Greater Manchester Joint Health Scrutiny Committee

Date: 18 February 2025

Subject: Greater Manchester Patient Access - Primary and Urgent Care

Report of: Katherine Sheerin – Chief Commissioning Officer, NHS Greater Manchester

---

Purpose of Report

To provide an update on primary and urgent care access to the Greater Manchester Joint Health Scrutiny Committee.

Recommendations:

The GMCA is requested to:

1. Recognise the ongoing work to support patient access to GP services in Greater Manchester.
2. Support measures to work with local people to ensure awareness of services available.

Contact Officers

Ben Squires – Director of Primary Care – NHS Greater Manchester; ben.squires@nhs.net

Gill Baker – Greater Manchester Urgent and Emergency Care Director: gill.baker5@nhs.net

Katherine Sheerin – Chief Commissioning Officer, NHS Greater Manchester: katherine.sheerin@nhs.net

Equalities Impact, Carbon and Sustainability Assessment:

It is recognised that people from disadvantaged backgrounds access health services at a later stage of illness. Whilst it is imperative to improve prevention and proactive care for all GM communities, it is also crucial to ensure that urgent care is available when needed. As such, services need to be easy to understand and access appropriately. To support practices to address health inequalities and support diversity in access to services there are ongoing quality initiatives around training and awareness, specifically in regard to LGBTQ+ communities and Black communities.

Risk Management

N/A

Legal Considerations

Delivering and improving primary care and urgent care services are part of the statutory delegated functions of NHS Greater Manchester.

Financial Consequences – Revenue

Financial consequences and healthcare budgets fall within the responsibility of NHS Greater Manchester (Integrated Care Board). Ensuring the right balance of prevention, primary care and urgent care is critical to delivery of the NHS GM Sustainability Plan which offers a financially balanced system focused on improving health outcomes.

Financial Consequences – Capital

N/A

Number of attachments to the report:

N/A

Comments/recommendations from Overview & Scrutiny Committee

N/A

Background Papers

1. Delivery Plan for Recovering Access to Primary Care: www.england.nhs.uk/publication/delivery-plan-for-recovering-access-to-primary-care/
2. Greater Manchester Primary Care Blueprint: www.gmintegratedcare.org.uk/primary-care/

3. Implications of Language Barriers for Healthcare: A Systematic Review (Shamsi et al. 2020): www.pmc.ncbi.nlm.nih.gov/articles/PMC7201401/pdf/OMJ-35-02-1900033.pdf
4. Experiences of NHS healthcare services in England (ONS): www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthcaresystem/datasets/experiencesofnhshealthcareservicesinengland
5. Nest steps for integrating primary care: Fuller Stocktake Report (NHS England): www.england.nhs.uk/wp-content/uploads/2022/05/next-steps-for-integrating-primary-care-fuller-stocktake-report.pdf
6. Summary letter from Lord Darzi to the Secretary of State for Health and Social Care (DHSC Independent Report): www.gov.uk/government/publications/independent-investigation-of-the-nhs-in-england/summary-letter-from-lord-darzi-to-the-secretary-of-state-for-health-and-social-care
7. GMICP | Greater Manchester Integrated Care Partnership
8. Greater Manchester Health and Social Care Partnership (GMHSCP), "Greater Manchester Health Trends," 2023
9. Joint Forward Plan | Greater Manchester Integrated Care Partnership
10. King's Fund, "Impact of Primary Care Access on A&E," 2022
11. NHS England » 2025/26 priorities and operational planning guidance
12. NHS England » Neighbourhood health guidelines 2025/26
13. Office for National Statistics (ONS), "Greater Manchester Demographic Data," 2023
14. Public Health England, "Health Inequalities in Greater Manchester," 2022
15. Urgent and emergency care survey 2024 - Care Quality Commission

Tracking/ Process

Does this report relate to a major strategic decision, as set out in the GMCA Constitution

No

Exemption from call in

Are there any aspects in this report which means it should be considered to be exempt from call in by the relevant Scrutiny Committee on the grounds of urgency?

N/A

GM Transport Committee

N/A

JHS Overview and Scrutiny Committee

18 March 2025

1. Introduction

This report provides an overview of access to primary care and urgent care services for the people of Greater Manchester. Each element is considered separately, and then recommendations are drawn together. It should be highlighted that because the Committee received a comprehensive report on access to GP Services at its February meeting, the primary care element concentrates on access to the other primary care providers – pharmacists, dentist and optometrists.

In order to help Committee members to navigate the report, it is set out in four sections as follows:-

Section 1: General Practice

Section 2: Pharmacy

Section 3: Dentistry

Section 4: Urgent Care

Section 5: Recommendations

Section 6: Glossary of Terms

SECTION 1

GENERAL PRACTICE

Background: **Access to General Medical Services**

The Committee received report on GP Access in February 2025. Key points from this report include:

> 78.3% of respondents in GM reported that their overall perception of experience of their GP practice (for those who tried to contact the practice within the last 28 days) was good. 14.9% said it was neither good nor bad and 6.9% reported their experience as poor (Office for National Statistics (ONS) Health Insights Survey reported on 30th January 2025).
>
> GP practices across Greater Manchester have continued to deliver increased numbers of appointments since 2019, with 1.37m appointments delivered within 14 days in the month of October 2024 alone. For all GP appointments delivered in October 2024, the figure is 1.79m. Whilst the data indicates seasonal dips in appointment counts, data from December 2024, shows an increase of nearly 20,000 appointments delivered within 14 days compared to December 2023.

As work continues into 2025/26 to improve GP access, it was noted that the Committee suggested that additional indicators considered to provide a more comprehensive view of GP access and quality should include a focus on patient health outcomes, using a holistic view of all services provided, and considered the impact on individual patients, their families, and the wider community.

To build upon this previous GP Access report received by the Committee, this report provides a focus on primary care access to community pharmacy and NHS dental services and urgent emergency care (UEC).

SECTION 2

PHARMACY

2.1 Background

Health and Wellbeing Boards (HWBs) in England hold statutory responsibility to publish and keep up to date a statement of the needs for pharmaceutical services of the population in its area, referred to as a pharmaceutical needs assessment (PNA). PNAs are used by the NHS to make decisions on which NHS funded services need to be provided by local community pharmacies.

PNAs across Greater Manchester have historically recognised that local provision of community pharmacy across the region have been higher than the national position. However, recent years has seen a reduction in the numbers of community pharmacy branches, reflecting national trend. There is currently review of needs assessment taking place across the GM HWBs to update published PNAs.

Greater Manchester currently has **622 branches** of which 51 are distance selling pharmacies

This compares to position in March 2023 with 638 branches of which 15 were distance selling pharmacies at that time.

It has been well documented in the media that community pharmacy providers have faced significant pressures, resulting in a number of closures across the country. There has been particular focus on closures of branches previously delivered by Lloyds This h as been particularly notably corporate provision by Lloyds Pharmacies and Boots. Greater Manchester has not been exempted from the impact of these national pressures. However, a number of potential closures have been mitigated by change of ownership and through consolidation of services between two branches in close proximity (for example an application for consolidation in February was between two branches 40 metres apart).

There has been an increase in the number of Distance Selling Pharmacies (DSPs often known as 'Internet Pharmacies') situated within Greater Manchester. These providers offer pharmaceutical services nationwide, but by virtue or proximity supplement local provision. However, it should be recognised that national regulations restrict the provision of face-to-face services by these pharmacies.

Community Pharmacy services are governed by the National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013. As a primary care provider, community pharmacy is well-known as a dispenser and retailer of medicines, but its role is in fact much broader and includes other NHS and publicly funded services.

NHS patient services delivered by Community Pharmacy include a number of national clinical services:

- Pharmacy First (PF)
- Pharmacy Contraception Services (PCS)
- Hypertension Case Finding (HCF)
- Discharge Medicines Service (DMS)
- Seasonal Vaccination services (Influenza and Covid)

There are also a number of services locally commissioned within Greater Manchester which include:

- Minor Ailments Service (MAS)
- Smoking Cessation Services (SCS) – referred by acute and mental health trusts

To further develop the service, offer of community pharmacy, NHS GM has also engaged in service pilots for:

- Independent Prescribing Pathfinder programme
- MMR vaccination
- Early Cancer Diagnosis
- Electronic prescribing by secondary care services

There are also a number of public health services which are commissioned from community pharmacy by local authorities, such as supervised methadone consumption, needle exchange, smoking cessation and sexual health services.

