnard**	**Full draft review and approval**
0.8	**Update to drivers**	**18th July 2018**	**T. Emery / E Price**	
0.9	**Plan review and formatting**	**18th July 2018**	**I. Moses**	
1.0	**Draft to UEC ITB for review**	**19th July 2018**	**S. Barnard**	
1.1	**Revision of Project titles**	**25th July 2018**	**T. Emery/E Price**	**Finalisation of project titles**
1.2	**Revised driver diagram**	**26th July 2018**	**E. Price**	
1.3	**Revised workforce and digital template added**	**08th Aug 2018**	**M. Waistell**	
1.4	**Formatting amendments and addition of glossary**	**7th Sept 2018**	**E. Price**	

1. Introduction

Across Greater Manchester (GM), we are working together to radically reform public services. Our ambition is to improve outcomes for our people, increasing independence and reducing demand on public services. Health and social care reform is at the heart of the local reform agenda.

Our overarching vision for health and social care is to 'deliver the fastest and greatest improvement in the health and wellbeing of the 2.8 million people living across Greater Manchester.'

The delivery of high quality urgent and emergency care services is a critical part of the Greater Manchester reform programme and remains an ongoing challenge due to increases in demand for services, an ageing population with increasingly complex conditions and developing a workforce for the future.

Equally, these challenges, alongside devolution, provide an opportunity for Greater Manchester to fundamentally re-think our approach to urgent and emergency care, with innovation at the heart of what we do; testing new models of care, utilising technology and systems working.

The four-hour A&E waiting time target is a pledge set out in the NHS Mandate. The operational standard is that at least 95% of patients attending A&E should be admitted, transferred or discharged within four hours. The measure is a useful barometer of how the whole urgent and emergency care pathway is operating across health and social care. Equally, achievement of this target requires a whole system effort that can only be delivered through effective collaboration and partnership working.

A white paper on Urgent and Emergency Care (UEC) reform was published by the Greater Manchester Health and Social Care Partnership in March 2017. This has provided a blueprint for us to engage further with localities and key stakeholder groups to design an improvement and transformation programme for the next two years.

2. Vision and Aims

Following some early engagement we have developed the following vision and aims for the Urgent and Emergency Care Improvement and Transformation Programme.

"Our vision for Greater Manchester is to work together to support people to stay well and to provide the highest quality urgent and emergency care that is safe, coordinated and patient-centred.

Our services will be easy to access and understand. Patients will tell their story once, be treated with compassion and receive care as close to home as possible."

This is underpinned by four principle aims:

1. We will develop and deliver GM standards of care for the whole urgent and emergency care pathway, which fully meet the needs and rights of our population, in line with the NHS constitutional standards, best evidence and national guidance.

2. We will provide an equitable and fully integrated urgent and emergency care service for patients with physical, mental health or social care needs, via localities across the whole of GM.

3. We will harness technology, collaborative working and information sharing so that the population of GM will be able to access the right advice, care or support in the right place, first time.

4. Year on year, we will reduce attendances to Emergency Departments (ED) and reduce the length of stay for those admitted to an acute hospital bed by enabling patients to self-care and recover through improved primary, community and social care services working together. This will be underpinned by a philosophy of 'home first' wherever safe and appropriate.

3. Programme Design

There is system-wide recognition that urgent and emergency care is inherently complex due to the diverse range of services, organisations and requirement to work across geographical and organisational boundaries. As a result, many of the problems and potential solutions remain ill-defined and will require an iterative development process using tests of change.

On this basis, the programme has been designed (and will be delivered) under the principles of improvement science and large scale transformational change (see figures 1 and 2 below). On this basis, the Greater Manchester Health and Social Care Partnership (GMHSCP) UEC team will work with systems to ensure the correct level of support is provided to enable systems to deliver the plan.

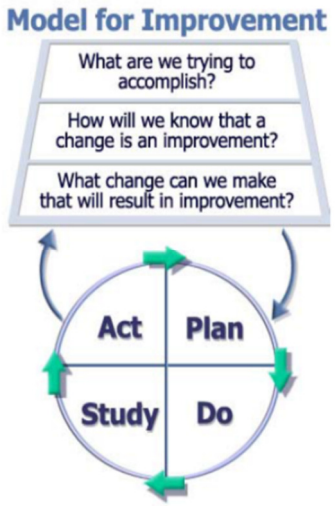

Figure 1

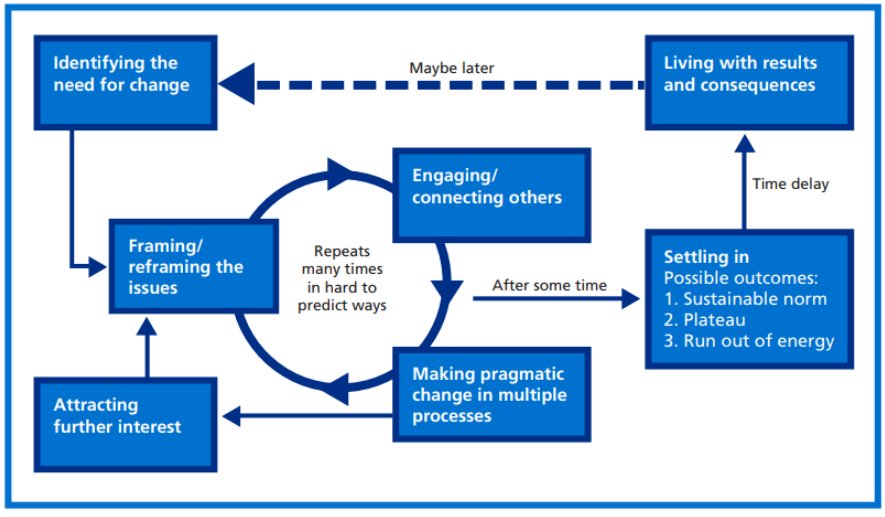

Figure 2

The plan has been co-produced with over 130 stakeholders across Greater Manchester. An early part of the design work was the identification of what we need to do consistently well to achieve our

programme aims – our primary drivers. The four primary drivers identified were Stay Well, Home First, Patient Flow and Discharge and Recovery.

The four primary drivers have been developed into the four principle work streams for the programme. For each work stream, we have an agreed Senior Responsible Office (SRO) from the wider Greater Manchester system. These SROs are senior system leaders from provider, commissioning and clinical roles associated with urgent and emergency care.

Four rapid design workshops (one for each work stream) were held in early June 2018. These workshops provided an opportunity for localities and stakeholders to contribute to the design of the programme and also to highlight areas of good practice that can be built upon within the programme. The workshops have also helped bring together existing urgent and emergency work into one single plan to reduce unnecessary complexity within systems.

The outputs across all of the workstreams have been reviewed and considered with a view to interdependencies, themes and specific deliverables. In total, nineteen specific service improvements have been identified and grouped into workstream areas which will be underpinned by enabling workstreams such as workforce, systems operations, system measurement, digital interoperability, innovations and communications. The enabling workstreams will run for the full duration of the programme until March 2020.

Figure 3 on the following page is the Driver Diagram for the UEC Improvement and Transformation Programme. This is 'our theory of change'. The diagram sets out the aims of the programme, the high level outcomes, and the changes we plan to test, with timescales for wave 1 and wave 2 projects.

It is recognised in the development of the plan that, while there are four separate work streams, there is a significant overlap in terms of operation of the UEC pathway and how patients transition through. The programme structure and governance will ensure that the four work streams remain connected to ensure design and delivery of a fully integrated and seamless pathway of care.

The plan sets out a series of 'Wave 1' deliverables, which are to be achieved in advance of, or during, winter 2018. The reminder of the plan is described as 'Wave 2' activities, which will commence in Q4 of 2018 and through to 2019/20.

Figure 3

Greater Manchester Urgent & Emergency Care Reform and Transformation Driver Diagram – "Our theory of change"				
Our vision for Greater Manchester is to work together to support people to stay well and to provide the highest quality urgent and emergency care that is; safe, coordinated and patient-centred. Our services will be easy to access and understand. Patients will tell their story once, be treated with compassion and receive care as close to home as possible."				
What are we aiming to achieve?	**How will we measure success?** (Outcome /Impact Measures)	**Primary Drivers** (What we need to do consistently well to achieve the aim)	**Secondary Drivers** (The changes (identified via workshops) that we believe will positively impact on the primary drivers and help achieve the aim)	**Timeline**
1. We will develop and deliver GM standards of care, for the whole urgent and emergency care pathway, which fully meet the needs and rights of our population, in line with the NHS constitutional standards, best evidence and national guidance. 2. We will provide an equitable and fully integrated urgent and emergency care service for patients with physical, mental health or social care needs, via localities across the whole of GM. 3. We will harness technology, collaborative working and information sharing so that the population of GM will be able to access the right advice, care or support in the right place, first time. 4. Year on year, we will reduce attendances to Emergency Departments and reduce the length of stay for those admitted to an acute hospital bed by enabling patients to self-care and recover through improved primary, community and social care services working together. This will be underpinned by a philosophy of 'home first' wherever safe and appropriate.	• Potentially avoidable attendances at A&E referred from elsewhere in the system • Proportion of attendances at type 1 A&E that are self-referred • Emergency admissions for urgent care sensitive conditions • Emergency admission rates for cases that can be managed outside hospital (avoidable)	**Stay Well**	**Wave 1 Change Projects**	
			Early Identification of Frailty	October 2018 to March 2019
			Flu Immunisation Programme	September 2018 to March 2019
			Wave 2 Change Projects	
			Community Navigation	3rd September 2018 to 31st March 2019
			Improved access to Care Planning	August 2018 to March 2019
		Home First (Attendance & Admission Avoidance)	**Wave 1 Change Projects**	
			Design and test Integrated Urgent Care Service (including UTC's) in 5 localities	July 2018 to March 2019 (Test bed go live 1st November 2018)
			Health Care Professional Referral Management	June 2018 to December 2018 (Go live 1st November 2018)
			Nursing and Residential Triage Tool (NaRTT) implementation	June 2018 to December 2019 (Go live 1st December 2018)
	• Number and proportion of stranded patients (pts with a LoS of 7 days or more) • Number and proportion of super-stranded patients (pts with a LoS of 21 days or more) • Bed occupancy level • Discharge to normal place of residence • Number and proportion of delays attributed to social care • Number and proportion of patients whose ongoing health and social care needs are assessed on an acute site.	**Patient Flow**	**Wave 1 Change Projects**	
			Early discharge planning and patient flow	August 2018 to April 2019
			Length of Stay reviews- standard operating procedure	August 2018 to January 2019
			Frailty Response at the Front Door (Emergency Department)	July 2018 to September 2019 (Go live 1st December 2018)
			Ensure safe and effective care in Emergency Departments	August 2018 – August 2019
			Ambulance handover at Hospital	June 2018 to September 18 (Go live 1st September 2018)
			Wave 2 Change Projects	
			Ambulatory Care	January 2019 to September 2019
		Discharge & Recovery	**Wave 1 Change Projects**	
			Trusted Assessor	July 2018 to 30 August 2019 Go live 1st October 2018
			Patient Choice	July 2018 to April 2019 Go live 1st October 2018
			PTS Discharge Profiling	June 2018 to February 2018
			Transfer and Repatriation	July 2018 to August 2019
			Wave 2 Change Projects	
			Integrated Transfer Team and Standard Operating Model	May 2018 to December 2018
			Review transfer pathways for patients with complex needs	July 2018 to August 2019
Enabler Projects	**Systems measurement** – Data quality/Data sharing and interdependency mapping **Systems operations** – resilience/demand management and responsiveness **Workforce planning** – GM staff bank/standardisation/governance **Digital** – technical interoperability and innovation			

Appendix A contains high level project plans for each of the individual workstreams and enabler projects. Each project plan has an identified objective, rationale for the proposed change, an explanation of what good looks like and a suite of measures.

