Greater Manchester
Integrated Care Partnership Board

Date: 28th March 2025

Subject: Supporting People to Return Home from Hospital and to Live Well at Home

Report of: Colin Scales, Deputy Chief Executive, NHS Greater Manchester and Stephanie Butterworth, Tameside Council Director of Adult Services and Chair of GM ADASS.

PURPOSE OF REPORT:

This paper is a follow up to the paper received at ICP Board in November which presented the overall factors affecting UEC standards of care performance in GM. The purpose of this report is to provide the Integrated Care Partnership (ICP) Board with a comprehensive overview of the discharge part of the Urgent and Emergency Care (UEC) pathway in Greater Manchester (GM).

Supporting people home safely from hospital is only one part of a complex system of which there are at least three key levels of activity –

- attendances and admissions – why are so many more people attending and being admitted to hospital
- what happens when someone is in hospital – how efficient is the flow and what prevents timely discharge

- What happens when someone is ready to go home but are delayed (NCTR)

This report aims to highlight the current challenges faced by the health and social care system in supporting people home from hospital and to illustrate how various stakeholders are collaborating to enhance and improve discharge processes. By addressing these issues, the report seeks to inform the ICP Board in making informed decisions to improve flow within the hospital, optimise resource utilisation, and ultimately enhance the quality of care provided to the residents of Greater Manchester.

It is presented to ICP Board in the context of what is happening across GM to develop the Live Well model, particularly the health and care contribution to Live Well. It highlights both successful areas and those areas causing delays, with a focus on enhancing resources in neighbourhood settings to support timely discharges and reduce wait times, aiming for better outcomes for people and a more efficient and responsive healthcare system.

This report also contains some reflections for the Urgent & Emergency Care Pressures experienced in the winter period of 2024/25, highlighting to the board some of the challenges, good practice and learning to be had for future years.

RECOMMENDATIONS:

The GM Integrated Care Partnership Board are requested to:

1. Note the contents of the report, particularly the current challenges and good work underway to address them.

2. Discuss the opportunities for further collaborative improvement between health, care and wider public service to improve discharge from hospital, and build on our Home First approach, in the context of the GM Live Well model.

3. ICP Board members are asked to comment on the role of all public services in preventing hospital admissions through a 'Hospital Second' approach to admission avoidance. To support further work in this area, it is intended that a

further paper focusing on admission avoidance in the context of the GM Live Well model is brought to the next ICP Board.

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Executive Summary

Purpose of the Report

This report provides the Integrated Care Partnership (ICP) Board with an overview of the discharge component of the Urgent and Emergency Care (UEC) pathway in Greater Manchester (GM). It aims to highlight current challenges and collaborative efforts to improve discharge processes and support people returning home from hospital.

Supporting people home safely from hospital is only one part of a complex system of which there are at least three key levels of activity –

- attendances and admissions – why are so many more people attending and being admitted to hospital?
- what happens when someone is in hospital – how efficient is the flow and what prevents timely discharge?
- What happens when someone is ready to go home but are delayed (NCTR)?

Policy and Legislative Drivers

- **Care Act (2014)**: Defines the role of adult social care in supporting hospital discharges.
- **NHS England Operational Planning Guidance:** Sets out priorities for the NHS in 2025/26 regarding reducing long lengths of stay in hospital and collaborating with partners.
- **Hospital Discharge Guidance**: Introduced during the COVID-19 pandemic to streamline the discharge process. Sets out definitions and processes for 'No Criteria to Reside'.
- **NHS Greater Manchester Sustainability Plan:** Sets out GM's commitment to developing proactive care models which enable people to manage health and ill-health in the most appropriate setting.

Performance

Greater Manchester is performing at the national average for people having a length of stay (LOS) of 7 days or more in hospital. It is above the national average for people

who experience a LOS 14 days and 21 days or more in hospital - this longer than average long LOS is contributed to by the higher acuity and complexity seen in our population

We know that when people stay in hospital longer, they are more likely to experience deconditioning, which may mean that they are unable to return home independently.

In GM, a significant challenge is the increasing number of people experiencing delays away from home and classified as NCTR in hospital. On average in January 2025 the ICB was 2.8% behind its target, with an average of 803 (15.3%) beds across the acute hospitals occupied by patients not meeting the criteria to reside. High NCTR numbers contribute to elevated bed occupancy, disrupting patient flow and adding pressure on A&E departments.

Hospital process delays account for around a third of all delay reasons for people on the NCTR list. Work is underway across Greater Manchester to improve in hospital discharge processes.

Capacity related delays account for 33% of all delay reasons recorded (This category is very broad and includes delays with any service required by the person including intermediate care, social care, equipment and housing).

In GM 80% of people on the NCTR list are aged 65 and older. Our population who are over 65 is steadily growing, so our work in GM to support older people to Live Well at Home is essential to ensure that they are not disproportionately affected by challenges being discharged from hospital. 11% of the total NCTR list size is made up of people who are awaiting pathway 3, which is a discharge to a permanent 24-hour care placement. However, the actual pathway that a person is discharged onto, may change once full assessment has taken place, with the person being discharged home with support (Pathway 1) or to a rehabilitation setting (Pathway 2). For example, recent analysis in Manchester showed that 55% of people identified as requiring a pathway 3 bed, were diverted home. This demonstrates that delays in discharging people could be avoided if a 'Home First' approach was consistently adopted from hospital.

Challenges with Timely Discharge

Challenges experienced in supporting people quickly home from hospital are multifactorial. This report builds on evidence presented to ICP Board in November 2024 regarding the changing acuity and complexity of demand being seen in our UEC services, driven in part by demographics and health inequalities in GM. Additional challenges which are specific to the discharge part of the UEC pathway relate to risks within the care provider market, workforce challenges and barriers created by variability between localities and outside of GM.

Collaborative Improvement Initiatives

In GM we work together at place and GM, and across health and adult social care to drive continuous improvement through transformational change, focussing on growing best practice approaches to grow what we know works well. We utilise funding across sectors to facilitate this change and make the case for further investment to prevent admissions, as well as support people home from hospital. GM Live Well, and specifically the health and care contribution to Live Well through the development of integrated neighbourhood services, provide the foundation for collaboration to improve discharge pathways and processes. The report identifies a range of initiatives which are proving successful across GM including Home First approaches, Intermediate Care development, the GM Hospital at Home programme, the dementia Front Runner programme, market development work and progress with blended health and care roles.