NHS delivery of clinical services is seen as an important contribution in supporting patient care and reducing demand for GP appointments. Nationally the role of community pharmacy is recognised as part of the Primary Care Access Recovery Programme (PCARP).

As part of the PCARP saw the introduction of national service developments whereby:

- Pharmacy oral contraception (PCS) and blood pressure (HCF) services were expanded and re-launched in December 2023, to increase access and convenience for millions of patients, subject to consultation.

- Pharmacy First was launched in January 2024, whereby community pharmacies are able supply prescription-only medicines for seven common conditions.

Through the introduction of Pharmacy First, the contraception and hypertension services it was anticipated that NHS services could potentially save 10 million appointments in general practice a year.

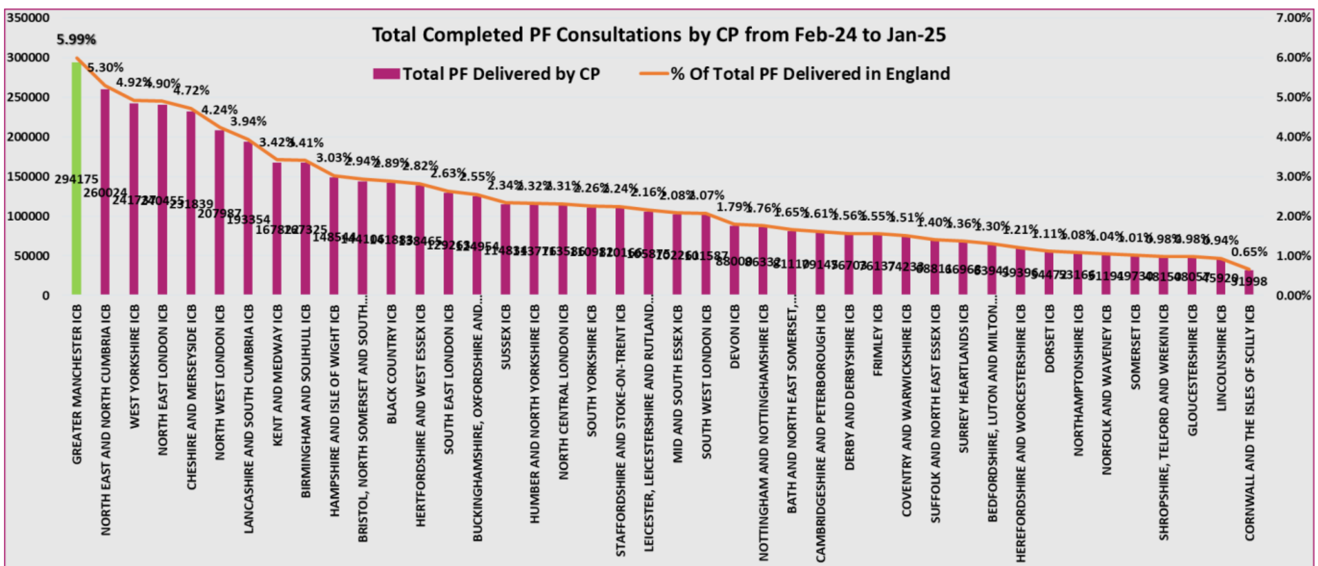
2.2 Pharmacy First

The nationally commissioned Advanced Service: ‘Pharmacy First’, launched on 31st January 2024 replaced the Community Pharmacist Consultation Service (CPCS). The new service consists of 3 elements: Clinical Pathways, urgent repeat medicines supply and NHS referrals for minor illness.

The ‘Clinical Pathways’ element includes 7 new clinical pathways which enables patients to be referred, or self-refer, to a community pharmacist for advice and first line treatment for a series of conditions: acute otitis media, acute sinusitis, acute sore throat, impetigo, infected insect bites, shingles and uncomplicated urinary tract infections (UTIs) in women.

Greater Manchester has the highest number of Pharmacy First “completed” consultations across the 42 ICBs in England, at 211,713 since the scheme formally began in January 2024. Work continues to further increase consultation numbers, including engagement with general practices less actively referring into the service and further supporting those /who are. This is to ensure that all suitable patients are referred to community pharmacy to create capacity for general practice to see patients with more complex needs.

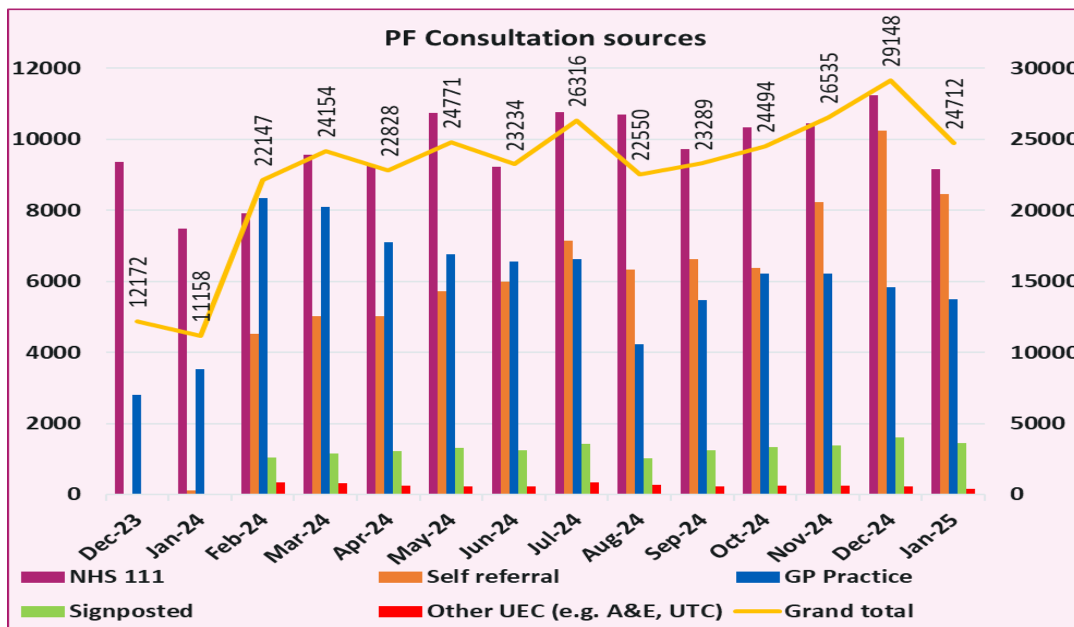
Figure 1: Pharmacy First activity across 42 ICBs (Feb 24 – Jan 25)



Community Pharmacies can receive referrals from a series of routes, such as via General Practice, through walk-ins, via the UEC system and NHS 111.

There is work to progress across Greater Manchester to embed opportunity of referral from UEC services into Pharmacy First services across Community Pharmacy. This will reduce demand at Urgent Treatment Centres and A&E, providing more convenient and appropriate care for patients.