The plans describe different approaches to managing the changes. For example, some are described as co-ordinated tests of change across Greater Manchester, some are more about further review and development of new models or standards and some are focussed on implementation (where the required change and next steps are more clearly understood).

4. Programme Timescales

The high level timescales for the Wave 1 projects are set out in figure 4 below. The UEC programme will be live following UECITB approval until the 31st March 2020. Provided below, are the high level timelines for each of the Wave 1 projects.

						Key		Preparatory phase
	Wave 1 UEC Projects							Go live
ID	Workstream	Project	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18
1	Stay Well	Early Identification of Frailty				TBC		
2	Stay Well	Flu immunisation programme						
3	Home First	Design and test Integrated Urgent Care Services including Urgent Treatment Centres in five localities						
4	Home First	Nursing and Residential Tool (NaRT) implementation						
5	Home First	Healthcare Professional referral management						
6	Patient Flow	Ambulance handover at hospital						
7	Patient Flow	Ensure safe and effective care in ED (GP streaming and ED safety checklist)						
8	Patient Flow	Frailty response at the front door- Emergency Department						
9	Patient Flow	LoS reviews- standard operating procedure						
10	Patient Flow	Early discharge planning and patient flow						
11	Discharge and Recovery	Trusted Assessor						
12	Discharge and Recovery	Patient Choice						
13	Discharge and Recovery	Transfer and repatriation						
14	Discharge and Recovery	PTS discharge profiling						

Wave 2 projects will commence in Q4 2018/19 with the final timelines to be confirmed following further discussions with the wider system.

5. Locality-Level Actions

The strategic approach to implementing the programme is that each locality will take ownership of the realisation of each work stream/projects within their area with the UEC programme team assuming a facilitative/supportive role to deliver service improvement across a number of organisations/services with a view to influencing and improving system working and development. The expected outputs of the programme will be the development of new models of care, standardised clinical and good practice guidelines that can be adopted across the GM footprint.

Locality Urgent Care and Delivery Boards will be expected to review the Greater Manchester UEC Improvement and Transformation Plan and undertake a local baseline assessment against the plan.

Locality Urgent and Emergency Care Delivery Boards will be expected to provide a response to the GMHSCP by the end of August 2018 and have developed or adapted local planning by the end of September 2018.

Locality Urgent and Emergency Delivery Boards will be expected to align their agendas to reflect the structure of the GM UEC Improvement Plan with regular monitoring and reporting against agreed metrics.

6. Work Stream Project Details

6.1 Stay Well

GMHSCP recognises the importance in enabling people to stay well which is predicated upon the prevention of ill health, early intervention when required and self-care. As such the overall purpose of the Stay Well work stream is to support people to stay well, building community resilience enabling GM citizens to access care and support in the community, reducing the need for escalation to emergency care and to make decisions and choices when their health changes, improving outcomes for patients and the GM system.

The four key projects for this workstream include:

- Community navigation
- Early Identification of Frailty
- Improved Access to Care Plans
- Flu Vaccination Programme

A GM wide staying well communications plan be developed and mobilised through the existing GM UEC Communications sub group.

6.2 Home First

The purpose of the workstream is to ensure that when patients need to access to urgent or emergency care that the right care can be accessed at home or as close to home as possible via working with the wider whole local healthcare system thereby reducing the requirement for urgent and emergency escalation, improving outcomes for patients and the GM system.

- The primary focus of this workstream will be the development of an outline specification for locality based integrated urgent care services which will be tested in four localities within GM. The specification will include but is not limited to, a range of supporting services with links and consideration to emerging urgent care treatment centres. This will include Ambulance 999/111 demand management processes and NHS 111 online.
- Health Care Professionals (HCP) referral management: This project is intended to improve the process of flow of referrals to acute care from the community, matching capacity and demand and improving patient experience and outcomes.
- The Nursing and Residential Home Triage Tool (NRHTT) project is intended to reduce the number of 999 calls received from Care Homes and subsequent avoidable escalation to Accident and Emergency departments (A&E), by the provision of education and training to Care Home staff.

6.3 Patient Flow

The overall purpose of the work stream is to facilitate patient flow through hospital by reducing lengths of stays, delayed transfers of care and through the development and utilisation of best practice methodology. The work stream will promote sharing of good practice, new models of care, improved analysis and system level understanding which in turn will improve outcomes for patients and the Greater Manchester system. Improving patient flow is central to patient experience, clinical safety and reducing pressure on staff. Without this, patients may find themselves on wards unsuitable for their care; delays can lead to poorer patient and carer experience including increased harm caused to patients and inefficient use of hospital resources. Emergency departments (ED) can, as a result, become crowded, unsafe and as a consequence, routine activities are not undertaken in a timely fashion. Ultimately outcomes for patients are worse, particularly for frail older people who are the highest users of acute hospitals in Greater Manchester.

The identified project areas are:

- Improving Ambulance handover/turnaround at hospital: This project aims to reduce variation in ambulance handover at A&E thereby maximizing the availability of resource to respond to 999 calls and reduce the risk to emergency patients waiting for an ambulance response in the community.
- Frailty Response at the Front Door (ED) Model: This project will scope existing models, develop clinical standards across GM to manage frailty at the front door of ED, implement test site(s), and to agree a GM model which can be commissioned across the GM area.
- Ensure Safe and Effective Care in ED: This project will improve the processes and functioning of ED's across GM to support safe and effective patient care and zero tolerance of minor breaches of the ED 4 hour standard.

- Early discharge planning and patient flow: Currently the approach to discharge planning is inconsistent and does not routinely commence early in the patient journey leading to delays in discharges and associated increases in delayed transfers of care.
- Ambulatory Emergency Care (AEC): EDs in GM have become the default position for the majority of urgent and emergency care where many of the patients could and should be managed through the use of ambulatory emergency care services such as community IV services, outpatients or hot clinics. This project is intended to maximize the implementation of AEC across GM to ensure timely evidenced based care thus supporting the improvement of patient flow.
- Implementation of a standard operating procedure to carry out length of stay (LoS) reviews to ensure GM consistency, in terms of methodology, coding, system intelligence and identification of opportunities to reduce LoS.

6.4 Discharge and Recovery

The purpose of the work stream is to assist care systems across GM to safely transfer patient care back into the community setting, supporting patients back to their normal place of residence, and improving outcomes for patients and the GM system.

The identified project areas are:

- Trusted Assessor model for Care Homes: To develop and test a GM Trusted Assessor model which can then be rolled out across GM, reducing the delay for patients awaiting care home assessment and improving the ability to transfer of patients in line with expected date of discharge. This will also support care homes to have confidence that the approach will not compromise Care Quality Commission (CQC) registration.
- Transfer and repatriation: There are known delays in the transfer and repatriation of patients within and outside of the GM area. Adoption of the Acute Hospitals Repatriation Policy, systematic use of agreed escalation routes in a timely fashion and oversight by the GM UEC Hub is expected to reduce delays, develop integrated system working and improve patient experience and outcomes.
- Supporting phased implementation of the common GM Patient Choice Policy and Standards: Patient and family choice is identified as one of the top five reasons for delay across GM. A patient choice policy is in place across GM, but this is not consistently applied and as a result discharge planning is not optimised resulting in delays of transfer/discharge and reduced outcomes for patients.
- GM integrated transfer (discharge) team standard operating model: Across GM there are multiple transfer teams with variable staffing models and operational procedures including documentation. The variation in practice as a result impacts adversely on LoS. This project will seek to define a standardised model which can be implemented across the GM footprint.
- Patient Transport Service (PTS) discharge profiling: This project aims to reduce the number and unnecessary duplication of abortive PTS journeys from acute hospitals and release

capacity back into the system. This will ultimately inform the future commissioning of patient transport services in Greater Manchester.

- Review transfer pathways for patients with complex needs including people with memory loss, dementia and delirium to ensure there is care home capacity for patients with complex needs. The current care home bed capacity across GM is underutilised and does not meet the needs of those patients with complex needs leading to delays in transfers of care

7. Programme Governance

7.1 Structure

The proposed UEC governance structure is set out in figure 5 below. The GM UEC Improvement and Transformation Board will meet every two months and be responsible for overseeing delivery and review of the UEC Improvement and Transformation Programme.