Conclusion

The report underscores the need for a collaborative approach across the health and care system to address discharge challenges. The ICP Board is invited to comment on the ongoing work and suggest further areas for improvement.

1. Introduction

Supporting people to be discharged home in a timely and safe way is essential so that people have the best experience, and the hospital operates at its optimum. A streamlined discharge process not only improves people's satisfaction but also enhances operational efficiency and optimises resource utilisation. In GM, the system frequently encounters challenges that delay people being discharged as soon as they should be, adversely affecting people's outcomes and flow within the hospital. By addressing delayed discharges, also known as 'No Criteria to Reside' (NCTR), we aim to ensure people who are medically fit can return home or move smoothly on to their next stage of care and support if needed.

The main focus of addressing the number of days a person is kept away from home is to ensure the Greater Manchester Integrated Care System (ICS) effectively supports people returning home from hospital. Part of this involves coordinating efforts across health and social care providers to create a seamless transition, ensuring access to follow-up care and community support if needed. By tackling delay issues, the ICS aims to enhance individuals' outcomes, reduce readmissions, and optimise healthcare resources, promoting a healthier and more independent life for people to live well at home.

Greater Manchester's Live Well movement seeks to optimise systemised neighbourhood models across GM, drawing in health and care with all other relevant public services, the independent care sector and the Voluntary, Community, Faith and Social Enterprise Sector (VCFSE). It promotes a culture of prevention with a workforce that focusses on person-centred ways of working. This culture is essential, not just in the way we respond to what people want through to preventing people from being admitted into hospital, but also in the way we support people through the discharge process to return home first where possible.

2. Policy and Legislative Drivers Affecting Discharges in Health and Social Care

The term of No Criteria to Reside" (NCTR) was established in 2022 and refers to people who are medically fit to leave the hospital but remain there due to various non-medical reasons. In GM, a considerable number of people are classified as NCTR, meaning we have significant numbers of acute beds occupied which is impacting on patient flow and outcome.

Health and social care play a crucial role in supporting people to return home from hospital and live well at home. This involves a coordinated approach to discharge planning, ensuring that, where needed, people have access to the necessary medical care, rehabilitation, and social support. Health professionals work closely with social care providers to understand what support people need to return home, arrange for home adaptations if required, and provide ongoing care and support if needed. This collaborative effort helps to promote individuals' recovery, reduce the risk of readmission, and enhance overall well-being by enabling people to live well and independently in their own home.

Supporting people to live well at home is at the heart of our GM strategy, with a focus on prevention, enabling people to live well for longer, independently and safely. This will reduce the significant health-inequalities, ensure people live better lives with better outcomes and ensure an effective use of resources across the health and care system.

Adult Social Care (ASC) aims to support people to live well and independently at home, with the best quality of care and support and places personalisation at its heart, supported by a sustainable workforce, and underpinned by a strengths-based approach.

Evidence shows that people recover best in their own home supported by their families and living in a familiar environment. Supporting people home whenever possible is a shared priority across health and social care, with social care supporting around 500 people across GM home from hospital every week.

Schedule 3 of the Care Act (2014) sets out adult social care's role in supporting people being discharged from hospital who have care and support needs.

Greater Manchester's sustainability plan recognises the importance of taking action to keep people physically and mentally well with focus on:

- considering the environments in which people live and work, and the experiences they have
- delivering more consistent proactive care to support effective population health management
- reducing disparities in care for people in deprived socioeconomic groups

One of the five pillars of the GM sustainability plan is proactive care, which focuses on catching ill health early, managing risk factors, and delivering evidence based, cost effective interventions to reduce the level of harm. This is part of NHS GM's 5-year plan to invest in planned population health interventions to reduce prevalence and invest in communities.

The hospital discharge pathway was introduced to streamline the process of supporting people out of hospital to home. This pathway ensures that people receive effective discharge planning, including medication management, follow-up appointments, and necessary support services. The discharge pathways 0, 1, 2, and 3 were introduced as part of the "Discharge to Assess" (D2A) model during the COVID-19 pandemic. This model was implemented following the release of the Hospital Discharge Service Guidance in March 2020. The pathways are designed to streamline the discharge process and ensure patients receive appropriate care based on their needs:

- Pathway 0: Simple discharges with no input from health or social care.
- Pathway 1: Support to recover at home, with input from health and/or social care.
- Pathway 2: Rehabilitation. this could also be at home
- Pathway 3: 24-hour care placement, either permanent or temporary

According to the John Bolton's model to support people home and improve hospital discharge processes, particularly focusing on the needs of older people, the pathway discharge recommendations are **Pathway 0**: 50-60%, **Pathway 1**: 30-35%, **Pathway 2**: 5-10%, **Pathway 3**: Less than 5% and ideally close to 1%.

His work emphasises the importance of capacity and demand planning to manage hospital discharges effectively.

The NHS England 2025/26 priorities and operational planning guidance highlight the importance of reducing hospital length of stay and ensuring patients receive care in the most appropriate setting. This involves increasing the percentage of people discharged by or on day 7 of their admission, in line with existing guidance. Additionally, collaboration with NHS and local authority partners is essential to reduce the average length of discharge delays, in accordance with the Better Care Fund (BCF) policy framework. Integrated Care Boards (ICBs) should review BCF commitments to ensure optimal resource use and plan sufficient intermediate care capacity to meet demand, including during surge periods throughout the year.

3. National Context

According to The King's Fund, delayed discharges from hospital are 'a widespread and longstanding problem that can have a significant impact on both patients' recovery and the efficiency and effectiveness of health and care services. (Hospital discharge funds: experiences in winter 2022-23, The King's Fund, 2023)

The Nuffield Trust reports that the number of patients in acute hospitals ready for discharge but experiencing delays rose by 43%. This increase saw the daily average climb from 8,545 patients in June 2021 to 12,223 patients in June 2024. The situation peaked in January 2024, with 14,096 patients facing delays in leaving the hospital. Delayed discharges from hospital (Delayed discharges from hospital, Nuffield Trust, 2024)

4. Greater Manchester Performance

GM performance with the 4-hour standard of care continues to be challenged and is not improving at the rate set within our 2024/25 plan. The paper presented to ICP Board in November identified the factors affecting performance in GM. This report focuses in more detail on discharge specific performance.