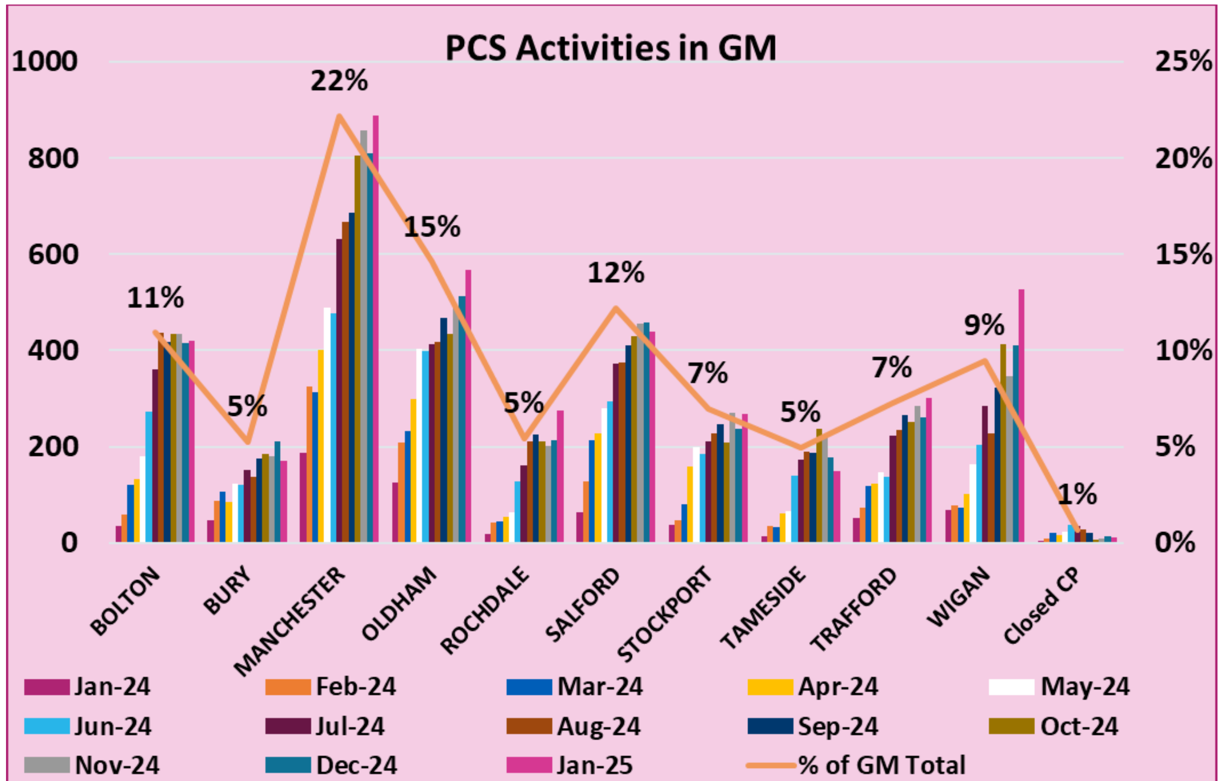
Figure 2: Pharmacy First Consultation Sources (Dec 23 – Jan 25)



Pharmacy Contraception Services

Initiation of contraception by community pharmacists became part of the service in December 2023. The following graph indicates provision of this service across the GM localities.

Figure 3: Contraceptive Services activity across GM (Jan 24 – Dec 24)



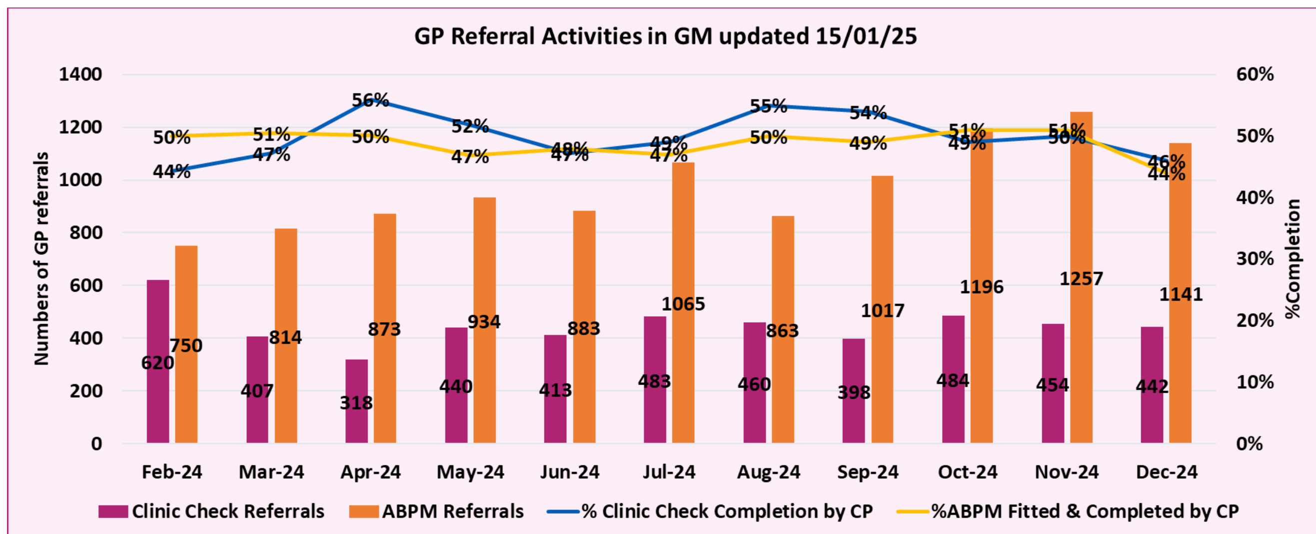
2.3 Hypertension Case Finding

Cardiovascular disease is a critical clinical risk for the population of Greater Manchester. The increased capacity to identify patient risk through hypertension case finding by community pharmacy contributes to the prevention approach within GM.

575 (95%) GM community pharmacies were registered to provide the service up as of 30th December 2024.

GPs can refer any patient requiring a Blood Pressure (BP) check or Ambulatory Blood Pressure Monitoring (ABPM) using EMIS local services button. Patients requiring follow-up by their GP are notified by electronic message, clearly stating the urgency of the follow-up dependent upon BP reading. Activity is set out in the table below.

Figure 4: GP referrals to Blood Pressure checks and ABPM delivered by pharmacies in Greater Manchester (Feb 24 – Dec 24)



"**The blood pressure service finder**" is a patient facing website supporting the public to find a pharmacy which offers NHS free blood pressure services, utilising a post code search tool.

> **www.nhs.uk/nhs-services/pharmacies/find-a-pharmacy-that-offers-free-blood-pressure-checks/**

2.4 Discharge Medicines Service (DMS)

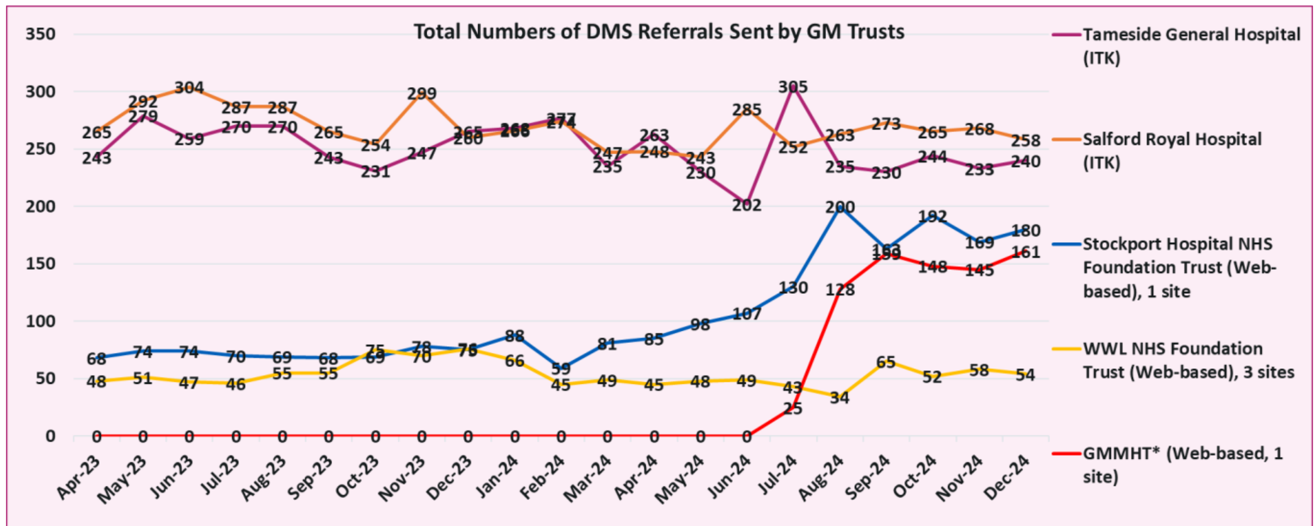
Hospital services are encouraged to consider referral of patients who are admitted to hospital who would benefit from support with their prescribed medicines post discharge.