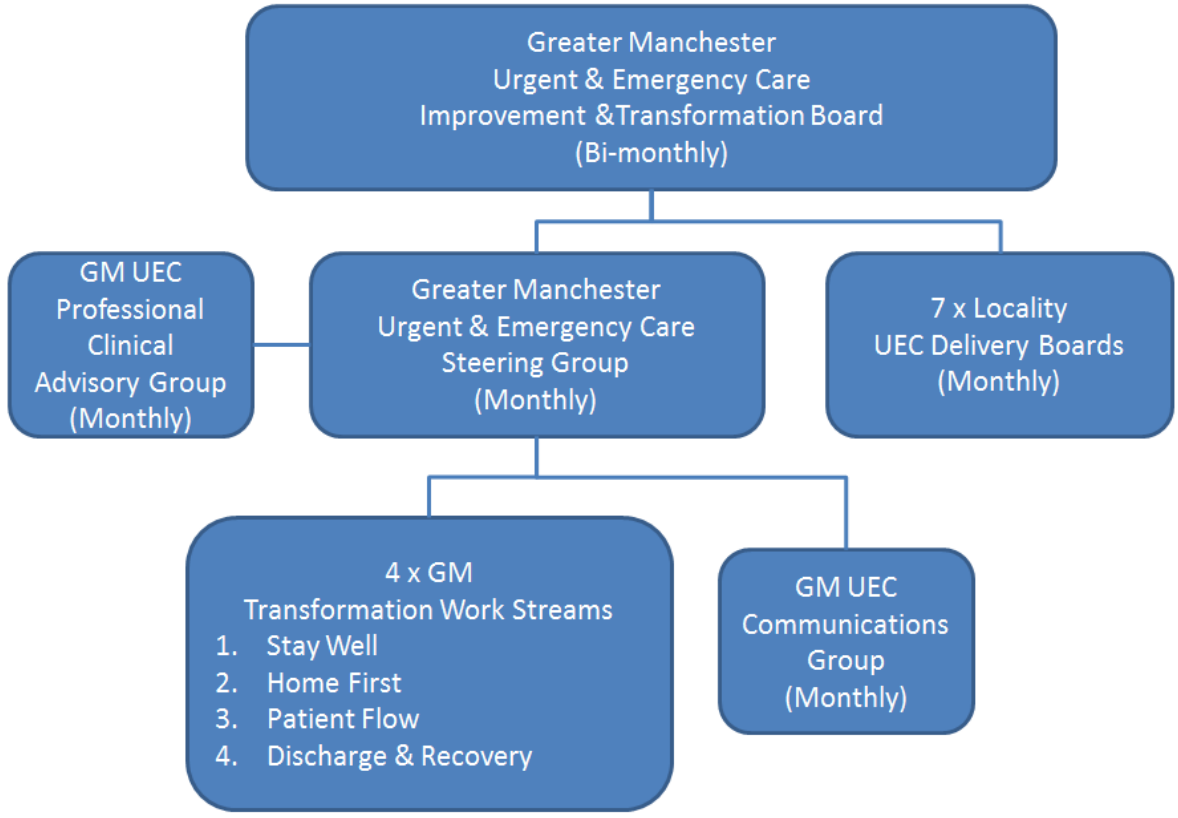

Figure 5

The Locality UEC Delivery Boards will be expected to adopt the same core agenda as the GM board to ensure a system-wide approach to the same priority areas and full alignment with the transformation plan.

The Professional Clinical Advisory Group will have a membership that is representative of professional groups and clinical staff (including social care). The board will be responsible for the design of clinical pathways or models of care, including the development of GM UEC clinical standards. The board will also be responsible for reviewing the UEC pathway quality and safety. This group will be chaired by the GM UEC Clinical Lead.

The GM UEC Steering Group will consist of the UEC Improvement and Transformation Board Chairs, the work stream SROs and members of the GMHSCP UEC Team. They will meet monthly to review the UEC transformation work programme at a more tactical level. The group will be responsible for supporting development of the programme, reviewing progress, risk management and helping to provide assurance to the UEC Transformation Board.

The oversight of UEC performance will be monitored through the GM Performance and Delivery Group on a monthly basis.

7.2 Programme Reporting and Controls

- Agreed governance approach is in situ
- Monthly UEC programme highlight reports will be provided
- Locality GM UEC Boards will oversee locality development and performance on a monthly basis
- GM UECITB to track progress on locality plans via dashboard with reporting by exception and action learning style approach for shared issues/common areas of concern
- GM UECTIB to identify locality support requirements and develop a support offer
- GM UEC Professional Clinical Advisory Group to oversee clinical impacts and to provide expert clinical advice
- Briefing updates to be provided to the Director of Operations group on an agreed reporting basis
- Application of the use of agreed project methodology including risk and issue management
- Communications both internal and external to GMHSCP

7.3 Risk and Issue Management

- Risks and Issues will be managed at both the programme and project levels.
- The Programme Manager will maintain a log for all risks and issues affecting the overall programme and those escalated by project managers.
- All risks and issues will be allocated to a named individual for resolution purposes.
- A standard risk and issue log template is in place, the embedded document provides the current risks and issues for information.

UECRisk and Issues Template August201

8. Assumptions

The following assumptions apply:

- That national policy will not deviate significantly from existing strategy
- That there will be full GMHSCP Executive support for the programme
- That the previous allocation of the GM Transformation Fund will support the implementation of this programme
- That there is an available workforce pool to staff the programme team and associated project/task and finish groups
- That Commissioners, Localities and External Stakeholders will be fully supportive and engaged
- Sufficient resources will be available to deliver the work-streams when internal resources have been utilised to the full
- That there will be the provision of specialist support to deliver specific aspects of the programme, for example business intelligence

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9. Appendices and Programme Drivers

Primary Driver- Stay Well – WAVE 2 SRO: Claudette Elliott Service Improvement Lead: Ian Moses	
Action: Community Based Navigation **For: Test of change**	**GM Collaborative Improvement Approach/ Locality Actions** **Start Date:** 3rd September 2018 **End Date:** 31st March 2019 **Duration:** 180 days
Objective: To develop a consistent community based navigation offer across all GM Localities which helps people to stay out of hospital, which support the turnaround of patients arriving at ED and supports discharge planning.	
Rationale: We know that there is a need to engage with vulnerable individuals to ensure that their health and social care needs are being met as early as possible, preventing escalation of chronic illness, or the avoidable exposure to illness. Additionally, recognising the issue of social isolation resulting in access to health care, there is an opportunity to bring together health and social care assets to help patients stay well. GM has a variety of service models and staff providing community navigation functions in various ways. The approach is inconsistent and people are not fully supported to access the services that best meets their needs in a timely manner.	
What does good look like: ***People will be provided with care navigation at any point along a care pathway which will utilise an asset based approach and include social prescribing.***	

Locality Actions		Timeline	**GM Actions**		Timeline
1	*Locality identification of test bed sites – draw upon current GM practice*	*September 2018*	***1***	*GM to scope current models operating across GM*	*During August 2018*
2	*Locality test bed site commences test of change (TOC)*	*Sept 2018 to March 2019*	***2***	*GM to deliver workshop to refine the test model including approach to those people at risk of frailty*	*By end August 2018*
3	*Locality provides benefits analysis and lessons learnt*	*March 2019*	***3***	*GM to develop/ test/evaluate model in the community and at the front door of ED. Potential test area Wythenshawe and the Red Cross*	*October 2018*
4	*Subject to successful evaluation roll out of approach across GM*	*April 2019*	***4***	*GM evaluation of TOC.*	*March 2019*
Metrics • *For identified high intensity users a reduction in the rate of utilisation of other services.*		**Guidance** http://www.pat.nhs.uk/our-services/navigator-service.htm ..\..\Project Planning\Social Prescribing fwk.pptx Social Prescribing framework.docx			

Primary Driver- Stay Well – WAVE 1 SRO: Claudette Elliott Service Improvement Lead: Ian Moses	
Action: Early identification of frailty **For: Implementation**	**GM Collaborative Improvement Approach/ Locality Actions** Start Date: October 2018 End Date March 2019 Duration: 180 days
Objective: Early identification and assessment of the risk of Frailty via UEC responses such as NWAS 999/PTS.	
Rationale: To identify initial points of contact where an early frailty assessment can be undertaken to increase the levels of identification of frailty and subsequent care planning to enable people to stay as well as possible.	
What does good look like: All patients identified as meeting a frailty threshold will have a frailty baseline assessment. This assessment will be available to a range of professionals who may be involved in the patient's care, including in the acute and emergency setting.	

Locality Actions		Timeline	GM Actions		Timeline
1.	*Localities to adopt the GM Frailty Charter principles*	*TBC, dependent upon the launch of the GM Charter*	***1***	*GM/NWAS to agree the frailty assessment tool to be used (Rockwood)*	*August/September 2018*
2	*Localities to test the frailty model in their UEC environment*	*October 2018 to March 2019*	***2***	*GM to meet with NWAS to identify two areas within which a new model can be tested*	*October 2018*
3	*Localities to explore the use of community based Consultant outreach (extensivists) in their areas to support frailty management.*	*October 2018 to March 2019*	***3***	*NWAS to educate staff on the identification of frailty*	*October 2018*
			4	*GM/NWAS to prepare patient pathway for 999 and PTS crews*	*November 2018 to Mar 2019*
			5	*GM/NWAS to agree procedure for escalation based on outcome of assessment*	*November 2018 to Mar 2019*
			6	To develop and roll out a common shared record service allowing access to t patient data and visibility of current frailty assessment.	By March 2019

Metrics

- *Number of patients by practice who have a frailty assessment in place*
- *Adoption of a common frailty assessment by NWAS*
- *Number of NWAS staff trained in use of agreed frailty assessment*
- *Number of patients by practice who are identified with frailty by NWAS/PTS*

Guidance

http://www.bgs.org.uk/campaigns/fff/fff_full.pdf

http://www.bgs.org.uk/fitforfrailty-2m/campaigns/fit-for-frailty2/fff2-campaign/fff2-lite-vn

https://www.england.nhs.uk/ourwork/ltc-op-eolc/older-people/frailty/supporting-resources-general-practice/
https://improvement.nhs.uk/resources/good-practice-guide-focus-on-improving-patient-flow/

Primary Driver- Stay Well – WAVE 2 SRO: Naveen Riyaz Service Improvement Lead: Ian Moses	
Action: Improved access to care plans **For: Development**	**GM Collaborative Improvement Approach/ Locality Actions** Start Date: August 2018 End Date: March 2019 Duration: 173 days
Objective: To review NWAS ability to access current care plans for identified people with LTC's via the use of tablet based electronic records at the point of care	
Rationale: To develop an interim solution for winter that will support the reduction of avoidable transfers of patients to ED	
What does good look like: At the point of care NWAS will be able to access an up to date current care plan for patients with LTC's. This will ensure that patients are cared for in the most appropriate setting.	