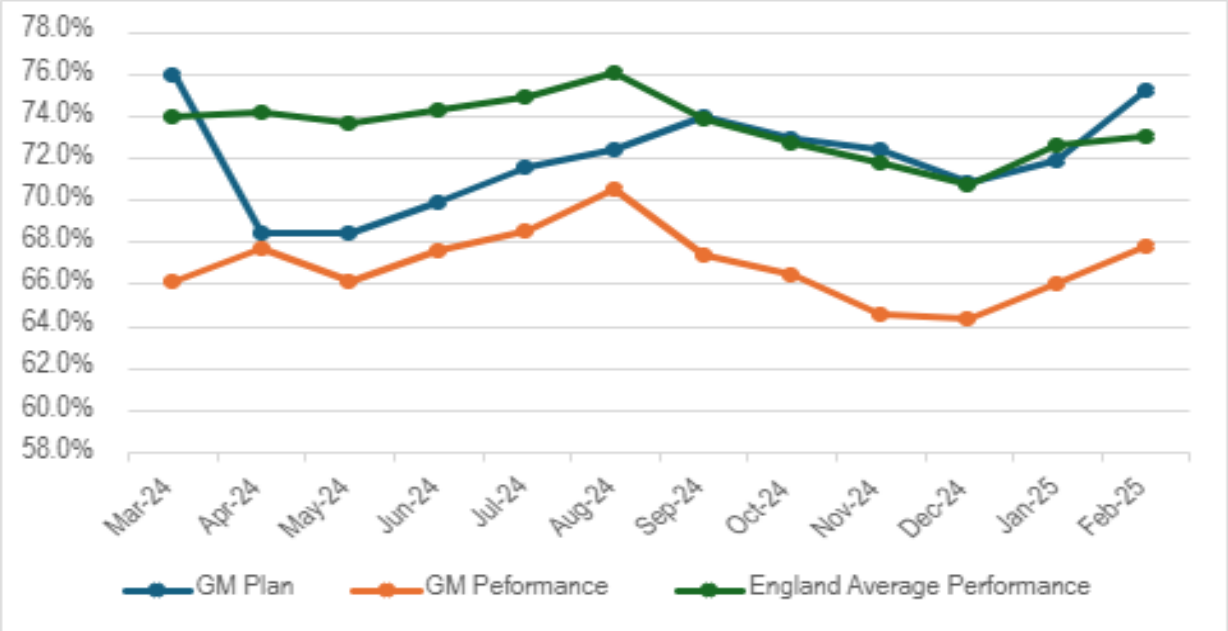

Chart 1: GM 4 Hour Standard of Care performance compared to GM plan and England average

This next section of this section sets out our performance against key discharge related metrics. These fall into three main areas:

- Long lengths of stay in hospital; this allows us to understand when people may stay in hospital for a longer period of time than is ideal, even when the person still has a medical reason to be in hospital
- No criteria to reside data; this allows us to understand the reasons that people are staying in hospital after the person no longer has a medical reason to be in hospital
- Discharge pathway data; this allows us to understand the types of support people receive when they leave hospital.

A 12-month data period has been used to reflect current performance, ensuring data availability and consistency in addressing the issue. A 12 month period of data is used as it is available to illustrate trend over time.

Long Lengths of Stay

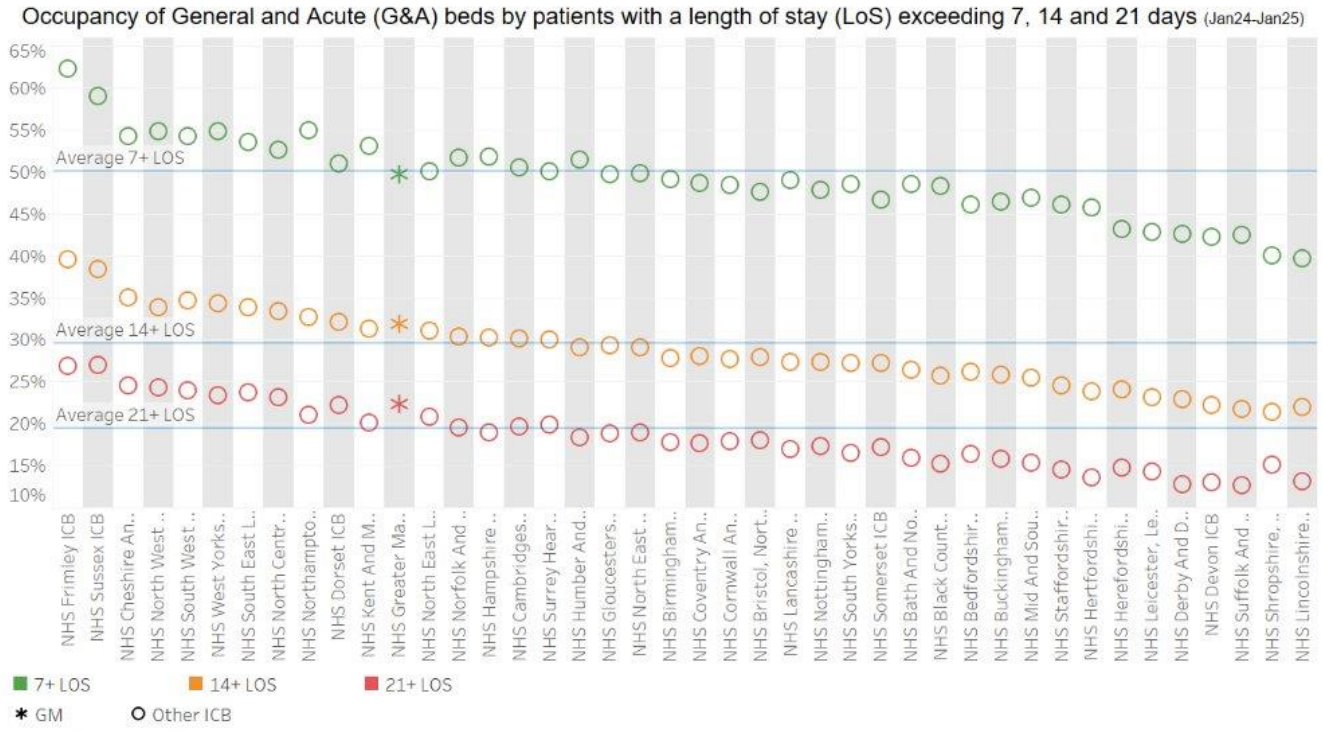

Chart 2: Comparison of NHS GM to all other ICSs for LOS exceeding 7, 14 and 21 days

