ICC Case study: Greater Manchester

Case study name	**Greater Manchester**
Case study type	Integrated Care System (ICS)
Lead / Host	Greater Manchester Integrated Care Partnership (ICP)
Type of model	Clinician to clinician
Model name	Greater Manchester Urgent Primary Care Alliance (GMUPCA)
Status	The model is well-developed and has been in operation via a formal commissioning arrangement since 2021, after a series of initial pilot phases
Summary of key findings	• GMUPCA activity levels and capacity are very high relative to other Integrated Care Coordination (ICC) models included as case studies in this evaluation – routinely exceeding 500 clinical cases a day through the GM Clinical Assessment Service (GMCAS). After an initial piloting period, the model has buy-in and representation from all ten localities within the Greater Manchester footprint • The model uses the Adastra data system, which displays information to assist with decision-making – patient's demographic information, pathway of consultation, electronic health records and GP records. This system connects with primary care and is installed at each secondary care facility • The service uses a mixed service model with staff able to work on site across various locations or remotely. Some Urgent Treatment Centre services are co-located. This model is viewed favourably by staff, allowing them to benefit from co-location and remote working where appropriate • The CAS model prevents around 85% of NHS 111 cases and around 50% of 999 calls it receives from using an ambulance. Of the 85%, 21% of cases are referred onto other partner services using the GMUPCA model. A recent financial analysis found that it generates £3 of value for every £1 spent. Higher acuity cases have a much higher return on investment ratio • A recent survey of patients engaged by the GMUPCA model found they valued being treated by the right clinician in the right service. However, they were not always aware of being managed by GMUPCA and were most negative about waiting times with all forms of emergency response from other providers in the system • There are plans to expand the model, including wider NHS 111 code set inclusion, category two 999 work, primary care direct referral and Urgent Community Response direct booking.

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1.1 Description of the ICC model

The Greater Manchester Urgent Primary Care Alliance (GMUPCA) is a large care coordination model covering the whole of Greater Manchester (GM), that hosts most features of Integrated Care Coordination (ICC). The model is well-developed and has been operating for approximately five years. The GMUPCA is an organisation of five providers (which also deliver core out-of-hours contracts, amongst others): Mastercall Healthcare, gtd Healthcare, Bardoc, Salford Primary Care Together and Wigan GP Alliance. It now operates from sites in all ten localities across GM.

The GMUPCA is described as a 'Macro Interconnected Web of Access' by system leaders. Most cases flowing through the group of partners are hosted on one shared Patient Management System (Adastra). Adastra has a macro shared area for common use (housing the pan-GM 24/7 Clinical Assessment Service (CAS) and Dental CAS, alongside other services) and then many smaller private areas for independent providers to use. Both areas are digitally connected to book directly internally into over 70 services hosted by the GMUPCA partners. Wider system community partners including the major mental health providers and hospital providers also have private areas and case access on the shared system; some use it for 'case receiving' i.e. from GMCAS, and some use it as their own triage system for 'hear and treat' having received a transfer of care ('case brokerage' via trusted assessorship).

The GMCAS acts as a front door to the wider care coordination function provided by GMUPCA and is a core element of the model. The GMCAS hub ('the hub') currently accepts around 600 cases a day, mostly from 999, NHS 111 and NHS 111 online. The hub operates 24 hours a day, seven days a week, 365 days a year, with a standard operating procedure (SOP) in place. It uses a mixed service model with staff able to work on site across various locations or remotely. They can easily and quickly communicate with colleagues via Adastra. The service is staffed mostly by GPs, Advanced Clinical Practitioners (ACPs) and care co-ordinators.

GMCAS provides a triage function and service desk that facilitates care coordination with hundreds of other functions and services across GM collectively, including prescribing, video consultation, care navigation, appointment booking, referrals to Urgent Community Response (UCR) and other community services and primary care. The GMUPCA partners also provide for six of the ten localities in GM a 'call before you convey' function via their Pathfinder service for North West Ambulance Service (NWAS) paramedics.

The figure below highlights the elements of care coordination included in the GMUPCA model, with reference to the national ICC specification elements.