Locality Actions		**Timeline**	**GM Actions**		**Timeline**
1.	*Locality to undertake a baseline assessment of patients identified with a LTC and % of patients identified who have a current care plan in place.*	*To commence 1st August 2018*	***1***	*GM to develop a self-assessment process for use by Localities in partnership with GMHSCP Primary Care. This self-assessment will include a threshold for inclusion and frailty levels.*	*To commence September 2018*
2	*Locality to develop a management plan to address to identified gap re patients with LTC's and care planning*	*To commence September 2018*	***3***	*GM to meet with NWAS to develop understanding of the NWAS tablet deployment timeline across GM so this can be aligned with Localities*	*September 2018*
3	*Subject to NWAS deployment time line to test electronic access to records within an identified Locality*	*September 2018*	***3***	*NWAS to develop and test the interface between MiG /Graphnet and mobile devices*	*September 2018*
4	*Test area to provide benefits summary*	*November 2018*	***4***	*GM/NWAS to develop a strategy for use noting the interdependencies with the emerging integrated urgent care service model*	*Sept 1018 to March 2019*
5	*Roll out the system across GM*	*November 2018 to March 2019*	***5***	*GM to coordinate NWAS electronic reporting function.*	*Sept 2018 to March 2019*

Metrics • *Baseline number of ambulance attendances to patients with LTC by Locality* • *All Localities to complete self-assessment/review process* • *Number of plans available electronically on NWAS system / % of patients identified with high risk of exacerbation / calling 999* • *Number of patients on LTC register* • *Number of patients on LTC register with a care plan in place* • *Number of patients with a LTC who were supported to remain at home after a call to 999 or 111.*	**Guidance** https://www.england.nhs.uk/2017/03/next-steps-on-the-five-year-forward-view/
Notes	**This project has a clear interdependency with:** • **NWAS roll out of digital devices to responding paramedics and others** • **The Local Access to Health Record project**
Primary Driver- Stay Well – WAVE 1 SRO: Claudette Elliott Service Improvement Lead: Ian Moses	
Action: Flu vaccination programme **For: Development**	**GM Collaborative Improvement Approach/ Locality Actions** Start Date: 9th July 2018 End Date: 31st March 2018 Duration: 90 days/120 days
Objective: Improve the uptake of influenza vaccinations for patient groups at increased risk, health and social care staff groups from the 2017/2018 baseline.	
Rationale: To reduce the impact of influenza for at risk patients, NHS and Social Care staff groups	

What does good look like in 2018/2019:

Influenza immunisation uptake

Patients aged 65 years and over- 85% **(10% increase from the 17/18 national baseline)**
Aged under 6 months to under 65 years in a clinical at risk group - 65% **(10% increase from the 17/18 national baseline)**
All pregnant women - 65% **(10% increase from the 17/18 national baseline)**
Eligible children aged 2 and 3 years of age -65%
Schools programme, reception to year group 4 – 65%
Health and Social Care workers – 85%

NB GM achievement for 2 and 3 years in 2017/18 was 43.5% and 45.1% respectively, with national ambition being between 40-65%)

Locality Actions		Timeline	GM Actions		Timeline
1.	*Locality to review and understand Locality performance in 2017/18 and to develop an improvement plan*	*To be completed by 28.08.2018*	***1***	*GM to support the development of the GM Flu communications campaign*	

Metrics	Guidance
Number and percentage of vaccinations in each target group **Number of confirmed flu cases by Acute Trusts** **Number of confirmed flu cases by CCG**	**..\Documents\20180403 GMHSCP Final Flu Report 1718 Season Approved plus covernote.docx**

Primary Driver- Home First – WAVE 1 SRO: Naveed Riyaz Service Improvement Lead: Ian Moses	
Action: Design and test urgent care services (including UTCs) in 5 localities **For: Development & Test of Change**	**GM Collaborative Improvement Approach/ Locality Actions** Start Date: 6/07/2018 End Date: December 2018 Duration: 127days
Objective: To develop and test a locality/GM IUC model. This will include the management of NHS 111, Ambulance 999/111 demand processes and local coordination of community response capability and patient flow	
Rationale: There is a need to bring together the health and social care response to urgent care needs. This recognises the pressure upon acute trusts and the opportunity to develop a shared response model which brings clinical assessment further forward in the patient's journey, providing care sooner and closer to home.	
What does good look like: Establishment of four pilot test sites to test out the Locality integrated urgent care service model concept	

Locality Actions		Timeline	GM Actions		Timeline
1	*Identified Localities to implement IUC test hubs*	*To commence July 2018*	***1***	*GM to identify four locality test bed areas.*	*Complete*
2	*Approval of test bed sites*	*August 2018*	***2***	*GM to facilitate the development of an outline urgent care integrated service specification in coproduction with Localities and OOH alliance. Specification to include, but not limited to, digital requirements, direct booking with 111, DOS requirements, colocation of GM operational hub and operational dispatch, use of urgent care practitioners, availability of real time data feeds from Acute Hospitals and bed occupancy rates. The specification will reference potential phase 2 developments such as home visiting capability,*	*To be completed by 1.10.2018*
3	*Test bed sites to provide benefits and lessons learnt analysis*	*March 2019*	***3***	*GM to develop consistent metrics*	To be completed by 1.10.2018
4	*Remaining Localities to implement GM IUC Model*	*To be confirmed with remaining Localities*	***4***	*GM to facilitate funding discussions to support technological development (NHS Digital) of the IUC hubs*	By March 2019
			5	GM to coordinate the communication strategy to support implementation of test sites.	To be completed by 1.10.2018
			6	GM to lead a workshop on the implementation of Urgent Care centres in GM Localities	By end September 2018
			7	NWAS to set up/ action Clinical Dispatch system.	By September 2018

Metrics • *Hubs in place and established* • *Number of 111 calls managed and closed* • *Number of cat 3&4 ambulance calls managed and closed* • *Number of ED attendances avoided*	**Guidance** england.urgentcarereviews@nhs.net https://www.england.nhs.uk/publication/general-practice-forward-view-gpfv/ https://www.england.nhs.uk/2017/03/next-steps-on-the-five-year-forward-view/ https://www.england.nhs.uk/wp-content/uploads/2014/06/Integrated-Urgent-Care-Service-Specification.pdf https://www.england.nhs.uk/wp-content/uploads/2017/07/urgent-treatment-centres%E2%80%93principles-standards.pdf https://improvement.nhs.uk/resources/quality-service-improvement-and-redesign-qsir-tools/ https://www.england.nhs.uk/publication/urgent-treatment-centres-principles-and-standards/ http://www.gov.uk/government/uploads/system/uploads/attachment_data/file/304139/Transforming_primary_care.pdf https://improvement.nhs.uk/resources/developing-people-improving-care/ http://www.bgs.org.uk/pdfs/2016_bgs_commissioning_guidance.pdf
Notes	This project will necessitate a period of 'double running' for some component services in order to develop the test bed sites and included services, in particular in the management of Ambulance C3/4 activity. Similarly, the longer term model will be dependent upon technical interoperability between hubs in respect of telephony and patient assessment system platforms.

Primary Driver- Home First – WAVE 1 SRO: Naveen Riyaz Service Improvement Lead: Ian Moses	
Action: HealthCare Professional (HCP) referral management **For: Development**	**GM Collaborative Improvement Approach/ Locality Actions** Start Date: June 2018 End Date: November 2018 Duration: 106 days
Objective: To reduce the pressure in A&E created by arrival of HCP patients and provide an effective environment for delivery of the 4 hour A&E Standard.	
Rationale: To reduce the footfall of HCP referrals in A&E and mitigate the surges in activity that impact significantly on patient experience, safety and performance.	
What does good look like: HCP referrals arrive in an appropriate setting (Ambulatory care acute assessment units) away from A&E at pre-agreed times improving the patient experience and helping clinicians to provide safe and equitable care. **HCP demand spikes will be smoothed across the working day enabling better planning of receiving functions, reducing avoidable overnight admissions.**	

	Locality Actions	Timeline		GM Actions	Timeline
1.	Locality to undertake a baseline assessment of impacts from current HCP referral activity	To be completed by 28.08.2018	**1**	GM to collate Locality baseline assessments	To be completed by 28.08.2018
2	Stockport system to develop a PDSA to test alternative model	To be completed by 15th August 2018	**2**	GM to support development and delivery of model currently in testing in Stockport	July – August 2018
3	Stockport system to implement PDSA and monitor impact over week one and review	15-22 August 2018	**3**	GM to liaise with Stockport & NWAS to develop and monitor PDSA	15-22 August 2018
4	Stockport to revise model and adapt if required	To be completed 27th August 2018	4	Plan for GM wide test of change using learning from Stockport`	October 2018
5	Stockport to provide benefits analysis	To be completed by 14th Sept 2018			
6	Localities to develop and implement a HCP referral model which could include patient testing within UTC and primary care development	To be confirmed			

Metrics	**Guidance**
• *A&E Standard* • *Soft intelligence on feel in A&E* • *NWAS turnaround data*	https://www.england.nhs.uk/ourwork/demand-and-capacity/
Notes	**There is an interdependency between this project and the development of the GM locality integrated Urgent Care Hubs, as some of the management of lower acuity HCP demand may be managed first in the hub for either sorting and development of a 'landing slot' process, or the application of community diagnostic support prior to admission with associated virtual wards.** **The application of virtual wards is dependent upon the hubs, and available digital infrastructure for near patient testing and remote monitoring.** **The application of landing slots is dependent on availability of resources to undertake early assessment in the community, rather than waiting for the end of traditional GP surgery times. Urgent Care Practitioner schemes will be a way of managing GP home visits.**

Primary Driver- Home First – WAVE 1 SRO: Naveen Riyaz	Service Improvement Lead: Ian Moses
Action: Nursing and residential home triage tool (NRHTT) **For: Implementation**	**GM Collaborative Improvement Approach/ Locality Actions** Start Date: June 2018 End Date: December 2018 Duration: 106 days
Objective: To support care home staff in decision making – Nursing and Residential Home Triage Tool (NaRT)	
Rationale: To reduce the number of patients referred to 999 system and improve the outcomes for patients who do not require an A&E disposition.	
What does good look like: Care and residential homes across Greater Manchester are trained in the use of the tool resulting in a reduction in 999 calls and greater use of local system support services.	