Greater Manchester is performing at the national average for people having a length of stay (LOS) of 7 days or more in hospital. It is above the national average for people who experience a LOS 14 days and 21 days or more in hospital. In the November 2024 Urgent Care paper to ICP Board, it was demonstrated that this longer than average long LOS is contributed to by the higher acuity and complexity seen in our population. In this paper, we focus on the impact that these longer stays have on people becoming stranded in hospital and not being discharged home in a timely way.

We know that when people stay in hospital longer, they are more likely to experience deconditioning, which may mean that they are unable to return home independently. This may include experiencing physical and cognitive decline. Cognitive disorientation and delirium associated with ill health while in hospital can lead to particularly poor

outcomes due to perceptions from professionals and family members that this is a permanent change in the person.

No Criteria to Reside

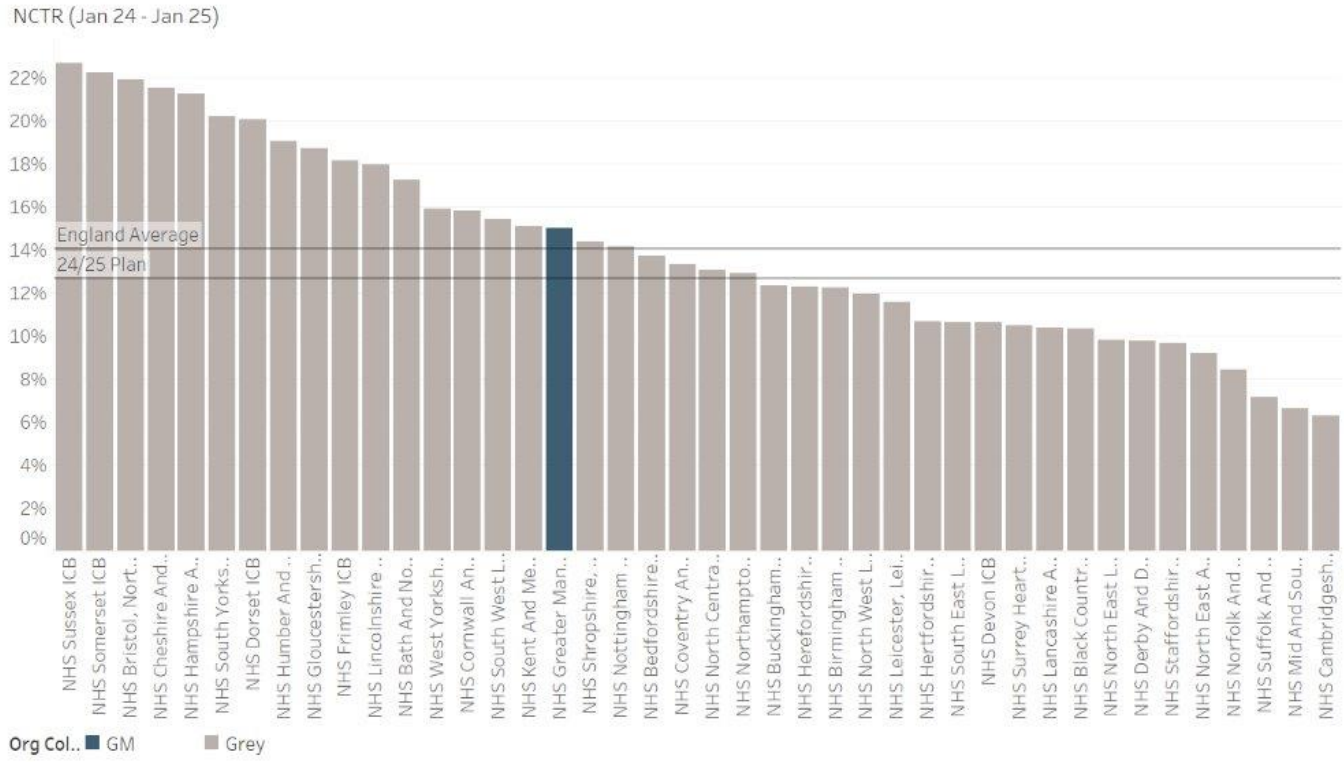

Chart 3: Comparison of NHS GM to all other ICSs for % of General and Acute beds occupied by people with No Criteria to Reside in hospital

The GM NCTR list size is above the England average (as a % of occupied General and Acute hospital beds). The NCTR list size sharply increased in June 2024 and continues to fluctuate. We are 3% points above our plan for the year. The total NCTR list size is currently around 800 people, which is more than the total number of G&A beds available in our largest two hospitals (Manchester Royal Infirmary or Salford Royal Hospital).

Hospital Process Related Delays- Hospital process delays account for around a third of all delay reasons for people on the NCTR list. Factors leading to these delays are multifaceted and include things such as awaiting assessments for discharge that need to happen in hospital, as well as waiting for relatively simple discharge tasks to be completed like take home medications to be ready and transport to be booked.

Work is underway across Greater Manchester to improve in hospital discharge processes and detail of this work is described in later sections of the paper.

Capacity Related Delays- Capacity related delays account for 33% of all delay reasons recorded. This category is very broad and includes delays with any service required by the person including intermediate care, social care, equipment and housing. It is important to acknowledge that, in GM 80% of people on the NCTR list are aged 65 and older. Our population who are over 65 is steadily growing, so our work in GM to support older people to live well at home is essential to ensure that they are not disproportionately affected by challenges being discharged from hospital. 11% of the total NCTR list size is made up of people who are awaiting pathway 3, which is a discharge to a permanent 24-hour care placement. However, the actual pathway that a person is discharged onto, may change once full assessment has taken place, with the person being discharged home with support (Pathway 1) or to a rehabilitation setting (Pathway 2). For example, recent analysis in Manchester showed that 55% of people identified as requiring a pathway 3 bed, were diverted home. This demonstrates that delays in discharging people could be avoided if a 'Home First' approach was consistently adopted from hospital.