There are three stages of service provided by community pharmacy:

- Stage 1 comparison of discharge summary to any meds awaiting collection in the pharmacy
- Stage 2 comparison of discharge summary to first Rx received post-discharge
- Stage 3 consultation with the patient

This service is an evidence-based intervention which improves compliance to prescribed medicines and reduces readmission to hospital. Activity is set out as follows:-

Figure 5: DMS referrals by GM Trusts (Aug 23 – Dec 24)



2.5 Minor Ailments Services (MAS)

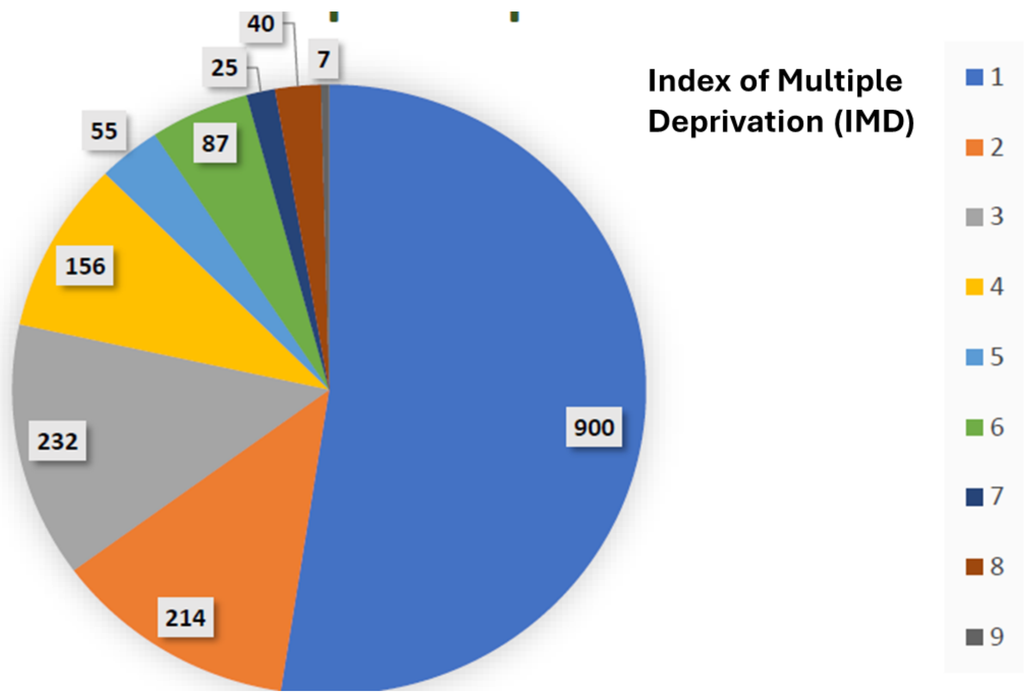
The Minor Ailment Service supplies patients NHS-funded medicines from a restricted formulary for minor ailments such as headlice, constipation and thrush.

This locally commissioned service complements the national Pharmacy First service where a supply can be made under the locally commissioned service following a referral from general practice, reducing escalations back into general practice to request a prescription in circumstances where the patient cannot (or will not) pay for medicines over the counter.

Legacy commissioning arrangements across GM from pre-2023 presented variable arrangements whereby services in some localities delivered to all patients who do not pay for prescriptions, some locality services were just for patients with certain prescription exemptions and some localities had no service. Through response to winter pressures, NHS Greater Manchester has established a consistent service model for the GM population.

Analysis of delivery during December 2024 strongly indicates that this local commission by NHS GM addresses inequalities across the region, whereby more than 75% of MAS activity was delivered by pharmacies in the most deprived areas of Greater Manchester.

Figure 6: Comparison of activity in Dec 2024 vs Index of Multiple Deprivation (IMD)



SECTION 3

DENTISTRY

3.1 Background

Patients are not registered with a General Dental Practice (GDP) in the same way as they are with a GP. Any patient may access dental services from any practice in any area. The spend on NHS Dental Services across Primary, Secondary and Community services in Greater Manchester is in the region of £225 million per annum.

In Greater Manchester there are:

- 347 Primary Care NHS Dental Contracts.
- 2 GM Urgent Dental Care providers delivering through 13 sites linked across networked provision for Greater Manchester. Patients can access urgent dental care at any of the sites across GM by ringing the UDC helpline on 0333 332 3800.
- 37 Urgent Dental Care Hubs that provide additional urgent dental care capacity, which were introduced in response to pressures during the COVID 19 pandemic but have been sustained as demand for urgent dental care access has remained high. Currently these are planned to operate until at least March 2024.

Specialised Dental Services

Community Dental Services (special care and paediatric) clinics delivered by Bridgewater Community Healthcare NHS FT, Northern Care Alliance, and Manchester Locality Care Organisation (MFT) – commissioned to provide specialist dental services to children and adults with additional needs on referral with clinics located within the community.
There are also 40 orthodontic primary care provider contracts and 10 specialist 'Tier 2' contracts for the provision of oral surgery on referral.

Secondary Care Dental Services

12 dental specialities (including Oral Surgery, Maxillofacial Surgery, Restorative Dentistry, Paediatric Dentistry, Periodontics) are available in Greater Manchester, commissioned from Manchester University NHS Foundation Trust, Northern Care Alliance NHS Foundation

Trust, Bolton Foundation Trust, Wigan Wrightington and Leigh Foundation Trust, Stockport NHS Foundation Trust, and Tameside and Glossop NHS Foundation Trust.

3.2 Improving Access to NHS Dentistry

On 7 February 2024 the government announced the national Dental Recovery Plan to be implemented from March 2024.

The national Dental Recovery Plan was launched in February 2024 and is focused on three areas:

- Prevention: For local government to implement focussing on oral health improvement, working with schools and family hubs.
- Access: Credited practice with a new patient activity tariff when they see patients who have not accessed services in the previous two years. This New Patient Premium is delivered within the established contracted activity and payments rather than directly attracting additional payment.
- Workforce: Mirror existing schemes in other contractor areas to support practices to recruit, such as 'Golden Hello's', expand skill mix to increase therapists and hygienist scope of practice.

3.3 Greater Manchester Dental Quality Access Scheme

The Greater Manchester Dental Quality Access Scheme was launched June 2023 and at present there are 149 Practices (43% of GM general dental contracts) are signed-up to deliver this scheme. The scheme was developed to support and sustain practices in being able to offer new patient and urgent care access.

The scheme has continued in 2024/25 and up to19 February 2025 delivered access for 72,731 patients new to the practices and 63,319 urgent appointments. Sadly 16,233 patients failed to attend for new patient or urgent care appointments in this period at participating practices.

The table below shows total number of new and urgent patients see under the scheme over 2023/24 and 2024/25 as well the number of patients that had appointments booked but then failed to attend.

Figure 7: Greater Manchester - number of patients seen under the GM Dental Quality Access Scheme

	2023 / 2024	01/04/24 -19/02/2025
New Patients Seen	105,135	72,731
Urgent Patients Seen	96,119	63,319
Patient Failed to Attend	20,761	16,223

The result of GM practices being signed up to these schemes has resulted in strong performance delivery of contracted activity, with more than 68% of contracts delivering more than 80% of their contracted Units of Dental Activity (UDAs) for the period up to September 2024, higher than 58% which is the national average position. Similarly, less than 3% of GM dental practice had delivered less than 30% of their contract in this period, compared with 6% nationally.

National access to NHS dental services was significantly impacted by the Covid pandemic. Services have continued to recover and access levels for the population are returning to pre-pandemic levels. However, there continues to be variation across the Greater Manchester localities. Through an oral health needs assessment, considering local service capacity, travel distance for services and epidemiology indication of oral health status, is being undertaken to inform possible future commissioning of dental services to address inequalities in dental access.

The following graphs provide indication of access levels across Greater Manchester.