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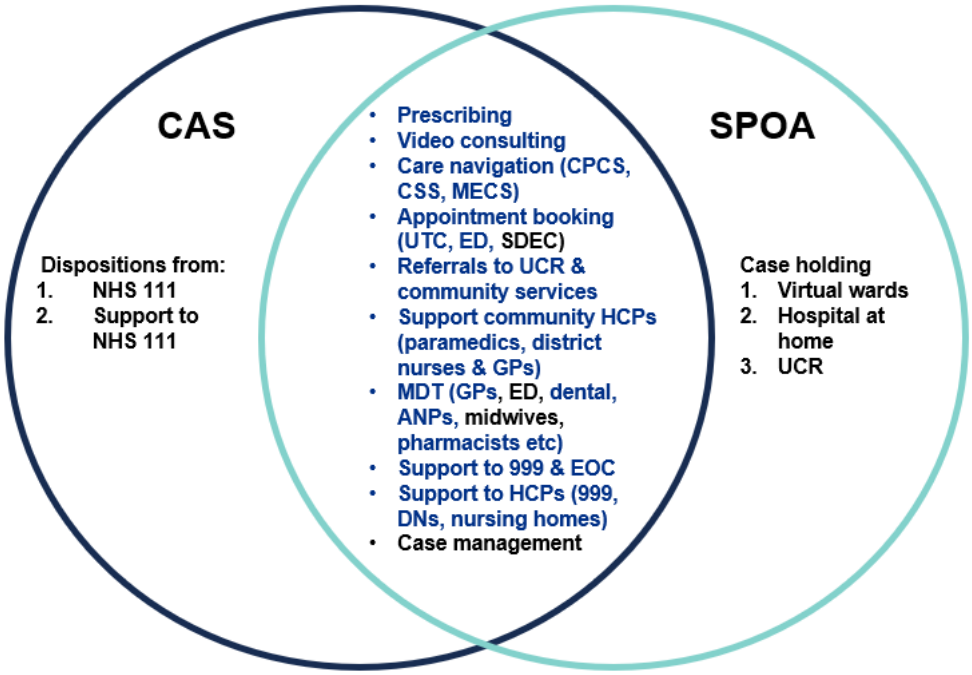
Figure 1.1 Care coordination elements provided by GMUPCA with reference to national ICC specification *(provided by the GMUPCA)*



Most of the referrals into the GMUPCA model come from 999 and NHS 111 via NWAS, or via NHS 111 online (but all of the partner services in the alliance take direct health care professional referrals, some walk-ins and some direct patient contacts). Although the GM Dental CAS is patient facing, in the main, the GMUPCA and its internal partners do not run patient facing services; most services are 'pre-faced' by NWAS who operate the majority of direct patient call handling. People who call NHS 111 and 999 are mostly triaged by non-clinical health advisors using the NHS Pathways telephone triage system. The triaged category three priority patients (or lower) are reviewed for suitability against exclusion criteria established by the model. Eligible patients are then electronically transferred from the NWAS system into the GMUPCA provider's system. NWAS will keep the case open during this review process and will close or act once a care decision is made by the GMCAS team.

When GMCAS receive a case from NWAS, they conduct a telephone consultation with the patient and determine a referral route (CAS will deal with the most urgent NHS 111 case types sent within 20 minutes, and the most urgent category three 999 case types sent within 30 minutes according to national code set standard requirements). For 999 the outcome could be referring the patient back to NWAS (with the same priority, downgraded or upgraded), on to the most appropriate service under the GMUPCA portfolio, or to other services including primary care and UCR. Alternatively, the case is closed after GMCAS staff provide the patient with advice. GMCAS staff can book patients directly into appointment slots or 'arrival times' of any facility or service who use the