	Locality Actions	Timeline		GM Actions	Timeline
1.	*Locality to undertake a baseline assessment of current Care Home 999 activity*	*August 2018*	***1***	*GM to develop a baseline assessments tool for localities to utilise and collate outputs.*	*Sept 2018*
2	*Locality to engage local care & residential homes and Local Care Organisations (LCO)*	*End of August 2018*	***2***	*GM to provide NRHTTtool and training*	*Oct-Nov 2018*
3	*Locality to develop plan to prioritise high 999 referral activity homes*	*Sept 2018*	***3***	*GM to ensure wider alignment into existing and planned care / residential home initiatives*	*Monthly*
4	*Locality to ensure care homes are aligned to timely access of local available schemes and services*	*Sept 2018*			
5	*Locality to monitor 999 activity generated by local care & residential homes in collaboration with neighbourhood teams*	*Monthly*			

Metrics	Guidance
• *999 calls from care/residential homes* Triangulate use of NaRT tool with local provision: • *Primary care support to care/residential homes with high 999 activity* • *Quality inspections of care/residential homes*	https://councildecisions.bury.gov.uk/documents/s14446/210984-LEAF013.pdf

Notes	Link with Winter Planning Process

Primary Driver- Patient Flow – WAVE 1 SRO: Jude Adams	Service Improvement Lead: Colin Kelsey
Action: Ambulance handover at hospital **For: Implementation**	**GM Collaborative Improvement Approach/ Locality Actions** Start Date: 1st June 2018 End Date: 30th Sept 2018 Duration: 61 days
Objective: To reduce the percentage of ambulance handovers that are delayed and reduce the number of ambulance turnaround times over 30 minutes.	
Rationale: To reduce variation in ambulance handover at A&E thereby maximising the availability of resource to respond to 999 calls and reduce the high risk to emergency patients waiting in the community.	
What does good look like: Each Acute site implements the Standards for Greater Manchester - Ambulance Handover Process **Increase the number of turnarounds achieved in less the 30 minutes on all GM acute sites.**	

	Locality Actions	Timeline		GM Actions	Timeline
1.	*Local UEC Boards sign up to the 5 GM Principles within the AH standards*	*August 2018*	***1***	*GM UEC Delivery Board approve AH standards*	*July 2018*
2	*Acute Trusts work towards adopting the 3 GM and AH standards*	*Aug – Sept 2018*	***2***	*GM UEC to develop and implement the improvement work to reduce the demand within Stay Well workstream*	*Ongoing*
3	*Acute Trusts review local model against the ECIST Gold Standard Front Door*	*Sept 2018*	***3***	*GM UEC improvement work on HCP referrals to minimise demand on A&E at peak times*	*October / November 2018*
4	*Local systems monitor delivery against the defined metrics*	*Weekly*	5	GM UEC Board to review Handover Standard at least annually.	Annually
5	System RCA for long delays >30 and remedial action in Local UEC Boards	Monthly			

Metrics

- ***Average turnaround per site against the agreed maximum 30 minute standard***
- ***Reduced variation across GM in relation to turnarounds exceeding 30 minutes***
- ***Compliments/complaints received from patients / families relating to the arrival or handover at ED***
- ***The number of serious incidents / StEIS associated with long handover delays***

Guidance

Safer, Faster, Better illustrates wider UEC actions that can improve ambulance handover:
https://improvement.nhs.uk/resources/safer-faster-better-transforming-urgent-and-emergency/

Tactical Advice to Hospitals and Ambulance Services:
https://improvement.nhs.uk/documents/848/ECIP_Reducing_Ambulance_Handover_Delays_March_2017.pdf

https://nhsicorporatesite.blob.core.windows.net/green/uploads/documents/Patient_Flow_Guidance_2017___13_July_2017.pdf

Notes:	**GM UEC improvement work on patient flow and discharge and recovery workstreams for example ambulatory care, LOS reviews and improved discharge processes.**

Primary Driver- Patient Flow – WAVE 1 SRO: Jude Adams		Service Improvement Lead: Teresa Emery			
Action: Frailty response at the front door (emergency department) **For: Implementation/Development /Review**	**GM Collaborative Improvement Approach/ Locality Actions** Start Date: July 2018	End Date: September 2019	Duration:316 days		
Objective: To develop and implement a front door frailty model for GM.					
Rationale: Identification and management of people who are frailty at the front of the hospital has been identified as best practice.					
What does good look like: There is early identification of people who are frail and are presenting at ED in line with the GM preferred frailty identification tool. All acute trusts have an evidence based frailty response at the front door.					
Locality Actions		**Timeline**	**GM Actions**		**Timeline**
1.	*Locality to undertake a baseline assessment of current frailty provision at the front door across GM.*	*To be completed by 31. 09.2018*	***1***	*Develop a GM baseline assessment tool. Identify and share best practice for managing frailty across GM. Identify and facilitate opportunities to provide peer support for implementation.*	*31.08.2018*
2	*Locality to develop a management plan to address identified gaps and develops a test of change to implement a frailty model.*	*To be completed by 31.11.2018*	***2***	*Work with Professional and Clinical Advisory Group to develop a GM specification which describes the minimum requirement for frailty provision at the front door, based on GM and national best practice.* *Workshop to be established with interested leads across GM.*	*30.10.2018*
3	*Locality to implement frailty PDSA*	*To be completed 31.12.18.Localities who wish to implement earlier will be supported to do so.*	***3***	*Evaluate and spread learning from early tests of change.*	*From January 2019.*
4	*Phased implementation of front door frailty offer which meets GM specification.*	*To be completed by 31.08.2019*			
Metrics • ***TBC with the GM Professional Clinical Advisory Group.***		**Guidance** **Patient flow guidance:** https://improvement.nhs.uk/documents/1426/Patient_Flow_Guidance_2017___13_July_2017.pdf **Acute frailty network:** https://www.acutefrailtynetwork.org.uk/			

Notes	**Front door model to include best practice identified by Patient Flow Guidance and Acute Frailty Network and describe the minimum MDT and assessment requirements of the model. GM offer: There is the potential to carry out a 6 A's audit and/or ambulance arrivals audit based on the ECIP methodology. Phase 2: There is the potential to explore the development of acute frailty units across GM.**

Primary Driver- Patient Flow – WAVE 1 SRO: Jude Adams Service Improvement Lead: Teresa Emery

Action: Ensure safe and effective care in emergency departments **For: Development/ Implementation**	**GM Collaborative Improvement Approach/ Locality Actions** Start Date: August 2018 End Date: August 2019 Duration: 365 days

Objective: Improve the processes and functioning of emergency departments across GM to support improving safe and effective patient care and zero tolerance of minor breaches of the ED 4 hour standard

Rationale: ED performance remains challenged across GM.

What does good look like: All patients attending an emergency department should receive timely assessment and clinically appropriate high quality care

	Locality Actions	Timeline		GM Actions	Timeline
1.	*Locality to undertake a baseline assessment of current implementation of ED safety checklist*	*To be completed by 28.08.2018*	***1***	*Develop ED checklist baseline assessment tool. GM Urgent and Emergency Care Professional Clinical Advisory Group to develop model for implementation of the ED safety checklist across GM*	*15.10.18*
2	*Systems to establish test of change to implement ED safety checklist*	*To be completed by 31.10.18*	***2***	*Develop a GM ED care bundle with the GM Urgent and Emergency Care Professional Clinical Advisory Group, early model for test to be available in November 2018.*	*28.02.2019*
3	*ED safety checklist to be in place across all EDs in GM with continued QI approach to refine and improve application*	*To be completed by 31.12.18*	***3***	GM to run a workshop and support (to be agreed) for implementation of the ED safety checklist	31.10.18
4	*Systems develop tests of change and identify ambition for adopting the ED care bundle*	*To be completed by 31.11.2018*	***4***	Complete reviews of ED GP streaming services across GM to identify	20.09.2018
5	Early test of ED care bundle on a small number of sites.	To start from 01.12.2018. Early adopters can go live earlier and will be supported to do so.	5	Share best practice for GP ED streaming and identify opportunities for improvement.	22.10.2018
6	Systems develop tests of change and identify ambition for adopting the best practice for ED GP streaming services	31.12.2018	6	Develop and agree a GM standard for GP ED streaming and integrated urgent care services, which takes into account cost effectiveness.	30.11.2018
7	Phased implementation of tests of change.	From 01.04.2018, full implementation across GM by 30.09.2019	7	Share best practice and identify from ED care bundle and opportunities for improvement.	On-going

Metrics • ***Proportion of ED attends streamed to GP ED service*** • ***Proportion of ED minor attends streamed to GP ED service*** • ***Minors attends performance against the 4 hour ED standard*** • ***4 hour ED performance***	Guidance GP ED streaming: https://www.england.nhs.uk/wp-content/uploads/2017/07/principles-for-clinical-streaming-ae-department.pdf

Primary Driver- Patient Flow – WAVE 1 SRO : Jude Adams	Service Improvement Lead: Teresa Adams
Action: Early discharge planning and patient flow **For: Implementation/Development /Review**	**GM Collaborative Improvement Approach/ Locality Actions** Start Date: 1st August 2018 End Date: 31st April 2019 Duration: 283 days
Objective: Establish early discharge planning for all patients admitted to an acute hospital and improve patient flow	
Rationale: Discharge planning does not routinely happen early in the patient journey, leading to delays in discharging patients requiring supported discharge. This results in extended hospital stays for patients and poor patient flow.	
What good looks like: There is early identification of people who are likely to require support on discharge from an acute setting. On admission all patients and their carers are actively involved in planning their care including what is important to them and to support discharge or transfer of care. They will be provided with the key information on when they are likely to go home and how to access services, enabling them to plan and make informed choices to support safe and timely transfers of care.	