FIGURE 8: Patient Access for Greater Manchester (Patients seen in previous 24 months)

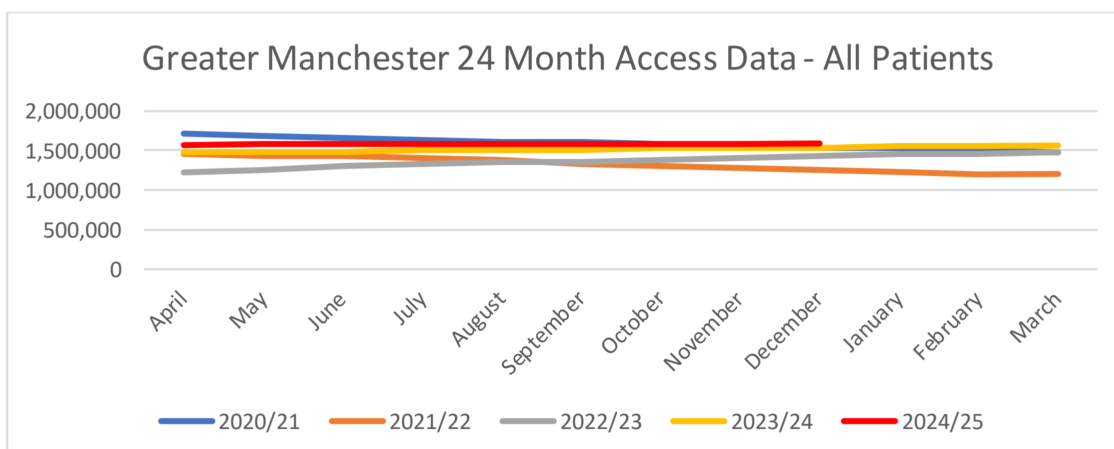


FIGURE 9a: Adult patients seen in the previous 24 months as a percentage of Local Authority population

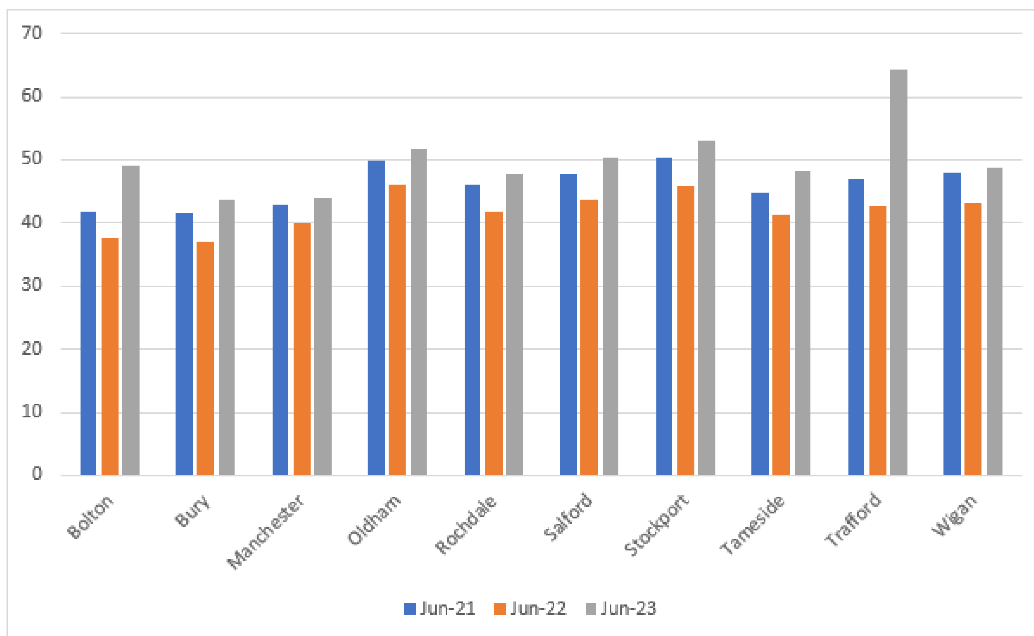
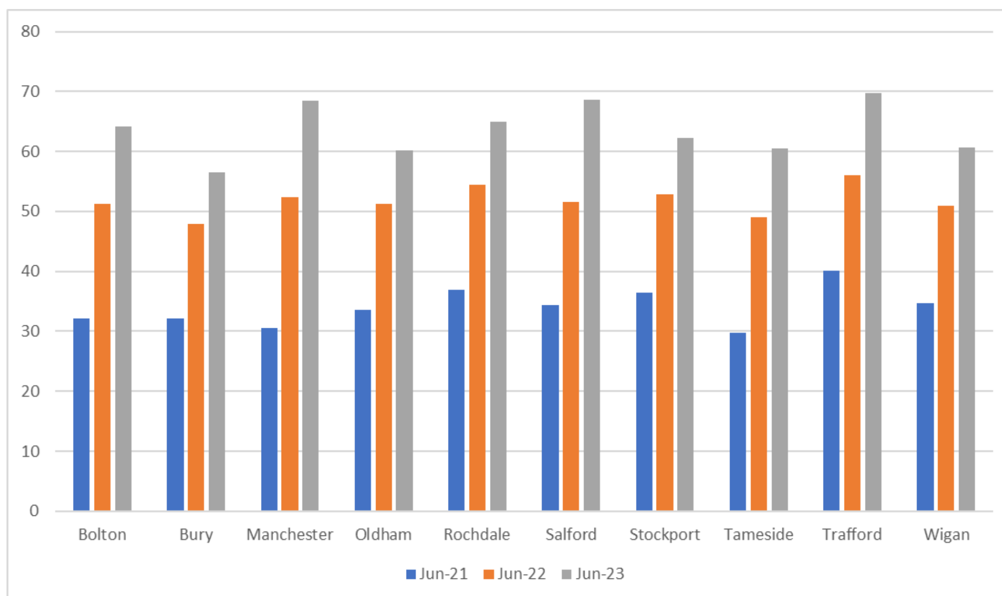


FIGURE 9b: Child patients seen in the previous 12 months as a percentage of the Local Authority population



3.4 Access to Urgent Dental Care

Dental practices offer urgent dental care to their patients.

For members of the public who do not have a regular dental practice, the Greater Manchester Dental Helpline (0333 332 3800) provides advice and clinical triage, booking patients into appointments with Urgent Dental Care services across GM.

Urgent Dental Care is available across Greater Manchester from 8am to 10pm 365 days per week including Bank Holidays. The service is provided according to strict clinical criteria, patients are assessed by a clinical member of the team via telephone and will be offered a face-to-face appointment once triage has been completed.

Urgent dental problems include the following conditions:

- Dental and soft-tissue infections
- Severe dental and facial pain: that is, pain that cannot be controlled by the patient following self-help advice
- Fractured tooth or teeth

The dedicated urgent dental care service operates from 13 different locations across Greater Manchester and patients can choose to be seen at the location most convenient for them.

In addition to the dedicated service, a network of dental practice across GM offers urgent dental care appointments available through the Dental Helpline. This network of providers are known as Urgent Dental Care (UDC) Hubs. The UDC Hubs currently deliver approximately 17,000 appointments for urgent dental care per year.

The government has an explicit manifesto to deliver an additional 700,000 urgent dental care appointments nationally. NHS GM is currently reviewing local arrangements in order to comply with this commitment, taking consideration of emerging NHS planning guidance.

SECTION 4:

URGENT AND EMERGENCY CARE SERVICES

4.1 Background to Urgent and Emergency Care in Greater Manchester

Access to urgent and emergency care (UEC) is a critical component of any healthcare system, ensuring that individuals receive timely and appropriate medical attention during acute health crises. In Greater Manchester (GM), a region known for its diverse population and varying socio-economic conditions, the challenges surrounding access to healthcare are particularly pronounced. Despite the presence of numerous healthcare facilities and services, residents often face significant barriers that impede their ability to obtain necessary care promptly.

The increasing demand for urgent and emergency services has strained the existing healthcare infrastructure. Factors such as an aging population, rising prevalence of chronic diseases, and socio-economic challenges contribute to higher utilisation rates of emergency services. Consequently, emergency departments often face overcrowding, leading to extended waiting times and potentially compromised quality of care.