Discharges by Pathways

The proportion of people on the NCTR list discharged on each pathway has remained relatively stable from March 2024 to January 2025. Chart 4 below shows that the majority of people leaving hospital leave without support. The recording of the 'Unknown' pathway for NCTR affects data quality and the accurate reflection of pathway discharges. It is reasonable to assume that most people who leave hospital with no pathway assigned, are discharged on P0 (no support required). The majority of people with no pathway assigned have a criteria to reside (i.e. are medically required to be in hospital) up until the point that they leave hospital and very small numbers are assigned to pathway 1, 2 or 3 at the point of discharge.

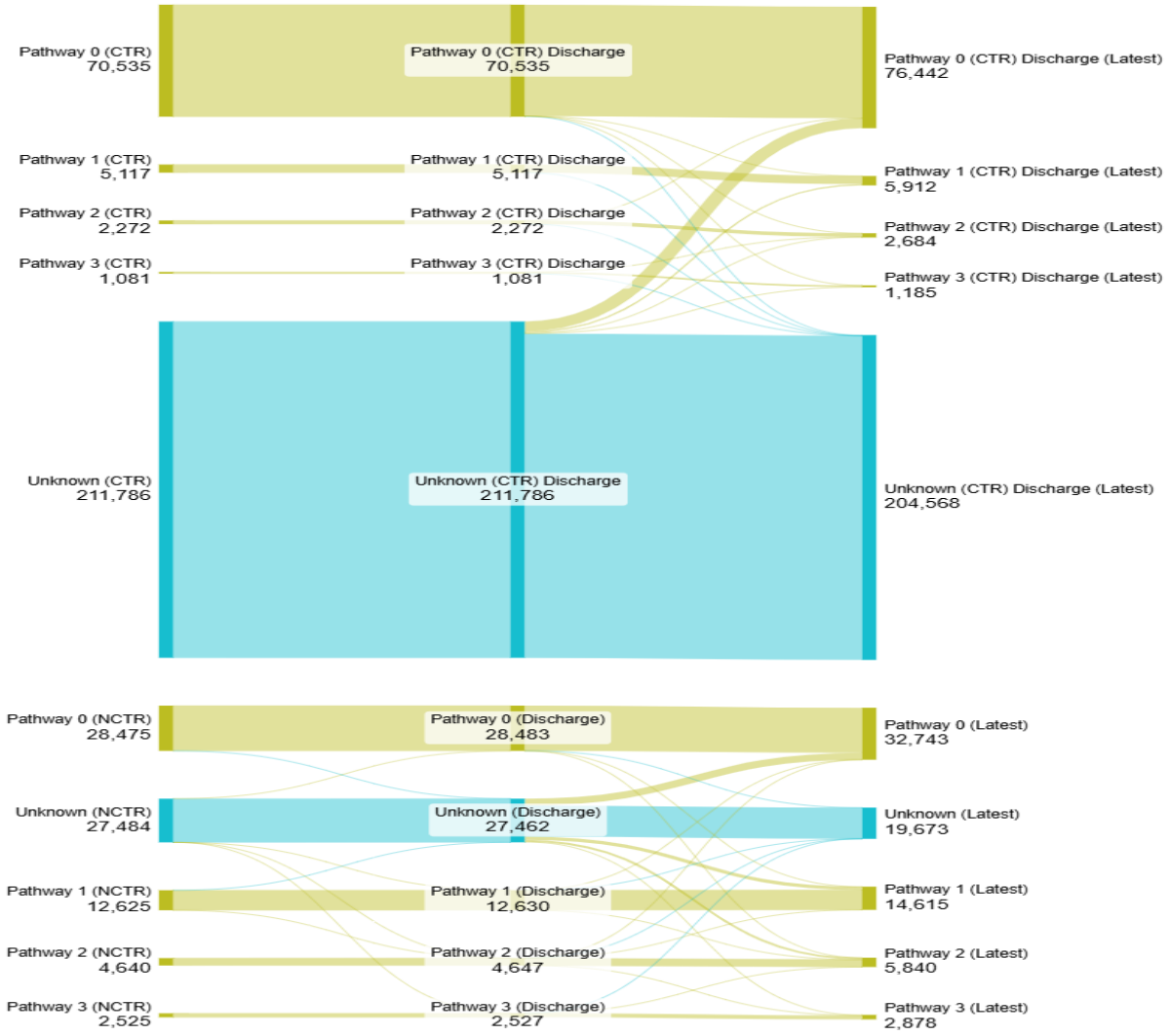

Chart 4: Diagram showing movement from initial NCTR pathway to latest pathway at discharge

Chart 4 shows that there is considerable movement between the initially assigned pathway and the pathway on discharge for people who are NCTR. This movement between pathways is a result of assessments being undertaken in hospital, which take time. Whilst assessment is important to make sure that a discharge is safe, this can also be a delay in getting people home at the earliest opportunity, especially given that the biggest proportion of people go on to leave hospital with no support (P0 and unknown). A Home First approach to discharge support means that wherever possible, people should be discharged as quickly as possible and for assessments to take place at home. GM has a strong commitment to Home First principles; however, this evidence would suggest that there is still a greater opportunity to avoid assessment in hospital and to speed up discharges home.

5. GM Challenges with supporting people home in a timely way

This section of the report sets out the key challenges being experienced in GM which are affecting the discharge home of people in a timely way:

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

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

Winter Peaks - in winter 2024, GM experienced significant pressures on hospital services, which ultimately impacted patient discharges and hindered the creation of effective patient flow. The combination of increased patient numbers, higher acuity levels, and workforce challenges contributed to a strained healthcare system, making it difficult to manage discharges efficiently and maintain smooth operations. This situation highlighted the urgent need for enhanced support and strategic planning to address these seasonal pressures.

Between the winter of 2023 and the winter of 2024, GM saw a significant increase in hospital activity. For instance, there was a notable rise in flu-related hospitalisations, with a 49% increase in just one week in December 2024. Additionally, hospital bed occupancy rates remained high, averaging around 92.8% in late January 20242. These figures highlight the growing pressures on the healthcare system during this period.