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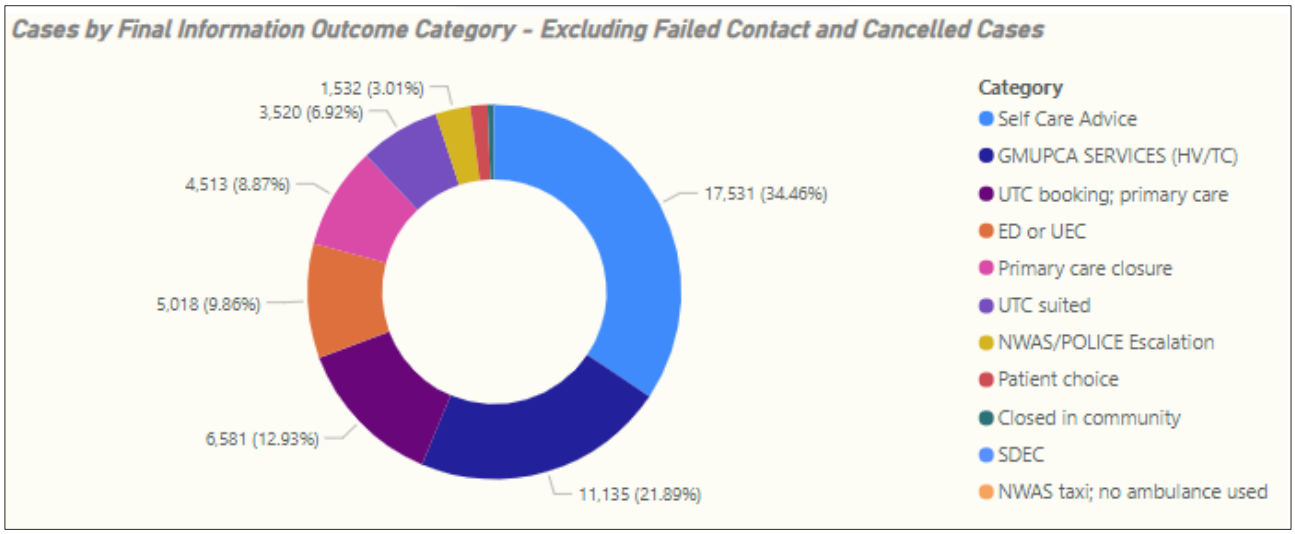
calendar in the Adastra system. Adastra is installed at every emergency department (ED) and urgent treatment centre (UTC) in GM.

Of the NHS 111 cases that the GMCAS is profiled for the majority have the NHS 111 service outcome of 'advised to attend ED'; the GMCAS closes over 85% of these whilst avoiding ED use. Furthermore, the model closes 21% of cases (up to 250 per day) internally by referring onto other services within the GMUPCA portfolio, using its care coordination functions. The figure below details typical GMCAS case outcomes in 2024:

Figure 1.2 GMCAS case outcomes between January 2024 and July 2024 *(provided by the GMUPCA)*



The GMUPCA model currently delivers some aspects of ICC, including direct referral and booking into UCR, Hot Clinics, Urgent Treatment Centres (UTC), ED, same day emergency care (SDEC), acute frailty units and acute respiratory infection (ARI) hubs. It provides multi-disciplinary urgent care advice, remote clinical review and proactive management of urgent care coordination. GMUPCA also operates across a relatively large geographical footprint and processes large volumes of activity across many providers and services.

1.1.1 Staffing

The table below (Table 1.1) describes the staff employed to deliver the CAS element of this ICC model alone and their roles.

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Table 1.1 Summary of staff and roles included in GM's ICC model (GMCAS)

Role	Responsibilities	FTE
GP	Clinical assessment	24.6
Clinical Practitioner (nursing)	Clinical assessment	14.9
Shift Lead (front line operational)	Shift coordination - hub staff	5.6
Care Coordinator (front line operational)	Initial referral contact	8.9
Director of Operations	Strategic role	0.4
Director of Finance	Strategic role	0.2
Director of Governance	Strategic role	0.2
Medical Director	Strategic role	0.2
Chief Information Officer	Strategic role	0.2
Head of Operations	Strategic role	0.5
Finance Manager	Support role	0.6
Workforce Manager	Support role	0.2
HR Manager	Support role	0.2
Business Intelligence	Support role	1.5
Communications Manager	Support role	0.1

1.1.2 Operating costs

The funding for the model is provided by GM Integrated Care Board (ICB). From an estate perspective, the delivery is from a combination of the providers' contact centre/clinical hub locations, as well as from a proportion of remote workers.

The cost per case of the GMCAS element of the GMUPCA model ranges from ~£36-42 per case. The higher the acuity of the case, the higher the cost.

Those with senior responsibility for the service reported that picking the right balance of clinicians to acuity and scale is a means to manage an efficient cost base for the model. They also noted that highly effective CAS models will always produce a high benefit to cost ratio.