Moreover, public awareness and understanding of when and how to healthcare services remain challenging. Many individuals are unsure about the appropriate use of emergency services versus other healthcare options, such as NHS 111 or walk-in centres. This confusion can result in the misuse of emergency departments for non-urgent conditions, further exacerbating the strain on these critical services. There is also the perception (and sometimes a reality) of difficulties in accessing primary and community care services. Steps to tackle this are outlined in the sections above.

Addressing these issues requires a multifaceted approach, including improving the distribution of healthcare resources, enhancing public education on healthcare access, and implementing strategies to manage demand effectively. By tackling these challenges, GM can work towards a more equitable and efficient healthcare system, ultimately improving health outcomes for its residents.

4.2 **Contributing Factors to Access Challenges**

Numerous factors create challenges for our population in accessing urgent and emergency care at the right place and time when needed.

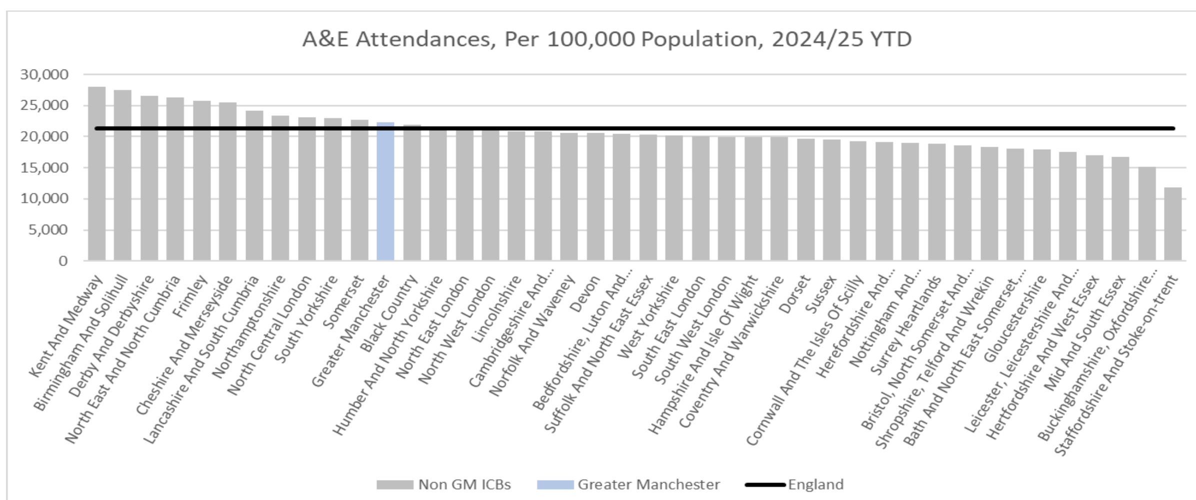
4.2.1 **Increased Demand and Acuity**

Nationally, A&E departments have seen a rise in demand, with GM experiencing a 15% increase in A&E attendance over the last decade, compared to a national average of around 10% (Public Health England, 2022). This rise is due to factors like population growth, increased chronic illness rates, and healthcare access challenges. In January 2025 GM A&Es saw on average 3,900 attendance per day, this is 0.2% above plan across the GM ICS.

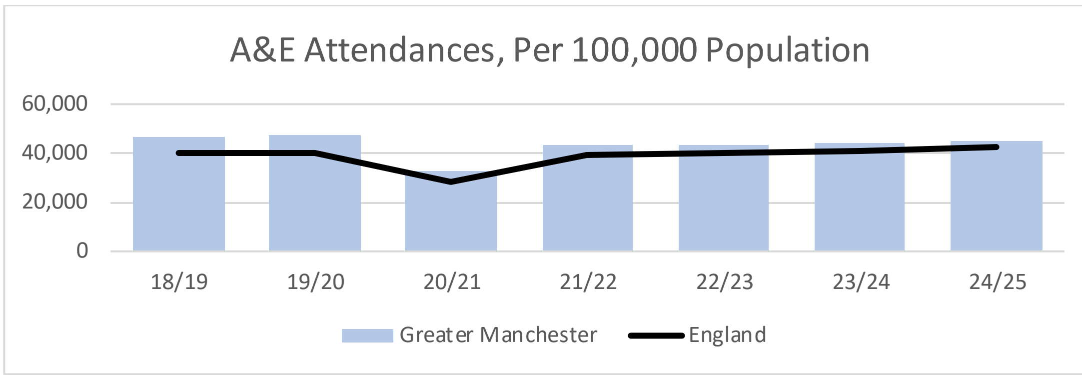
In GM, total A&E attendances have remained relatively stable over the past three years. However, there has been a significant increase in Type 1 demand, indicating a shift in how and where people seek healthcare. GM is in the top quartile for A&E attendances per 100,000 population in the 2024/25 year to date and has been above the national average for attendances per 100,000 population since before the pandemic.

We proportionally have more A&E activity in Type 1 emergency departments than the rest of England. 71.89% of A&E attendees so far in the 2024/25 year have presented at our emergency departments with Type 1 acuity. This positions us 12th out of 42 Integrated Care Boards (ICBs) in terms of this demand in our A&Es and when we use HRG (Healthcare Resource Group) codes we see that acuity has significantly increased, particularly over the past 12 months.

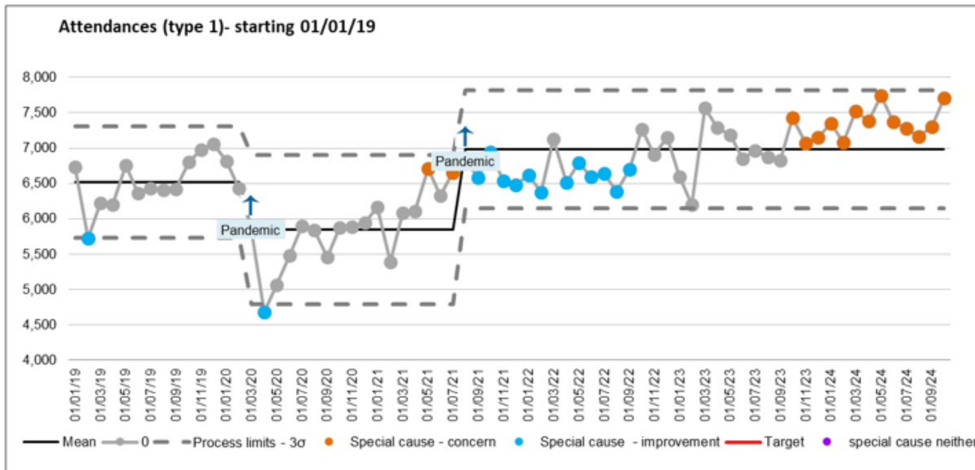
These trends are illustrated in the graphs below.



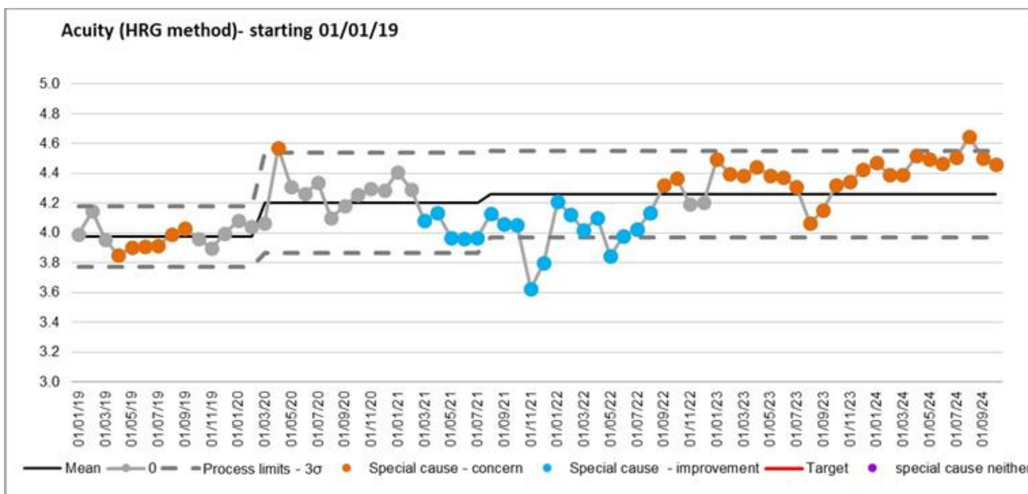
Graph 1 – GM A&E Attendances (all) per 100k population Year to Date 24/25



Graph 2 – GM A&E Attendances (all) per 100k population 2018/19-24/25



Graph 3 – GM A&E Attendances (type 1) 2019-2024



Graph 4 – GM Levels Acuity

4.3 Access to Alternatives

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

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

However, it should be highlighted that more recent feedback indicates that the perceptions of people in Greater Manchester regarding ease of contacting GP practices is better than for the Northwest and nationally, at 74.5% for GM, 73.9% for the NW and 71% nationally (Office for National Statistics: 2025).