	Locality Actions	Timeline		GM Actions	Timeline
1.	Implementation of key elements of the SAFER patient flow bundle: Systems continue to implement the SAFER patient flow bundle for example board rounds and flow from assessment areas to wards by 10 am.	On-going	**1**	Work with the GM Urgent and Emergency Care Professional Clinical Advisory Group meeting to develop and describe the senior clinical role in supporting early discharge planning: • Engage with clinicians to develop consistent application of Expected Dates of Discharge (EDDs) • Establish GM model to enable senior clinician attendance and active participation in board rounds	31.11.18
2	*Implement delivery of 33% of discharges by 12 midday across all systems.*	*To be completed by 31st December 2018*	***2***	*Develop approach for reducing waits for patients who are not medically optimised.* *Explore use of Appropriateness Evaluation Tool or similar audit tools to understand the potential opportunities to support timely delivery of care.*	*28.02.2019*
3	*Identify systems who will test standardised discharge documentation and implement test of change*	*To be completed by 31st December 2018*	***3***	***Interdependency with Discharge and Recovery:*** *Development of patient facing early discharge planning resource for use by Trusts on admission to hospital to support patient flow.*	*28.02.2019*
4	*Roll out of standardised discharge documentation across GM.*	*September 2019*	***4***	*Evaluate impact of tests of change for implementing discharge planning resource.* *Develop implementation plan across GM.*	*31st April 2018*
5	*Localities to review flow coordinator role against current practice and identify where it would add value to implement.*	*To be completed by 31.09.2018*	***5***	*Describe 'Flow Coordinator' role and share across GM*	*31.09.2018*
6	*Identified localities to implement flow coordinator roles*	*To be completed by 31.12.18*			

Metrics • ***Proportion of discharges by 12 midday*** • ***Stranded patient metrics*** • ***Reduction in LoS***	**Guidance** **SAFER Patient flow bundle** https://improvement.nhs.uk/resources/safer-patient-flow-bundle-implement/
Notes:	**Enablers: SAFER, Red2Green, EndPJparalysis** **Phase 2: explore GM ambition that patients who are clinically optimised should not be in hospital >than 24 or 48 hours.**

Primary Driver- Patient Flow –WAVE 2 SRO: Jude Adams	Service Improvement Lead: Teresa Emery
Action: Ambulatory care **For: Development /Test of change**	**GM Collaborative Improvement Approach/ Locality Actions** Start Date: August 2018 End Date: August 2019 Duration: 365 days
Objective: To maximise the implementation of AEC across GM to ensure timely evidenced based care and improve patient flow.	
Rationale: Ambulatory emergency care (AEC) is best practice for safe and effective patient care and to support patient flow.	
What does good look like: The number of people managed through ambulatory emergency care (AEC) services is optimised across GM; with a core service offer including people who are frail delivered in a dedicated area. The GM model will ensure people are managed in the most appropriate service relative to their clinical need for example community IV services, primary care and out-patients or hot clinics.	

	Locality Actions	Timeline		GM Actions	Timeline
1	Locality to develop a management plan to address to identified gap	To be completed by 31.11.18	**1**	GM to carry out data analysis review of current models of AEC provision across GM. Identify best practice and opportunities for expanding AEC and managing patients in the most appropriate setting	31.10.2018
2	Systems to identify tests of change to implement AEC based on gap analysis and GM model	To be completed by 30.11.18	**2**	Based on outputs of AEC data analysis develop the key components of a test of change	30.11.18
3	Identify localities to engage and commence a in a test of change for AEC accelerator programme	To start by January 2019 however localities wishing to be an early adopter can do so.	3	GM Clinical Reference Group to develop a GM exemplar model and minimum standard to support optimising AEC (including core services required in other settings e.g. community, primary care). Identifying key components for tests of change.	31.03.2019
4	Phased testing of GM model	Phase 1 testing to start from January 2019, see above.	4	Share best practice and share across GM and facilitate peer support and facilitation to implement best practice	From 30.11.2018 and on-going
5	Phase2 testing of GM model	Phase 2 testing to start from 1.4.2019			
6	Full implementation of GM AEC model	To be completed by 31.9.2019	5	GM and ECIP support for tests of change	31.08.2019
Metrics – to be confirmed post data analysis		**Guidance** https://improvement.nhs.uk/resources/good-practice-guide-focus-on-improving-patient-flow/ https://www.ambulatoryemergencycare.org.uk/BAAEC/BAAEC-Resources/AEC-Directory https://www.rcplondon.ac.uk/guidelines-policy/acute-care-toolkit-10-ambulatory-emergency-care			

Primary Driver- Patient Flow – WAVE SRO: Mary Fleming	Service Improvement Lead: Teresa Emery
Action: Length of stay (LoS) reviews - standard operating procedure **For: Development & Implementation/**	**GM Collaborative Improvement Approach/ Locality Actions** Start Date: August 2018 End Date: 31.1.2019 Duration: 132 days
Objective: To reduce the number of stranded patients across GM. To develop and test a GM Standard Operating Procedure for length of stay (LoS) reviews of all stranded patients with a LoS of 7 days or more across GM. This will enable systems and GM to understand key constraints to patient journeys and put in place improvements to address these.	
Rationale: All GM systems have completed length of stay reviews in April 2018 using the ECIP methodology. This had a positive impact on numbers of stranded patients in acute beds across GM	
What does good look like: All localities use a standardised approach to carry out length of stay reviews, so that there is a common methodology and coding enabling systems and GM to share data and develop improvement opportunities to reduce patient delays.	

Locality Actions		Timeline	GM Actions		Timeline
1.	*Localities to undertake LOS reviews as per GM model*	*To start in August 2018.*	***1***	*GM to develop and agree with systems a common timescale for completing length of stay reviews across GM.*	*To be completed by: 31.08.2018*
2	*Localities to commence use of standard format of LoS reviews*	*To start in August 2018*	***2***	*GM to develop a standard format and operating procedure to undertake LoS reviews. This will include a consistent methodology for GM codes, membership of the review teams, and preformatted documentation and outcome reports.*	*To be completed by 10.08.2018*
3	*Locality to develop PDSAs for addressing key constraints identified by the length of stay reviews*	*To be completed by 31.09.2018*	***3***	*GM to develop a standardised report for the outcomes of the LoS review*	*To be completed by 31.08.2018*
4	*Systems to identify themes that would be beneficial for addressing at a GM level.*	*To be completed 28.02.2019*	***4***	*GM to develop plans for phase 2 plans to address areas where it would beneficial to manage delays and develop improvement plans at a GM level.*	*31.03.2019*

Metrics

- ***DTOC***
- ***Los >20>13>6***
- ***Proportion of people discharged from hospital back to their pre hospital residence***
- ***Number and proportion of readmissions within 7 days***

Guidance

https://improvement.nhs.uk/resources/safer-patient-flow-bundle-implement/

https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/efficiency-and-sustainability-adult

GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Primary Driver- Discharge and Recovery - WAVE 1 SRO: Mary Fleming	Service Improvement Lead: Teresa Emery
Action: Trusted assessor (TA) **For: Development & Implementation**	**GM Collaborative Improvement Approach/ Locality Actions** Start Date: July 2018 End Date: 30th August 2019 Duration:
Objective: To develop and test a GM Trusted Assessor model for care homes using a collaborative improvement approach	
Rationale: The GM length of stay review identified delays for assessment of patients awaiting transfer to other settings.	
What does good look like: The home first principle is adopted across GM and that no person is assessed for long term care in an acute setting. People are transferred in a timely manner to other settings using a trusted assessor model with care home providers and there is reduction in duplication of assessment.	

Locality Actions		**Timeline**	**GM Actions**		**Timeline**
1.	*Locality to undertake a baseline assessment of current TA provision*	*To be completed by 31.08.2018*	***1***	*GM to develop a baseline assessment process. Collate locality baseline assessments to identify the current state of trusted assessment models across GM*	*September 2018*
2	*Localities to identify care homes to participate in a test of change*	*October 2018*	***2***	*GM to identify best practice across GM*	*September 2018*
3	*Localities/care homes to identify process/local metrics*	*October 2018*	***3***	*GM to coproduce key components of trusted assessor model for a test of change with associated documentation and measures of success with systems and the care home sector.*	*October 2018*
4	*Localities to develop PDSA and identify the number of care homes that the test of change will be implemented.*	*November 2018*	***4***	*GM to facilitate discussions with CQC and stakeholders to support TA assessment model and care home assessment requirements for CQC*	*October 2018*
5	*Identified Localities to undertake test of change*	*December - March 2019*	*5*	*GM to facilitate discussions with the Care Home sector*	*On-going*
6	*Spread of model across all localities and care homes in GM*	*31st August 2019*	*6*	*Learning from test of change to be incorporated into the GM model with key components and associated documentation.*	*April 2019*

Metrics

- *DTOC*
- *LoS*
- *Data from LoS review: number of delays associated with care home assessments*
- *Number of assessments undertaken by a TA*
- *Number of assessment completed using the agreed Locality TA model.*

Guidance

https://improvement.nhs.uk/documents/1426/Patient_Flow_Guidance_2017___13_July_2017.pdf

https://www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/Quick-Guide-discharge-to-access.pdf

https://www.england.nhs.uk/urgent-emergency-care/hospital-to-home/improving-hospital-discharge/trusted-assessor/

https://improvement.nhs.uk/resources/developing-trusted-assessment-schemes-essential-elements/

https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/systems-resilience/high-impact-change-model

	https://improvement.nhs.uk/resources/safer-patient-flow-bundle-implement/ england.urgentcarereviews@nhs.net http://www.careengland.org.uk/sites/careengland/files/downloads/Vanguard_learning_guide__Dementia_v4.4.pdf https://www.england.nhs.uk/new-care-models/vanguards/care-models/care-homes-sites/ https://www.local.gov.uk/stepping-place-integration-self-assessment-tool https://improvement.nhs.uk/resources/developing-people-improving-care/ https://www.nuffieldtrust.org.uk/research/putting-integrated-care-into-practice-the-north-west-london-experience integrated-care-north-west-london-experience-0-web-final.pdf
Notes:	

Primary Driver- Discharge and Recovery – WAVE 1 SRO: Mary Fleming	Service Improvement Lead: Teresa Emery
Action: Patient choice **For: Implementation**	**GM Collaborative Improvement Approach/ Locality Actions** Start Date: 6th July 2018 End Date: 31st April 2019 Duration: 305 days
Objective: Support the implementation of patient choice policy across GM to maximise patient flow during winter 2018/19. Using the learning from early tests of change to inform the next phase of the roll out of Patient Choice	
Rationale: The GM length of stay review identified patient and family choice as one of the top 5 delays across GM.	
What does good look like: Discussions around discharge and transfer of care will take place when the patient is first admitted to hospital so that proactive discharge planning can occur. When patients are medically optimised they are able to transfer to onward care in a timely manner and will be managed in the most appropriate care setting for their needs.	