1.2 Commissioning and setting-up the ICC model

Many of the founding GMUPCA partners have been in operation in GM for nearly 30 years. Their contracting portfolios are made up of approximately 70 service elements.

GMUPCA is viewed within GM as a care coordination model, and an expansion of the 'macro-CAS' model initially provided by the GMCAS. The GMCAS led to commissioning of Adastra and the partnership between the alliance partners.

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The GMCAS was initially hosted by one of the lead Clinical Commissioning Groups (CCGs) in GM and was established as a three-month proof of concept in March 2019. It was subsequently remobilised to support winter pressures in November 2019 and has been active continuously since then. The model has grown overtime, from taking less than 50 cases a day to taking over 500 a day.

To foster system buy-in, staff in the CCG team setting-up the GMCAS promoted cost saving/cost avoidance solutions to commissioners and senior clinicians, such as medical directors of CCGs and NWAS leaders. Multiple six-month proof-of-concept pilots, with intermittent funding from NWAS via the CQUIN (Commissioning for Quality and Innovation) regional Alternative Patient Assessment Service (APAS) fund, were delivered. The pilots were designed to demonstrate a new way of working to reduce ambulance demand on local EDs, and consequently, improve ED performance.

During the set-up phase, buy-in was difficult to obtain across the system. For example, NWAS was hesitant to delegate its patient safety responsibilities to other providers. Commissioners were concerned about cases getting lost in the system and potential delays in emergency ambulance response times. To overcome this, shared governance mechanisms were established and there was rigorous testing to make sure the GMCAS was working. While it took some time to persuade the ten different localities to commit to the new service, they began to see the benefits after commissioning rounds of short-term testing.

The GMCAS was formally commissioned in 2021, when the GMUPCA created and submitted a business case to the ICB. A single contract is now in place between the GMUPCA and the GM ICB.

Since then, GMUPCA has continued to expand its functions to include more aspects of care coordination and integrate them digitally with the GMCAS. There is an aspiration (but no formal commitment) across the GM Integrated Care Partnership (ICP) and its place-based stakeholders to expand the GMUPCA model into one providing full ICC functions.

1.3 Learning from delivery

1.3.1 How are patients accepted for clinical assessment?

In relation to the GMCAS, patients who contact NHS 111 (via the phone or online) or 999 and reach a category three (or lower) ambulance response are accepted into the GMUPCA model via GMCAS. The model accepts all age referrals. GMCAS staff will check the inclusion/exclusion criteria of suitable services and, if eligible, patients will be referred electronically from the NWAS system into Adastra. While GMCAS are reviewing a patient's case, they are responsible for the clinical risk. NWAS keep the case on their system while GMCAS contact the patient and do a further clinical assessment.

Once the outcome has been agreed – which could be conveying an ambulance, GMCAS staff referring the patient onto other services or if the patient requires an NWAS taxi to ED – this is

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actioned accordingly. If the GMCAS has dealt with the case, it will be closed. Decisions are recorded on Adastra, the GMUPCA clinical patient system and if relevant, will be transferred to the digital systems of services receiving onward referrals. Each case has an Adastra case number created for tracking.

Adastra displays several pieces of information to assist with decision-making:

- **Patient demographic information**
- **Pathway of consultation** – for example a timeline of the current communication pathway, with information about the triage
- **Electronic Health Record (EHR**) – information including medications and allergies, no documents or recent consultations are included
- **GP Connect** – which provides part of the GP record.

Most of the GMUPCA partners have local agreements for direct EMIS access, to view information that would otherwise only be available to their GP.

The GMUPCA electronic patient record (EPR) platform Adastra is used by ED, UTC, mental health providers, out-of-hours services and other 'local points of access' across the GM ICB. Adastra is used to book patients into UTC appointments and for direct GP bookings, as well as pushing cases into other different services within the system. If services are not on the Adastra platform, GMCAS staff are able to manually refer patients through NHS Service Finder, Directory of Services (DoS)[1] or NHS Pathways. They also use their own knowledge of the system's health and care services and can also consider the previous experiences and preferences of patients and carers in making a referral decision.