4.4 Population Growth, Demographics & Health Inequalities

GM is one of the UK's most densely populated areas, with around 2.8 million residents and 3.3 million registered with a GP. Over the past decade, GM's population has grown by 7%, a rate 6.3% higher than the national average, driven by urbanisation, internal migration, and international immigration. This growth and high population density increases demand for healthcare services, especially emergency care.

GM faces significant disparities impacting A&E attendance, primarily due to poverty, which is both a cause and consequence of ill health. GM is one of the most deprived areas in England, with 1.1 million residents living in the most deprived 10% of areas in the UK. This deprivation leads to higher A&E attendance rates, often for conditions that could be managed in other settings.

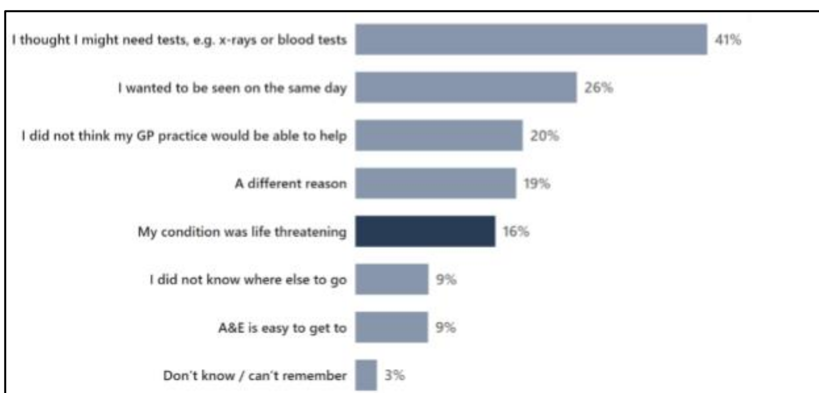
Health inequalities experienced by people in GM result in a cycle of high intensity use of UEC services and deteriorating health. Ensuring our neighbourhoods have the capacity and flexibility to provide intensive and personalised support to our most under-served populations will be a critical success factor on reducing this cycle and improving health outcomes.

4.5 Public Perception

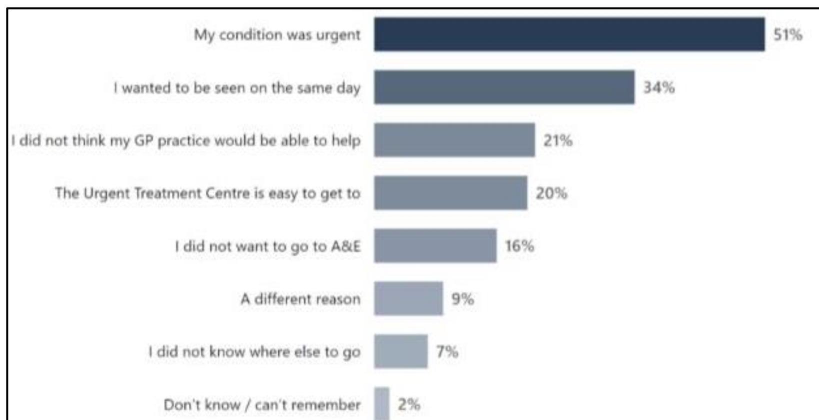
There is a consistent view that easier and extended access to community services like GPs, specialists, or pharmacies would reduce A&E visits. Public perception and experience of A&E services are declining, with concerns about long waiting times and the appropriateness of care received. This feedback highlights the need for improvements in patient experience and service delivery. People describe a complex system, where it is not easy to receive the help that they need.

A public survey conducted by the Care Quality Commission in 2024 asked why respondents attended urgent and emergency care, rather than opting to receive care from another service. Results show that a lack of timely access to other services may be contributing to unnecessary attendances at urgent and emergency care services. Two thirds (66%) of A&E respondents said they contacted another service before attending A&E, while a third (34%) of respondents went directly to A&E.

Of those who went directly to A&E, 20% went because they thought their GP practice would not be able to help (UTC 21%), and 26% wanted to be seen on the same day (UTC 34%), with 9% (20% UTC) of people asked stating ease of access to the A&E department and a further 9% (7% UTC) of people not know where else to go as factors influencing their decision to go directly to A&E. Of those who contacted another service, over a third contacted a GP (A&E 36%; UTC 48%), but 28% of those said the practice did not provide the help they needed (UTC attendance 44%). This is shown in the graphs below.



Graph 5 Reason(s) for attending A&E first for help with a condition.



Graph 6 Reason(s) for attending UTC first for help with a condition.

NHS 111 also has the ability to divert patients to other services, where appropriate, and avoid unnecessary urgent and emergency care attendances. Of those who contacted another service, the NHS 111 telephone service was most commonly contacted (A&E 40%; UTC 37%). However, 12% (UTC 11%) of A&E patients said the NHS 111 telephone service did not provide them with the help they needed.

A public engagement event in 2021 revealed that 70% of A&E attendees had tried to contact another service first, with most contacting their GP practice (27%) or NHS 111 (22% by phone, 6% online), and 5% calling 999. Many attendees (78%) felt their visit was appropriate, but a notable minority felt A&E was their only option due to unavailability of other services or difficulty getting appointments.

Feedback indicated that NHS 111 is often seen as too risk-averse, with less than 50% reporting a positive experience, which discourages its use. Many people are unaware of the full range of services NHS 111 offers, such as booking out-of-hours GP appointments. However, only 18% of patients who contact 111 are directed to urgent & emergency care.

There is a consistent view that easier and extended access to community services like GPs, specialists, or pharmacies would reduce A&E visits. Public perception and experience of A&E services are declining, with concerns about long waiting times and the appropriateness of care received. This feedback highlights the need for improvements in patient experience and service delivery. People describe a complex system, where it is not easy to receive the help that they need.

4.6 System efficiency

System inefficiencies within the NHS create bottlenecks and delays, significantly impacting access to urgent care. These inefficiencies include prolonged waiting times for appointments, inadequate coordination between services, and insufficient staffing levels.

Effective management of patient flow is crucial, as a well-coordinated discharge process improves patient satisfaction and optimises resource use. However, the GM health and social care system often faces challenges that delay discharge, negatively affecting patient flow and outcomes.

Delayed discharges reduce hospital bed availability for new patients, contributing to longer A&E and ambulance waiting times. These delays can also lead to longer hospital stays, increasing the risk of infections and loss of mobility, making it harder for patients to regain independence. GM's performance in managing delayed discharges is challenging, with an increasing number of patients assessed as having 'No Criteria to Reside' (NCTR) remaining in acute beds. On average in January 2025 the ICB was 2.8% behind its target, with an average of 803 (15.3%) beds across its acute hospitals occupied by patients not meeting the criteria to reside.

Reduced patient flow in acute hospitals increases A&E waiting times, worsening patient conditions and leading to more complex and costly interventions. This delay also causes emotional stress and anxiety, reducing patient satisfaction and discouraging individuals from seeking necessary care. Addressing waiting times is essential to ensure prompt and appropriate care, improving both individual health and the efficiency of the healthcare system.

4.7 Current Access to Urgent & Emergency Care

Recovering UEC services within the NHS is essential to ensure timely and effective medical attention for patients in critical conditions. UEC services are the backbone of the healthcare system, providing immediate care for life-threatening situations and urgent medical needs. However, the lack of access to alternative care in the community is impeding timely access for those who need it most.