Locality Actions		Timeline	GM Actions		Timeline
1.	*Adoption of GM choice policy via UEC Delivery Boards and a baseline assessment of current position (including acute trusts, community and mental health providers). Identify political appetite & risk for implementation of choice policy.*	*To be completed by September 2018*	***1***	*Develop a baseline assessment tool for localities.*	*August 2018*
2	*Develop and enact an implementation plan for choice policy and identify readiness for implementation.*	*By December 2018*		*Identify, describe and share best practice around implementation of choice policy in GM*	*September 2018*
3	*Test training material for implementation of choice policy*	*Start December 2018*	***2***	*Work with patient user groups to develop and test patient choice communication messages including patient and third sector groups.*	*31st October 2018*
4	*Phased implementation of best practice for early discharge planning and communication with patients and carers*	*December 2018*	***3***	*Develop and implement GM communication strategy for patient choice*	*30th November 2018*
4	*Evaluate progress on implementation, learning and test training materials.*	*February 2019*	***4***	*Develop test training materials.*	*31st November 2018*
5	Full implementation of choice policy across GM	*August 2019*	5	*Develop a training package for systems to support patient choice conversations*	*April 2019*

Metrics

- *DTOC*
- *Stranded patients*
- *LoS review data on patient and family choice*

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Guidance

https://www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/Quick-Guide-supporting-patients-choices.pdf

https://www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/Quick-Guide-discharge-to-access.pdf

Notes:	Interdependency with early discharge planning and integrated transfer teams work streams GM UEC Improvement Programme to work with GM social care programme to develop training package.

Primary Driver- Discharge and Recovery – WAVE 1 SRO: Mary Fleming	Service Improvement Lead: Teresa Emery
Action: Transfer and repatriation **For: Implementation**	**GM Collaborative Improvement Approach/ Locality Actions** Start Date: May 2018 End Date: December 2018 Duration:

Objective: GM Hub to collect and collate a live data management system for hospital transfer and repatriations

Rationale: Systems reported lengthy delays in transfer / repatriation of patients across and externally to GM, establishing a clear common understanding of these will allow systems to initiate escalation actions more promptly

What does good look like:
Systems will adopt the GM Hospitals Repatriation Policy and provide robust data to the GM UEC Hub promoting greater clarity and earlier escalation that improves patient experience and reduces stranded patients resulting from such delays.

	Locality Actions	Timeline		GM Actions	Timeline
1.	Localities to adopt GM Acute Hospitals Repatriation Policy	August 2018	***1***	GM UEC Hub / NWAS to agree holding of PID	June 2018
2	Acutes to provide data twice a day on patients awaiting transfer or repatriation	TBC	***2***	GM UEC Hub to produce data collection template	July 2018
3	Acutes to develop internal escalation process to manage patients transferring or repatriating within 48 hours	August – October 2018	***3***	GM UEC Hub to develop process for collating and prioritising patients exceeding 48 hours	August – Sept 2018
4	Local UEC Delivery Boards to develop monitoring of LoS metrics for patients awaiting transfer from / to local system.	August – November 2018	***4***	GM UEC Hub develop process to escalate to GM HSCP / UEC Delivery Board patient s>72 hours	November 2018

Metrics

- Stranded / Super-stranded patients awaiting transfer/repat**riation**

Guidance

GM Acute Hospitals Repatriation Policy

Primary Driver- Discharge and Recovery – WAVE 2 SRO: Mary Fleming Service Improvement Lead: Teresa Emery					
Action: Integrated transfer team and standard operating model **For: Development**	**GM Collaborative Improvement Approach/ Locality Actions** Start Date: July 2018 End Date: August 2019 Duration: 295				
Objective: To develop a GM model, documentation and Standard Operating Procedure for integrated transfer (discharge) teams					
Rationale: The GM LoS review has identified significant variation in transfer of care (discharge) practice across GM which is impacting on patient length of stay and outcomes.					
What does good look like:					
Locality Actions		**Timeline**	**GM Actions**		**Timeline**
1.	*Locality to undertake a baseline assessment of current provision*	*To be completed by 1.09.2018*	***1***	*GM to identify best practice across GM. Develop a baseline assessment template and collate locality baseline assessments.*	*31.09.2018*
2	*Locality to develop a management plan to adopt best practice model.*	*To be completed by 30.11.2018*	***2***	*GM to develop a local exemplar model including key components, key roles and functions that will support high impact change.*	*31.10.2018*
3	*Localities to develop and implement test of change to implement best practice GM model and documentation*	*To be completed by 31.12.18. Some localities may want to accelerate implementation and will be supported to do so.*	***3***	*GM to facilitate the development of common discharge documentation to support transfers of care across GM. NB not patient facing materials.*	*31.10.2018*
4	*Localities to identify if they wish to engage in a test of change for standardised documentation.* *Localities to implement test of change.*	*To be completed by 31.12.18. Some localities may want to accelerate implementation and will be supported to do so.*	***4***	*GM to facilitate peer support on sharing and developing best practice across GM*	*31.08.2019*
	Full implementation of GM integrated discharge model	*To be completed by 31.08.2019*			
Metrics • *DTOCs* • *Stranded pts* • *Metrics for trusted assessment to be agreed*		**Guidance** https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/efficiency-and-sustainability-adult			

Notes:	

Primary Driver- Discharge and Recovery – WAVE 1 SRO: Mary Fleming Service Improvement Lead: Colin Kelsey					
Action: Patient transport service (PTS): discharge profiling **For: Development**	**GM Collaborative Improvement Approach/ Locality Actions** Start Date: June 2018 End Date: Nov 2018 Duration: 105 days				
Objective: To reduce the abortive PTS journeys and release capacity for systems to support timely discharge					
Rationale: To reset additional spend on transport at locality level by utilising the capacity released by reducing the abortive PTS journeys					
What does good look like? ○ **Site specific abortive journeys would be reduced to a minimum making an efficiency saving that could be released specific to that site.** ○ **PTS resource released is able to focus on unplanned discharge activity improving more timely discharge, support flow and improve patient experience.** ○ **Release of PTS capacity will afford systems a cost saving on the use of third party providers which could be reinvested in discharge transport expertise, planning journeys and ensuring most efficient use of the DDV.**					
Locality Actions		Timeline	GM Actions		Timeline
1.	*NWAS to undertake a baseline assessment of current abortive journeys and costs*	*August 2018*	***1***	*GM to work with NWAS and identify the key priority systems with greatest benefits*	*August 2018*
2	*Localities to develop a management plan to address key contributory factors in abortive journeys*	*August / Sept 2018*	***2***	*GM to work with NWAS to secure a site specific resource from time saved*	*August / Sept 2018*
3	*Identified locality to develop PDSA using resource released by reduced abortive activity*	*Sept 2018*	***3***	*ID best practice from PDSA*	*Sept 2018*
4	*Locality / NWAS to produce report of impact of PDSA*	*October 2018*	***4***	*Organise GM wide roll out for PDSA*	*October / Nov 2018*

Metrics	Guidance
• *Reduced abortive journeys* • *Availability of PTS service vehicles for acute discharge activity*	
Notes	

Primary Driver- Discharge and Recovery SRO: Mary Fleming Service Improvement Lead: Teresa Emery	
Action: Review transfer pathways for patients with complex needs **For: Review**	**GM Collaborative Improvement Approach/ Locality Actions** **Start Date: July 2018 End Date: 31.08.2019 Duration: 90 days/120 days**
Rationale: The GM length of stay review identified delays in the transfer of care for some people with complex care needs, which included people with dementia and delirium.	
Objective: To improve the pathway for transfers of care for people with complex needs including those with memory loss, delirium and dementia.	
What does good look like: Home first is adopted across GM for all people including those with complex needs including memory loss, dementia or delirium, so that when they are clinical optimised wherever possible they should be supported to return to their own home for assessment. When they no longer require an acute hospital bed, but may still require care services they are provided with short term, funded support to be discharged to their own home (where appropriate) or another community setting. If assessment for longer-term care and support is required this should be undertaken at the right time and in the most appropriate setting, which for most people will not be in an acute bed. Safe transfer of care should be provided in a timely manner to a setting which meets their needs, with sufficient capacity across GM to meet demand.	

Locality Actions		Timeline	GM Actions		Timeline
1.	Localities and GM works with the home care market to completed bases line assessment.	To be completed by 31.09.2018	1	GM to carry out a review of current capacity within the care home and home care sector to identify capacity and gaps in provision.	To be completed by 31.10.10
2	Localities and GM work with the home care market to develop a test of change for new models of care for supporting transfers of care for people with memory loss, delirium and dementia.	To be completed by 31.03.2019 Some care home providers and localities may want to accelerate implementation and will be supported to do so, with the aim of introducing a test of change before 31.12.2018.	2	GM to develop a strategy for addressing gaps in provision for people with memory loss, delirium and dementia. This supports the principles of home first and the GM trusted assessor model which includes best practice.	31.01.2019
3	Implementation of new model across GM.	To be confirmed.	3	GM evaluates impact of tests of change with localities and care providers.	31.04.2019
				Develops GM model and implementation plan for timely transfers of care meeting the needs of people with memory loss, delirium and dementia.	31.06.2019

Metrics • DTOCs • Stranded patients • GM length of stay reviews: a reduction in delays for transfers to care homes.	Guidance: https://www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/Quick-Guide-supporting-patients-choices.pdf https://www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/Quick-Guide-discharge-to-access.pdf
	Notes: Interdependencies with the GM social care improvement programme, who are looking at the strategy for home care and care at home across GM.

Enabler- System Operations/Resilience/Demand Management/Responsiveness	
Action: System Operations	**GM Collaborative Improvement Approach/ Locality Actions** Start Date: July 2018 End Date: Dec 2018 Duration:
Objective: To understand the capacity required to meet the variations in demand across the calendar year	
Rationale: Surges in UEC demand historically create vulnerability in GM systems resulting in deterioration of the 4 hour standard and longer delay for NWAS in turnaround of emergency vehicles. The result is often a poor patient experience and greater risks to patient safety.	
What does good look like: • GM Demand and capacity is modelled over time with realistic provider/commissioner plans in place to ensure sufficient capacity at times of peak demand. • Hospital Patient Administration Systems and Real Time Bed Management systems are used to provide real time bed status and visibility of available capacity across the health and social care system, enabling the operational management of demand and capacity. • **NB: Please refer to the Workforce Enabler section**	

Locality Actions		**Timeline**	**GM Actions**		**Timeline**
1.	*Carry out a review of capacity requirements in line with population and UEC demand profile*	*August 2018*	***1***	*NHSI / HSCP to jointly review capacity across GM*	*July 2018*
2	*Review of current data management software and fitness for purpose*	*Sept 2018*	***2***	*GM to review the operation and focus of the GM UEC Hub in advance of Winter 2018-19*	*August 2018*
3	*Liaison with local partners to measure capacity in care/residential homes in real time*	*Oct 2018*	***3***	*GM to identify best practice in nursing home bed management tool*	*Sept 2018*
4	*Implement GM single escalation process in collaboration with GM UEC Hub*	*Nov 2018*	***4***	*GM with ECIP support to identify best practice*	*Sept 2018*

Metrics	**Guidance**
• 4 hour A&E Standard • 12 hour breaches • NWAS handover delays	https://improvement.nhs.uk/documents/1786/Emergency_Flow_Improvement_Tool_User_Guide_Sept_2017.pdf https://www.nao.org.uk/wp-content/uploads/2000/02/9900254.pdf

Notes:	This is an iterative field that will need to be adapted to emergent national and/or regional agreements on winter planning and response arrangements.