> *"If you say to them [patients], 'you've presented with this before. Where did you go? Is that still the most appropriate place? Would you like to go back there? [If] yes, we can rearrange that.'"*

Where a clinical consultation is required to reach a referral decision, GMCAS staff aim to complete category three cases within 30 minutes and category 4/5 cases in 60 minutes. Most referrals from NHS 111 are given an ED outcome within 20 minutes. In quieter periods, staff aim to reach a decision about a patient within 15 minutes. The busiest periods for the GMCAS tend to be out-of-hours, where patients are unable to access primary care services and, therefore, would contact 999 or NHS 111.

[1] Healthcare IT systems are able to use the DoS to enable bookings and referrals. NHSE have developed a Booking and Referring Standard to help providers send referral information between them quickly and safely.

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1.3.2 Clinical governance and risk sharing

The GMUPCA's operating model is jointly agreed through a system-wide memorandum of understanding (MoU). The MoU dictates where operational and clinical responsibility lies. For example, when a case is referred from the NWAS to the GMCAS, clinical risk belongs to the GMCAS, with NWAS retaining an interest. If the case is referred back to NWAS, the responsibility follows. GMCAS can hold cases while they are conducting a clinical assessment, but these cannot be held for more than a few hours.

In the event of clinical governance or negligence investigations relating to GMCAS cases, these will be conducted jointly, by both the Clinical Negligence Scheme for Trusts (CNST) and the GMCAS. If other services were involved in providing care, they will also be involved in the investigation and are expected to take joint ownership of the risk.

For managing clinical risk among wider systems partners, the GMUPCA employs a macro legally binding 'Alliance Agreement'. Wider integrated case transfers across non-internal members are governed by data protection impact assessments (DPIAs), a Community Case Transfer MoU and monitored under the Greater Manchester Urgent and Emergency Care (GMUEC) Governance Framework.

1.3.3 Use of the model by referring services

The inclusion/exclusion criteria applied to potential referrals into the model are also known as pre-agreed codes. The medical directors and CEO of the GMUPCA, and NWAS, worked together to determine the pre-agreed code set, to ensure that the correct cases are referred to the hub. This is still largely the same for NHS 111 and NHS 111 online cases into the GMCAS and other GMUPCA partner services directly. However, for 999 work via 'call before you convey/pathfinder' (call direct from paramedics) in GMUPCA partners this is based on the NWAS Pathfinder Algorithm. For 999 cases sent digitally to the CAS other agreed inclusion criteria are applied along with the clinical judgement of the NWAS dispatcher on what CAS can 'hear and treat' (usually resulting in 160-210 999 cases/day). The staff in GMCAS then apply a different set of inclusion/exclusion criteria, provided by the services they can refer into within the GMUPCA partners or wider services. This ensures patients are referred onto the correct services.

Interviewees described GMCAS as an integral part of the GMUPCA model and as well utilised; all ten localities (former CCGs) the GMUPCA is based in continue to fund the GMCAS to manage their urgent care demand and capacity.

Interviewees also noted that the number of cases GMCAS receive differs between seasons, with demand increasing during winter. To overcome this, last year staff rotas were adapted to reflect the learning that demand changes throughout the year.

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"Last year we slightly changed the model, because we reflected on the patterns throughout the year and the seasonality. That we would actually be some parts of the year that we knew would have lesser demand than others."

Although these wider usage trends have been identified, the number of emergency calls cannot be easily predicted on any given day, which impacts the number of staff needed within the GMCAS.

"We get something like three thousand five hundred emergencies per day in NWAS. On some days, that might be made up far more of category two emergencies, which don't go to CAS. They need ambulances sent. And other days, it might just shift the other way. In which case, there's loads to go to CAS. But in the main, it averages out over a course of a month, to be about five hundred and fifty calls a day, roughly."

Among the broad patient group accepted by GMCAS (category three and below) interviewees did not identify any one specific patient group as being disproportionally referred into the model but reflected on the varied case mix they respond to.

"I suppose we've got a real mix of patients that come through because it's just literally anybody who's deemed a cat[egory] three or four ambulance or suitable for an ED. So it could be anything from an injury to a stroke, to abdominal pain. We cover all sorts."

There are occasions where patients contact the NHS 111 Mental Health Service, but require physical health interventions. Currently, these patients would be required to call the NHS 111 service again to request alternative help. However, the GMUPCA is currently testing redirecting these calls straight into the GMCAS. Interviewees acknowledged that the model could take on a greater share of patients, but that current budget constraints prevent this.