Falls - the Greater Manchester NHS is facing a significant challenge with a high rate of falls, which make up about 8% of all hospital admissions for people over 65. This results in increased patient morbidity, with many experiencing fractures, head injuries, or prolonged hospital stays. The annual cost of falls in Greater Manchester is estimated at £250 million, adding pressure on healthcare staff and resources, and affecting overall service delivery. An outline business case is being progressed to develop a system approach to preventing falls, to reduce impact on our health and social care system and ensure better health and wellbeing outcomes for people.

Market risks -Currently there is sufficient residential and nursing provision as well as support for people living independently in their own homes. However, the adult social care market is fragile and the rise in National Insurance and Real Living Wage is placing additional pressure on independent providers. It is anticipated that there will be more change in the market, but commissioners are working closely with care providers and doing everything they can to support the market to remain resilient.

Complex Needs - There is increasing demand and complexity linked to demographic change, which represents a significant financial risk and pressure for councils. Supporting post-acute care poses a significant challenge, as the aging population and rising number of individuals with complex health needs require more comprehensive and coordinated care. This situation demands substantial investment in healthcare infrastructure, community services, and long-term care facilities. Additionally, the need for effective discharge planning and post-hospital support adds to the financial burden. Addressing these challenges is crucial for ensuring that councils can meet the needs of their communities while managing their resources effectively.

Workforce – Recruiting and retaining staff is a significant challenge in the health and care workforce and there is a lot of work underway to improve this such as creating more attractive career pathways, continued professional development and striving for better pay and reward conditions. Also, as we work towards more integrated working, and with the development of new blended and hybrid roles, we hope to see a positive impact on the workforce over time. There is a well-established workforce transformation programme in GM which supports the care and health sector to continue to recruit, retain and grow a sustainable workforce.

Out Of Area demand – It often takes longer to discharge people who are out of the area due to the additional resources required to coordinate with various providers who may have different processes and procedures. Engaging in conversations with these external providers can be time-consuming and complex, as it involves aligning different systems and ensuring all necessary care arrangements are in place. This can lead to delays in discharge, as more effort is needed to navigate these differences and secure appropriate post-discharge care for the person. As of 28th February, there were 62 people who were out of the GM ICS footprint which is 12% as a snapshot.

Mental Health - Delays often occur when people with mental health (MH) issues require a Mental Health Act (MHA) assessment following the initial liaison assessment. Coordinating and completing this process can take several hours, frequently resulting in breaches of the 4-hour standard of care. Additionally, national pressures on MH beds lead to longer waits for a bed in A&E, impacting both space and staff availability for further assessments. The term "clinically ready for discharge" is used for discharging people with mental health issues and differs from the "No Criteria to Reside" status. People with mental health problems typically require more time for discharge due to the complexity and multifaceted nature of their needs.

6. GM collaboration in supporting people home from hospital

We work together at place and GM, and across health and adult social care to drive continuous improvement through transformational change, focussing on growing best practice approaches to grow what we know works well. We utilise funding across sectors to facilitate this change and make the case for further investment to support

people home from hospital as well as prevent admissions. In GM, significant collaborative efforts are underway to support individuals in returning home from the hospital and living well at home. These initiatives aim to reduce unnecessary prolonged hospital stays, free up beds for new admissions, and implement admission avoidance programs. By embracing discharge home-first principles, the community is working together to ensure that individuals receive the necessary support to live well within their own homes and communities.

The NHSE guidance is specific that Home First and person-centred approaches need to be embedded throughout the health and care system so that appropriate risk-based decisions are always made, and hospital care only used when clinically necessary.

All localities in GM have made significant progress in developing neighbourhood approaches – and there are examples of excellent practice across the city region. Our priority now is to accelerate our progress so that the full neighbourhood model is consistently available to everyone in GM as one of the key components of Live Well.

7. Live Well Model

Greater Manchester's Live Well movement seeks to optimise systemised neighbourhood models across GM, drawing in health and care with all other relevant public services and the Voluntary, Community, Faith and Social Enterprise Sector (VCFSE). It promotes a culture of prevention with a workforce that focusses on person-centred ways of working. This culture is essential, not just in preventing people from being admitted into hospital through the ways in which we respond to people's needs in communities, but also in the way we support people through the discharge process to return home first where possible.

The GM Live Well model has great potential to function as an effective system facilitator, supporting a partnership approach to health and wellbeing in Greater Manchester. By fostering collaboration among various stakeholders, including healthcare providers, community organisations, and local authorities, the Live Well model aims to create a more integrated and holistic approach to health. This model emphasises prevention, early intervention, and community-led initiatives, which can help address health inequalities and improve overall outcomes. Through coordinated

efforts and shared resources, the Live Well model can enhance the delivery of services, ensuring that individuals receive the support they need to live healthier, more fulfilling lives. This partnership approach not only strengthens the healthcare system but also empowers communities to take an active role in their health and wellbeing.

Greater Manchester Combine Authority (GMCA) and NHS GM are working in partnership to convene the system for the further development of neighbourhoods across GM. We will work with localities and other partners to design the optimum neighbourhood model in 2025.

The following sections of this report identify specific components of the health and care contribution to Live Well which are supporting improvements in discharging people home from hospital:

Home first approach - When people who have been in hospital are ready to return home and need care and support, we adopt a 'home first' approach. This strategy prioritises helping individuals return to their original residence and regain their independence. By focusing on home-based care, we aim to provide the necessary support and resources to facilitate a smooth transition from hospital to home. In Bury, approximately 80% of people admitted to the hospital as an emergency admission successfully return to their original residence, highlighting the effectiveness of this approach. This not only promotes better health outcomes and quality of life for people but also helps to alleviate pressure on hospital resources by reducing the length of hospital stays and preventing unnecessary readmissions.

Taking a strengths-based approach - through the development of the national Frontrunner programme Fairfield Hospital has taken 10 days off the average length of stay of those people on the dementia ward, and well over 1/2 day off all other older adults. This has reduced demand on adult social care by over a quarter at the point of discharge and the additional space it has released in the hospital means urgent care pressure has been considerably reduced this winter with no escalations to Opel 4. This has had a positive impact on 100s of people lives, both people and staff, and many hundreds more people are now back at home which might not have happened

beforehand. The Northern Care Alliance NHS Foundation Trust (NCA) are now rolling this approach across their other hospital sites.