4.8 Key priorities for improvement

The Urgent and Emergency Care (UEC) Recovery Plan, published in January 2023 by NHS England to improve the quality and access of urgent and emergency care services, includes a number of key priority areas of focus. Combining these with the ambitions for Greater Manchester, to improve quality, experience, and timeliness of service delivery, the following 10 areas are identified as the High Impact changes:

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

4.8 Greater Manchester UEC Provision

GM has, over the last decade broadened its UEC services beyond the core A&E and Primary care offer and residents have access to a range of urgent and emergency care services across all localities to meet their healthcare needs. These include direct access to Walk in Centres, Urgent Community Response (UCR) Teams, Falls Pick-Up Teams, Urgent Treatment Centres (UTC), 111, 999 & A&E, with many open 24hrs and other for 12hrs a day, every day. From these access points there is further access to pathways that support A&E and acute admission avoidance, ensuring people are treated closer to home in line with the NHSE Neighbourhood Health guidelines, 2025.

The complex nature of urgent and emergency care services, involving multiple healthcare providers and varying levels of care, often leads to challenges in coordination and timely access for patients. A Single Point of Access (SPOA) is crucial for enhancing the efficiency and effectiveness of UEC services by providing a centralized hub for managing patient

referrals and coordinating care. This integrated approach fosters collaboration among community, ambulance, primary care, acute services, and social care, ultimately improving patient outcomes and streamlining care pathways. GM is progressing well with its SPOA development, with each locality having its own SPOA led by multi-disciplinary teams and excellent coverage regarding opening times. These teams have established links and pathways to other services, including 2-hour UCR, SDEC, UTC, community services, and primary care services.

GM has established common standards for Urgent and Emergency Care (UEC) delivery across 10 localities, in collaboration with the localities. Various initiatives have been implemented and progress is regularly assessed using a matrix scoring system. Over the past 18 months, GM has shown significant improvement, with all initiatives reaching mature levels. While core principles for UEC have been developed, there is still some variance in delivery. Efforts are ongoing to standardise the offer and ensure equity for patients.

4.9 Impact on UEC Performance & Outcomes

Current outcomes for patients UEC in GM show a mixed picture, while there have been improvements in some areas, challenges remain. Long waiting times and a lack of primary care appointments can significantly impact patient outcomes. Extended waiting times in emergency departments are associated with higher patient mortality and worse health outcomes. Delays in receiving timely care can lead to the deterioration of health conditions, increased stress, and prolonged recovery periods.

GM has seen improvements in some areas when reviewing performance, in January 2025 GM achieved the Category 2 ambulance response time target of <30mins, with a performance of 28mins 53 seconds and a reduction in 12 hr waits in A&E, and NHS GM continues to perform well when compared to its neighbouring ICB's, reporting only 8.38% of all ambulance handovers in the week commencing 17th February 2025 were delayed over 60 minutes. However, challenges remain in achieving the 4hr Standard of Care target along with other key metrics for UEC.

In terms of outcomes, GM is seeing more positive progress. The GM CAS enhances system capacity by intervening earlier in patient care, supporting the urgent and emergency care system by redirecting activity to lower acuity care or self-care. In 2023/24, GM CAS handled an average of 6,050 cases per month, successfully closing over 50% of 999 calls without needing an ambulance, thus freeing up more ambulance hours daily.

The GM Falls Pick Up service has significantly improved patient self-care support, with an increase from 39% in November 2024 to 71% in February 2025. Additionally, they have reduced the number of patients conveyed to the emergency department from 26% to 21% during the same period, successfully keeping nearly 80% of patients at home.

The Hospital @ Home programme plays an important role in supporting patients to access their treatment at home rather than in a hospital bed. Data has shown that 19,657 patients were admitted to a Hospital @ Home bed in 2024, (Month 1-8), patients who, without access to monitoring and treatment through the hospital @ home programme would be likely to increase demand in other parts of the system.

There are now 13 UTCs (2 awaiting full accreditation) across GM with every locality having at least 1. There are 4 other urgent care facilities that also see type 3 activity. Despite some data issues with Type 3 activity through GM's UTCs, there has been a 22.6% increase in attendances from 2023-24 to 2024-25, compared to a 3.8% increase in Type 1 activity. This demonstrates effective streaming of patients to lower acuity services where appropriate. On average, 96% of patients in this cohort were seen, treated, and either discharged or moved on within 4 hours in 2024-25

All 10 localities in Greater Manchester have a 2-hour Urgent Community Response (UCR) service, who consistently exceed the target of responding to 70% of referrals within 2 hours. During December 2024, 92% of all UCR standard referrals met this target, with referrals into the service increasing month on month and approximately 87% of discharged patients remained in their usual residence during December 2024

4.11 UEC Progress & Plans

Work is continuing across all 10 localities to improve access to services, increase offers, simplify access and reduce variation across our UTCs, UCRs and SDEC pathways to ensure people can access the right care at the right time in the right place, shifting care from hospital to community and treatment to prevention.

The GM Hospital @ Home (Virtual Wards) programme currently has capacity of 940 virtual beds with a plan to reach 970 by March 2025, with consistent 80% utilisation of its capacity. The programme has been reviewed recently and recommendations have been put forward to support improvements to maximise utilisation, re-align bed capacity to fit current demand and address variation in delivery models.

A further opportunity to support access to the right care at the right time and reduce the burden on our UEC services is to wrap personalised care around people with the highest intensity of needs. Health Inequalities experienced by people in GM result in a cycle of high intensity use (HIU) of UEC services and deteriorating health. Ensuring our neighbourhoods have the capacity and flexibility to provide intensive and personalised support to our most under-served populations will be a critical success factor on reducing this cycle and improving health outcomes. Work is underway to understand our current offer for high intensity users.

GM plans to enhance and develop its Single Point of Access (SPOA) system to streamline patient referrals, improve care coordination, and ensure timely access to appropriate healthcare services across the region. A single telephony system is being built and expected to be ready mid-March, with further work underway around identification of services and data to support with referrals. Communications and pathways are being developed with a planned wider roll out following test of change in 3 localities.

Despite good progress with the High Impact Initiatives as set out in the national UEC Recovery Plan, GM is not seeing the benefits in a comparable way to other ICBs. Therefore, a focus purely on improving UEC services in isolation of wider public service reform is unlikely to be enough to deliver the recovery required.

4.12 Conclusion

Greater Manchester's UEC system faces significant challenges due to increasing demand, demographic changes, and health inequalities. To address these issues, a comprehensive transformation of the health and care system is essential. This transformation should focus on delivering more care at home or closer to home, improving access, patient experience, and outcomes, and ensuring the sustainability of health and social care delivery.

Key strategies include enhancing primary care access, expanding community services, implementing Single Points of Access (SPOA) for streamlined referrals, and investing in digital health solutions. Additionally, improving the utilisation of Hospital @ Home beds, addressing health inequalities, and reducing hospital discharge delays through comprehensive planning are crucial steps.

By addressing these areas, Greater Manchester can enhance healthcare access, improve patient outcomes, and create a more efficient and responsive healthcare system, ultimately benefiting its diverse population.

SECTION 5

RECOMMENDATIONS

The challenges faced by GM's primary care and urgent care services are multifaceted and deeply rooted in the region's unique demographic and health profile. To improve access to healthcare for residents, especially in urgent and emergency care, it is recommended that Greater Manchester needs to focus on several key areas.

- Enhancing understanding by the public regarding the range of services available to support urgent care, particularly those in primary care (General Practice, Dentists and Pharmacists), including out of hours.
- Implementing true Single Points of Access (SPOA) for UEC will streamline patient referrals and coordinate care, ensuring patients receive the right care at the right time. Investing in digital health solutions, like telemedicine and remote monitoring, can improve access to care and support self-management of health conditions.
- Improving utilisation of Hospital @ Home beds through enhanced pathways and improved collaboration.
- Additionally addressing health inequalities by providing intensive and personalised support to underserved populations is essential to reduce high-intensity use of UEC services.
- Continuing to reduce hospital discharges though comprehensive discharge planning processes that begin at the time of patient admission.

SECTION 6

GLOSSARY OF TERMS

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

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

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

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

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

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

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

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

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

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

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

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

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

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