"We are in a challenging financial position as an ICB, so when we talk about what more could we do with the CAS, inevitably that has a cost attached to it understandably."

1.3.4 Co-location of the model and links to other services

Staff in the model are able to work remotely and this was a deliberate design feature. As GMCAS is a 24/7 service, it was viewed that remote working practices better suit staff working out-of-hours shifts. The use of the Adastra system also allows staff to virtually communicate with various teams. There is a shift leader available to support staff where required.

"If staff are working from home, they know they can go onto Adastra and instant message somebody to say 'can I have a chat'. And then yes, we're very keen to make sure staff are supported for working from home."

Remote working practices, facilitated by technology, also help out-of-hours providers which staff the model to manage their resourcing, as they can call on staff to support when needed rather than providing a fixed workforce.

"Because we've got an agile workforce, we can just put out SMS text messages to clinicians. Who will jump on for a couple of hours and help manage that demand."

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However, interviewees did acknowledge the benefits that might be derived from the model being more physically co-located with aligned services instead. These include:

- **Sharing knowledge** – one interviewee who operates from a co-located UTC mentioned the benefit of sitting beside other clinicians, included being able to share knowledge about the local area and suggest the best pathways for patients
- **Good for staff morale and confidence** – interviewees suggested that only seeing team members on screen can sometimes be demoralising, especially during busy periods. In addition, working in the same room was felt to remove any issues around staff not knowing who to pose relevant questions to.

1.3.5 Referrals to other services

As the model has been operating for several years, it has broadened its referral pathways and therefore its scope for care coordination over time. The services that staff are currently able to directly book or refer patients into are:

- All ED departments
- Some Same day emergency care (SDEC)
- All walk-in clinics
- All UTCs
- Some Urgent Care Response Teams (UCRTs)
- Most GP Practices
- The two large mental health providers
- Pharmacies (GMUPA Partners and services can provide prescriptions via the Electronic Prescription Service).

Although staff are fully briefed on the referral acceptance criteria of different services, interviewees noted that more work is required to standardise the pathways around SDEC in particular. Across GM, SDEC services continue to vary in their operational hours and referral criteria, despite the publication of national guidance. By standardising the criteria across the region, the model will have a clearer referral route for patients.

Interviewees highlighted other acute care departments as services which pose some challenges to making onward referrals. One stakeholder discussed acute wards being reluctant to accept patients directly via the GMCAS, preferring patients to be first triaged in ED before being accepted. Consequently, staff have been provided with stricter exclusion criteria to reassure them and acute services that they have selected the correct pathway for patients.

> *"There is a lot of closed doors with the acutes. A lot of them, they see it as additional work and you're saying, 'They're not additional work, this is a patient that will be coming to you.*

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Whether they walk through the door of A&E, or we send them to you. It's the same person."

With no clear referral route in place for SDEC services, GMCAS may need to refer patients for ED triage first, despite being confident that SDEC would be the most appropriate pathway for them.

Furthermore, some services such as UCR do not allow for digital direct booking to protect their own capacity levels, but case transfer via consultation with these services is generally regarded as efficient and relatively simple by GMCAS staff.

1.3.6 Digital solutions and tools

Overall, interviewees spoke positively about the digital solutions and tools in place in the model, despite suggestions for some further improvements (as discussed in Section 1.1.5).

"We've got the digital links into CASs to make it a really quick and efficient process of referral, it limits those patient touchpoints."

GMCAS staff can access the ambulance stack. They are also currently testing the Booking and Referral Standard (BaRS), which will be deployed between NHS 111, 999 and GMCAS. This will ensure that NWAS can send GMCAS cases directly and generate ambulance responses if it is decided an ambulance is required.

GMCAS staff use the DoS and are in the process of integrating it into the Adastra system. This allows staff to directly book appointments from the Adastra system into other EPRs. The Adastra system also houses a Care Connect function which allow direct booking into GP EMIS practices (permitting the GMCAS to book directly into primary care as a trusted assessor) and a Pathways Clinical Consultation Support function which permits interoperability toolkit (ITK) direct booking to ITK-enabled community end points (wider community booking is facilitated by warm transfer - when a call handler speaks with a new agent before transferring a call to them while the patient remains on the line).