Better outcomes for people – many localities are investing in reablement, extra care and technology. Manchester has invested in a new model of care and support (Better Outcomes Better Lives) and have reduced the length of stay for 55% of people in hospital, reduced unnecessary A&E admissions by 34% and avoided over £39m of homecare and residential care costs.

Care Transfer Hubs significantly improve the process of moving people from acute hospital settings to the appropriate form of care and support. This approach alleviates the pressures on acute hospitals, allowing them to focus on providing essential hospital-based care while ensuring people receive the necessary support for their recovery and rehabilitation in the most suitable settings.

Virtual wards – hospital at home provides care and medical treatment for people with acute conditions in their own homes, using a combination of technology and existing locality community resource to support people at home rather than in a hospital bed across 4 clinical pathways: frailty, acute respiratory, general medicine and heart failure. This can be used both to support people home from hospital as well as preventing people being admitted to hospital. Over a 6-month period, this supported just under 20,000 people and saved over 225,000 hospital bed days.

Northwest Ambulance Service (NWAS) plays a crucial role in supporting hospital discharges through Patient Transport Service (PTS). NWAS provides non-emergency transport for people who need assistance getting home after being discharged from the hospital. This service ensures that people can return home safely and comfortably.

A new care and support provider framework - in April 2025, a new provider framework will be launched to enable the co-design of new models of care and services with residents and providers. This initiative aims to address existing gaps and support individuals close to their homes and networks. The strategy involves commissioning as an integrated system to shape the market in response to current

and future needs, primarily to support people living well at home, but also to assist those returning home after long hospital stays or from outside GM.

This approach is expected to result in better choices, higher quality, and improved outcomes for the population, creating a more resilient market and achieving cost efficiencies. The focus will be on working collaboratively across different geographies to prevent the need for long-term care or hospital admissions. For those requiring support after a hospital stay, the framework will facilitate their discharge and subsequent assessment for recovery.

Intermediate care – both as part of the Community Services Review and locally led, we're defining what great intermediate care looks like which will be used as a standard for us to understand performance and outcomes.

- *In Rochdale*, they've redesigned their discharge to assess within their IMC setting at Tudor Court which has been live since July 2024, and a clear home first strategy signed up to by all partners.
- *In Stockport*, therapy led assessment and approach to reablement and intermediate care, has resulted in only 3% of people being discharged on pathway 3 and 71% on pathway 0.
- demand and capacity modelling has supported the development of future discharge processes and intermediate care model in *Wigan*. It is estimated that this will result in a 2-day reduction in LoS for pathway 1-3, 200 additional residents benefitting from home-based intermediate care services, 50 fewer new residential placements each year and 8-15 few short-term beds will be needed.

Blended roles – Work has been underway on developing and upscaling blended roles within home care and care homes for some time now and started in Tameside, but we are now seeing a real growth in different roles within the sector that in turn supports people better at home and improves recruitment and retention. For example, in the first six months of the allied health blended roles programme in Oldham we saw a reduction in emergency hospital attendance because of falls in the care homes where the initial pilot is taking place. In home care it has resulted in the ability to repurpose

district nursing capacity to those with more complex nursing needs and has seen an improvement in outcomes for individuals such as through more timely insulin administration.

Standardising Community Urgent Care Coordination - 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.

8. Urgent & Emergency Care Winter Reflections 2024/25

The winter of 2024/2025 (October 2024 – January 2025) presented significant operational challenges across the GM UEC system. Seasonal pressures, an increase in respiratory illnesses, workforce challenges, and capacity constraints led to sustained high demand, requiring a coordinated system-wide response. This paper evaluates the impact of winter on UEC services, synthesizing insights from the GM UEC System Group meetings, the GM winter preparedness event held in September 2024 and the GM System Coordination Centre (SCC) operations. It also incorporates reflections on the role of Primary Care expansion supported by capacity funding.

Demand and Capacity Challenges

Increased Patient Demand and System Pressures

During the 2024/25 winter period, the GM system experienced above planned levels of emergency department (ED) attendances and ambulance conveyances, driven by:

- A surge in respiratory conditions (influenza, COVID-19, RSV) as well as norovirus referred to as a quad-demic.
- Increased attendances of frail and elderly patients with falls and exacerbations of chronic conditions. Although, it can be evidenced the number of attendances and ambulance conveyances for this cohort of patients will have been reduced by the introduction of the pan - GM Falls Lifting Response service and the Hospital@Home

programme being able to support patients on two key clinical pathways of care - frailty and acute respiratory infections.

- Severe weather conditions, particularly early January 2025 which impacted mobility and led to more injuries and acute health events.

Hospital Bed Occupancy and patients with No Criteria to Reside (NCTR

Although some hospital sites reported higher bed occupancy levels during the winter months. Hospital occupancy levels at NHS GM level remained at approximately 92%, although corridor care is perceived to have normalised, and this sadly is associated with the quality of care for patients.

Patients with NCTR due to inefficient discharge processes continues to impact on patient flow and consequently causes congestion in ED, hence the increase in 12 hour waits. This also sadly has an association with quality of care for patients.
The 4-hour standard of care for all attendance types peaked at 66.1% during the 2024/25 winter months.

Ambulance Pressures and Handover Delays

Ambulance pressures have been experienced nationally and across the other Integrated Care System (ICS) footprints in the North-West. However the North-West Ambulance Service (NWAS) has continued to perform well across Greater Manchester throughout 2024/25 and particularly through the winter months except for January 2025 when the average category 2 response time exceeded 30 minutes by 1 minute 37 seconds.

In contrast, significant handover delays were experienced across the GM system during the winter months. This resulted in a revised set of Quarter 4 handover time trajectories being agreed with all acute trusts.

The Role of the GM System Coordination Centre (SCC) in managing operational pressures across the UEC system during winter 2024/25

The GM System Coordination Centre (SCC) serves as a central command for real-time operational coordination, ensuring integrated system-wide responses across GM's UEC services. The SCC:

The SCC has developed and implemented robust processes and protocols to mitigate risks to patient safety and care quality. These measures are particularly focused on patients experiencing prolonged admission waits, delays in ambulance handovers, and extended stays in health or social care settings.