Enabler- Digital /Technology/Interoperability and Innovation Service Improvement Lead: Ian Moses	
Action: Digital-Technology/Interoperability and Innovation **For: Development /Implementation /Review**	GM Collaborative Improvement Approach/ Locality Actions Start Date: TBC End Date: TBC Duration:

Objectives:

1. **To ensure that systems are able to allow sharing of relevant patient information to enable care decisions to be made without the need to escalate to another service.**
2. **To use available technology to support patients in their homes so that long term conditions can be monitored remotely, linking to community based response, facilitated by the locality integrated urgent care services**
3. **To develop new technological solutions which enable easier access to senior clinical support to patients and carers to support remote assessment and prescribing?**

Rationale:

Technology must be used as an enabler of both improved patient experience and quality of outcomes, where decision making is supported by accurate clinical information. Similarly, in a busy operational environment, it is essential to make best use of efficiency / time saving features which reduce avoidable travel for both patients and clinicians.

What does good look like?

The GM H&SC system is technically connected wherever a patient presents for an episode of care. The outcome of every contact is recorded and summarised back to one single data source.

Patients have easy access to self-assessment and monitoring either through their own technology (oximetry, blood pressure etc.) or through NHS provided technology which enables them to be helped to stay well, or receive care earlier, avoiding escalation to an acute episode.

Locality Actions		Timeline	GM Actions		Timeline
1.	*Support GM through the implementation of appropriate data systems locally.*	*TBC*	*1*	*Support the delivery of the Local Health and Care Record Exemplar (LHCRE) to enable the sharing of information and provide patients with increase access to their own information.*	*This programme has a 2 year delivery timescale.*
2	*Provide support to the scoping of Telehealth initiative*	*TBC*	*2*	*Scope the role out of a Telehealth initiative across Greater Manchester, including identification of funding requirements.*	*TBC*

Metrics **1. Shared Health Records are available across Greater Manchester.**	Guidance https://www.england.nhs.uk/digitaltechnology/connecteddigitalsystems/joining-up-health-and-care-data/
Notes	

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Enabler- OPEL Service Improvement Lead: Colin Kelsey					
Action: Systems operations – resilience/demand management and responsiveness **For: Development & Implementation**	**GM Collaborative Improvement Approach/ Locality Actions** Start Date: July 2018	End Date: Nov 2018	Duration: 120 days		
Objective: To develop a standard approach to escalation that contributes to effectively manage surges in demand across the GM.					
Rationale: To reduce vulnerabilities and variation caused by the use of unaligned protocols and slower wider system response leading to spikes in waiting times.					
What good looks like: • **An agreed set of GM escalation levels triggers and actions that align with national OPEL system.** • **Clear expectations around roles and responsibilities for all local stakeholders in surge escalation (providers , commissioners and local authorities)** • **Common understanding of mutual expectations across all agencies.** • **Tested escalation plans agreed leading into winter pressures**					
Locality Actions		Timeline	GM Actions		Timeline
1.	*Localities to share their local surge escalation processes with GM HSCP / NECSU*	*July 2018*	***1***	*GM HSCP will work in collaboration with NECSU to develop a single GM Escalation Model which is designed to identify and alleviate surges in demand through greater consistency across escalation levels.*	*August 2018*
2	*Local planning using the GM Escalation Model will include:* • *A common information picture* • *Common performance metrics/triggers which reflect system* • *pressure to generate a "system" response* • *Processes for co-ordinating capacity & managing*	*Sept 2018*	***2***	*GM HSCP to develop and share a real time UEC demand data set across the whole system*	*August 2018*
3	*Local table top testing of local Escalation Plan*	*Oct 2018*	***3***	*Secure an agreement across all stakeholders to provide mutual support to ensure safety and equitable access to services for the population*	*Sept 2018*
Metrics • *4 hour A&E Standard* • *12 hour breaches* • *Ambulance Response measures*		**Guidance** https://www.england.nhs.uk/wp-content/uploads/2012/03/operational-pressures-escalation-levels-framework.pdf			
Notes:					

Enabler- Workforce Service Improvement Lead: Teresa Emery	
Action: Workforce ***For: Review Development /***	*GM Collaborative Improvement Approach/ Locality Actions* *Start Date: August 2018 End Date: 31st March 2020*
Objective: To review and develop a clear workforce enabler strategy to underpin the UEC improvement and transformational programme.	
Rationale: To support the implementation of the UEC programme	

What does good look like?

1. ***A review of the following has been undertaken***
- ***Flexible working jointly to understand flows, workforce supply and issues around retention and lack of supply.***
- ***Flexible employment, rotational posts, joint recruitment/appointments and bank staff have been jointly reviewed and bank and shared bank alignment has been completed***
- ***A 'training passport' (mandatory training, core competencies and induction) have been developed to enable agile working/transfer of work-force across organisations***
- ***HR policies have been aligned across partners, such as secondment policies, learning and development opportunities to allow flexibility***
- ***Meetings of HR Directors, professional bodies and trade unions have taken place***
- ***Communications are sent across the system regarding changes and opportunities***

2. ***A three – five year workforce plan is in place.***
   - ***Modelling has been undertaken regarding the UEC workforce need across all partners, e.g. community, primary, secondary , mental health and social care***
   - ***The plan includes and aligns each partners organisational plan to the overall ICS/STP plan and there is agreement across partners around how it will be used. The UEC plan includes social care, both local authority and private, voluntary and independent sector with a strong emphasis on MDT care and 7 day working***
   - ***The plan considers recruitment, retention and development***
   - ***There is a UEC workforce lead on the ICS/STP Programme board2.7. The workstream is supported by Local Workforce Action Board (LWAB) and Health Education England (HEE).***
   - ***A workforce oversight group is in place***
   - ***The plan includes and aligns each partners organisational plan to the overall ICS/STP plan and there is agreement across partners around how it will be used***

Locality/GM Actions	*Timeline*
• *Identify Partnership SRO for UEC Workforce*	*August 2018*
• *Define terms of reference for Workforce Oversight Group, ensuring robust governance arrangements are in place.*	*September 2018*
• *Hold inaugural meeting of the Workforce Oversight Group (Workshop) to:* o *Identify key areas of support from the work of the key streams of the UEC Improvement and Transformation Programme in relation to work force.* o *Understand the UEC requirements of the work areas identified in the UEC Workforce Strategy.** o *Provide support to the development of the UEC Workforce Strategy and Delivery Plan.*	*September 2018*
• *Further develop the GM UEC Workforce Tool to enable initial and ongoing analysis of workforce requirements for UEC; and to embed in to operational and commissioning activities.*	
• *Design and implement the 'GM Passport' to develop mandatory training, core competencies, and induction to enable*	

	agile working between sites across Greater Manchester. *Further work to be scoped through the actions identified above.*	*November 2018* *April 2019*
Metrics ***TBC by the GM UEC Professional Clinical Advisory Group***		*Guidance* *•HEE STAR tool for workforce transformation* *•HEE meeting UEC workforce challenges* *Case studies* *•Dorset ICS flexible working MOU* *•HEE Midlands and East UEC Programme* *•South East Essex Collaborative Medical Bank* *•MERIT training passport* *•Colchester new roles case study: hospital ambulance liaison officer and patient safety nurse* *•Hospital ambulance liaison officer JD* *•Patient safety nurse JD Learning from the Vanguards: planning and modelling* *•Workforce matrix* *•Skills for Health, increase quality of healthcare, patient safety and productivity.* *•Retaining your workforce* *•Retrain, and Retain objectives.* *•EHCH Vanguard learning guide – workforce development* *Case study* *•Wakefield General Practice Workforce Development Academy focus on the Recruit,* *•Nottinghamshire STP / ICS - Insight and Learning Case Study*

Metrics	Guidance
TBC by the GM UEC Professional Clinical Advisory Group	GM Workforce Strategy •HEE STAR tool for workforce transformation •HEE meeting UEC workforce challenges Case studies •Dorset ICS flexible working MOU •HEE Midlands and East UEC Programme •South East Essex Collaborative Medical Bank •MERIT training passport •Colchester new roles case study: hospital ambulance liaison officer and patient safety nurse •Hospital ambulance liaison officer JD •Patient safety nurse JD Learning from the Vanguards: planning and modelling •Workforce matrix •Skills for Health, increase quality of healthcare, patient safety and productivity. •Retaining your workforce •Retrain, and Retain objectives. •EHCH Vanguard learning guide – workforce development Case study •Wakefield General Practice Workforce Development Academy focus on the Recruit, •Nottinghamshire STP / ICS - Insight and Learning Case Study

Glossary

Acronym/Abbreviation	*Explanation*
A & E	*Accident and Emergency department*
AEC	*Ambulatory Emergency Care*
AH	*Ambulance Handover*
CQC	*Care Quality Commission*
DTOC	*Delayed Transfer of Care*
ED	*Emergency Department*
GM	*Greater Manchester*
GMHSCP	*Greater Manchester Health and Social Care Partnership*
HCP	*Health Care Professionals*
LoS	*Length of Stay*
LCO	*Local Care Organisation*
NECSU	*North East Commissioning Support Unit*
NHS	*National Health Service*
NRHTT	*Nursing and Residential Home Triage Tool*
NWAS	*North West Ambulance Service*
PCAG	*Professional and Clinical Advisory Group*
PDSA	*Plan, Do, Study, Act*
PID	*Personal Information Data*
PTS	*Patient Transport Service*
SAFER	*Senior review, all patients, flow, early discharge, review.*
RCA	*Root Cause Analysis*
SRO	*Senior Responsible Owner*
TA	*Trusted Assessor*

TOC	*Test of Change*
UECITB	*Urgent and Emergency Care Improvement and Transformation Board*
UTC	*Urgent Treatment Centre*