Although interviewees acknowledged Adastra as a useful platform, they noted that GMCAS cannot currently book all services through the system, such as NHS Service Finder. It was also mentioned that some services, such as paediatrics, do not appear on Adastra as an option for onward referrals. Developing these referral routes was suggested as a way of avoiding unnecessary ED attendances.

"Paediatrics, I think we could get a few more avenues there. I am aware that we've got a couple of paediatric nurse practitioner or community nursing teams but not in every area that are on Adastra. So, if they're not there, people don't think of them so it's almost out of sight, out of mind. The go-to is, 'Well, you're just going to have to go to A&E.' So, it's that balance."

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1.3.7 Staffing and recruitment

The GMUPCA model is designed to involve senior clinical decision makers early in the patient pathway to ensure appropriate and effective care coordination. The GMCAS's clinical staff are made up of GPs (78%), ACPs (10%) and other clinical practitioners – the service's term for nurses working within the GMCAS (12%). Interviewees reported that the staffing of GMCAS with predominantly GPs and relatively senior clinical practitioners works well. They generally do not recruit staff who have less than two years' experience as a clinician.

While staff roles have not fundamentally changed since the model was established, approaches to managing cases have adapted, with remote consultations increasingly used. Senior staff have used detailed activity data to map staffing levels to busier geographies and times, and regularly review this to update staffing configurations.

Stakeholders reported that the key skills and experience needed to work in the model were: a knowledge of the services available for onward referral; managing clinical risk; and using digital tools to conduct remote consultations.

> *"If you've got a primary care and an urgent care background… so that you've got an awareness of what happens in primary care and also, you've got an awareness of what happens in out-of-hours urgent care. Because then you understand the system wide pressures and you can understand how to manage those. And the other thing is experience with doing remote consultations because not everybody likes to do that. So having a lot of experience in doing remote consultations [is important]."*

Interviewees working within the GMUPCA were generally positive about their experiences of working there. They were happy with the flexibility of the model working arrangements and more broadly saw it as bringing benefits to patient outcomes and the wider health and care system (further described in Section 1.4).

Interviewees identified several specific training needs required for staff working in the GMCAS specifically, most notably remote consultation/decision-making and responding to large volumes of calls. These needs have been addressed via training packages delivered to all staff, alongside other guidance and onboarding activities.

> *"We do shadow shifts, teaching, showing them the service before they go live, sharing as much information and training sessions as we can, and then that feedback via clinical guidance saying, 'Yes, that was the right thing to do for that patient,' or 'Did you consider sending them to this place,' or 'Excellent job, you've ticked all the boxes there and that patient had a good journey.'"*

Several aspects of staff performance are monitored and audited using detailed activity data to ensure there is appropriate clinical decision-making alongside efficient and timely caseload management.

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Interviewees reported intermittent recruitment challenges, potentially linked to the challenging nature of working in the model; the intensity and demand of the workload, with large volumes of referrals and clinical decisions taking place relatively quickly. Furthermore, they reflected that GMCAS's extended opening hours may not appeal to all potential staff. The model has had more success recruiting staff through internal appointments than through external recruitment.

1.4 Impact of the model and patient benefits

1.4.1 Monitoring and gathering evidence of impact

Activity levels for the GMUPCA model are very high relative to the other ICC models included in this evaluation. The service regularly reviews and monitors activity levels over time and has been trending recently toward 1000 cases per day passing through the GMCAS. The service runs regular reporting of service activity and some outcome-focused metrics to assess performance.

Interviewees suggest that the model is having a positive impact upon patients, staff and the wider health system in GM – most obviously upon the capacity and waiting times of ambulance services.

> *"We've stopped [a lot of cases] having ambulances, that's a massive resource that is then freeing up North West Ambulance Service to get better outcomes for those that are needing their category one and two responses. So, I think for those that don't use the CAS, but need an ambulance, we're getting them hopefully better response times. For those that use, that come through to us, hopefully we're educating patients, that actually maybe next time, there's alternatives as well."*

To further support this, activity data for the financial year 2023/24 indicates that fewer than 15% of cases the service receives are sent to ED or conveyed by ambulance. Over 85% of cases are closed with alternative outcomes identified, of which around 21% involve care coordination directly to other services within the GMUPCA portfolio, reducing the impact on other external community services.