A GM System Coordination Centre Leadership Group was established in early 2024, which is a group that brings together senior leaders across the system to monitor challenges, identify emerging risks, and respond accordingly. Meetings are held in alignment with system pressure levels, ensuring a structured and proactive approach to escalation management.

The SCC monitors demand and capacity pressures across acute, mental health, community, primary care, ambulance and adult social care settings, Coordinating Operational Pressures Escalation Levels (OPEL) escalations to ensure timely intervention and resource reallocation.

Operational Pressures and OPEL Activation

While many acute trusts across the country, including across the North-West operated at OPEL 4 for prolonged periods during the winter months, escalation to this level was relatively limited in GM. Similarly, several acute trusts across Lancashire, South Cumbria, Cheshire, and Merseyside declared critical incidents, having reached pressure levels exceeding the capacity of the national OPEL framework to manage effectively.

That said, GM operated at OPEL 3 for most of the winter 2024/25, experiencing OPEL 2 on just one occasion in December 2024 and twice in January 2025. Two acute trusts within GM escalated to OPEL 4 at points during the winter, though both quickly de-escalated following the implementation of local and ICS-level actions. These actions included collaborative system-wide interventions and the mobilisation of key partners

to manage pressures effectively. It is important to note that these escalations occurred in the context of exacerbating factors such as:

- High levels of staff sickness.
- Capacity constraints due to infection prevention and control (IPC) measures.
- Unexpected ward closures due to estates issues, which impacted bed capacity and patient flow.
- Unanticipated surges in demand, requiring rapid escalation management.
- The remaining three acute trusts in GM did not reach OPEL 4 but periodically implemented OPEL 4-level actions to pre-empt escalation and mitigate risks associated with increasing system pressures.

Key Factors Driving OPEL Levels

Several key factors contributed to the sustained OPEL 3 status across GM during winter 2024/25:

- **High Numbers of Patients with NCTR**: - Many acute trusts reported elevated NCTR levels, significantly impacting patient flow. Despite the implementation of local and system-wide initiatives to reduce NCTR, this remained a persistent challenge.
- **Limited Bed Capacity and High Acuity of Patients**: -Some hospital sites reported higher bed occupancy levels, largely due to an increase in acutely unwell patients requiring complex care. The misalignment between admission and discharge rates further contributed to sustained pressure across the system.

Ambulance Handover Pressures

While GM did not experience the same level of ambulance handover delays seen in other ICS regions, some sites faced higher-than-expected attendance rates, which periodically increased OPEL levels.

Future Integration of the OPEL Framework

Currently, the national OPEL framework is designed for acute hospital sites only. However, work is underway to develop an Integrated OPEL Framework, which will incorporate mental health and community services into a more holistic system-wide escalation model.

Expansion of the Primary Care Offer supported by Capacity funding

Recognising the impact of primary care accessibility on UEC demand, NHS GM allocated additional capacity funding to expand primary care services over the 2024/25 winter period. Key initiatives included:

- **Increased Same-Day and Out-of-Hours Appointments**

  General Practice (GP) extended same-day appointment capacity, reducing unnecessary ED visits, along with extended hours were implemented in high-demand areas, improving accessibility outside peak hospital times.
  In addition to this investment in digital consultations provided remote support, particularly for respiratory and chronic condition management.

- **Integration of Primary Care with Urgent and Emergency Care Pathways**

  Direct referrals from NHS 111 to GPs and Urgent Treatment Centres (UTCs) were enhanced. The GM Urgent Primary Care Alliance (GMUPCA) facilitated patient redirection to the appropriate care setting and pharmacy-led interventions helped reduce exacerbations of chronic conditions.

- **Community-Based Prevention Strategies**

  Enhanced home-based care support for frail patients prevented avoidable hospital admissions, along with rapid-response teams working alongside primary care to manage acute conditions in the community. Targeted winter vaccination programs were expanded in primary care settings.

Innovations In Managing Winter Pressures

Some examples of the innovations that have supported the management of the winter pressures include the GMUPCA running a Falls Lifting Response service for people over the age of 18 years who have fallen, with no significant injuries and in their place of residence. The service has been live since the 7 November 2024 and is available to residents across the whole of GM from 8am to 6pm 7 days per week, including bank holidays.

The service accepts referrals from NWAS, all Health Care Professionals (on scene), care homes and carers. The service response time is currently 45 minutes, negating a long-lie and potential conveyance to hospital and reducing unnecessary ambulance call outs for non-emergency falls.

In addition to the Falls lifting service, the Hospital@Home models across GM allowed more patients to be monitored at home, reducing unnecessary admissions. Digital monitoring tools helped manage long-term conditions, offering early interventions.

The 2024/2025 winter period tested the resilience of GM's UEC system. While enhanced planning from the GM Preparedness Event and expanded primary care access helped mitigate pressures, high hospital occupancy, workforce shortages, and ambulance delays remained significant challenges. Going forward, sustained improvement in Out of Hospital integrated system-wide solutions will be critical to improving future winter resilience.

The approach to UEC transformation needs to be centred around out of hospital community care, ensuring capacity and funding is aligned appropriately and that patients and health care professionals can easily be navigated to the most appropriate care.

9. Conclusion

The report underscores the need for a collaborative approach across the health and care system to ensure that people are discharged from hospital to home or the next part of their pathway as quickly and independently as possible. The challenges being experienced in public services relating to hospital discharge cannot be resolved by

one part of the system alone. GM Live Well, and specifically the health and care contribution to Live Well through the development of integrated neighbourhood services, provide the foundation for collaboration to improve discharge pathways and processes.

The GM ICP Board are asked to:

1. Note the contents of the report, particularly the current challenges and good work underway to address them.
2. Discuss the opportunities for further collaborative improvement between health, care and wider public service to improve discharge from hospital, and build on our Home First approach, in the context of the GM Live Well model.
3. ICP Board members are asked to comment on the role of all public services in preventing hospital admissions through a 'Hospital Second' approach to admission avoidance. To support further work in this area, it is intended that a further paper focusing on admission avoidance in the context of the GM Live Well model is brought to the next ICP Board.

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