In addition, interviewees reported that the model has improved wider collaborative working between other services via the use of regional co-located hubs (see Section 1.3.4). Staff from the ambulance service generally enjoy working with the service, and, alongside the staff working within the service, generally view it as an improved way of working across GM.

However, some stakeholders also reported some negative impacts for staff working in the GMCAS relating to the volume of activity being undertaken and expectations around delivery.

> *"What's uncomfortable is we normally have a bit of a-, not a break, but a bit of a slowdown and a catch up, don't we, over summer. I mean, it is horrendously busy in winter and the winter pressure is definitely recognised and staffed accordingly. But summer is now similar to winter, with maybe a 10% decrease rather than a 50% one. We don't understand why."*

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1.4.2 Patient experience and patient benefits

GMUPCA recently surveyed patients (n=156) to understand the patient experience of being supported by the model[2]. Results indicated that their experience is generally excellent with additional findings summarised in a recent report including:

- Patients valued the level of coordination that staff in the GMCAS supported them with to ensure that they were seen by the right clinician in the right service
- Patients are not always aware of which service they are speaking to (as cases seamlessly transfer from NHS 111, NHS 111 online and 999 direct to the GMCAS and onwards to GMUPCA services)
- Any complaints received tend to relate to the original call waiting times or the waiting times at hospital for onward referrals.

Staff working in the service confirmed these findings, reporting that patients were not necessarily aware their case was being referred to the GMCAS, but appreciated being treated at home or in a community setting where possible.

> *"Patients liked the fact that they'd been dealt with without having to go somewhere. Or that they'd been dealt with in a place that was nearer to home than they might have expected, and they didn't have to go and queue up somewhere and all that kind of stuff."*

There are plans to run further surveys in the future to monitor patient feedback on an ongoing basis. Despite successfully gathering patient feedback, some staff did report some difficulties in data collection that was specifically related to the service.

> *"I think they've tried doing it via text messages, but it is very difficult because I don't think patients are always able to differentiate which service they're wanting to give feedback on, because they may give feedback on 111, then the CAS, then the ambulance service that attends to them and then the treatment centre that they get sent to."*

Most staff working in the model are confident that it leads to patients seeing the right person at the right time. They expect that an expansion of the model (see Section 1.5) and well-established links with a full suite of community services will allow for an even more joined-up and appropriate response for patients.

The planned expansion is also predicated on the view among those with strategic responsibility and/or oversight of the service that more patients could benefit from using the service, including a wider group of patients currently accessing NHS 111 or primary care.

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[2] The sample size for this survey was 156. It is worth noting that this sample could be biased or representative of the patient population more widely.

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1.4.3 Value for money

Interviewees with strategic and/or financial oversight of the GMUPCA model reported that significant quantitative analysis, including some financial modelling of the service and its activity, has been conducted. The results of these exercises were reported to suggest that the GMCAS service (and the wider Urgent Primary Care Partner services in the GMUPCA portfolio) is providing value for money, primarily through its impact on reducing use of ambulance conveyances and other emergency care. Analysis found that the service generates £3 of value for every £1 spent. Some specific types of cases (generally those with higher acuity levels) have a much higher return on investment ratio than this, closer to £9 for every £1 spent.

> *"We did a really detailed review of the GMCAS operating model… We had to demonstrate the benefits of the GMCAS by describing what wasn't happening because of it. Not so much what it did do, but what it stopped happening somewhere else, as a kind of, cost avoidance. And ultimately it came back that even on our least optimistic scenarios it more than paid for itself…every £1 spend on the GMCAS put £3 back into the system."*

There is also increasing confidence that expansion of the model will further improve the service's value for money. There was, despite this, a recognition that the impact upon the healthcare system primarily represents a capacity saving rather than direct cash saving improvements. This is due to the current strain on emergency care functions more widely.

1.5 Next steps and improvements

The GMUPCA has three current pilots underway and planned:

- Placing CAS APs within the NWAS Clinical Support Desk (CSD) command centre to advise on higher 999 sends to GMCAS (live); initial week's testing increased 999 referrals by c.20%.
- Training APs on the NWAS dispatch system to send more 999 cases to CAS itself (training underway)
- Category two validation and sending to CAS (pending; SOP under compilation).

Interviewees suggested the following potential improvements or changes to the model:

- Expanding the offer to include some mental health-related referrals and teams
- Further expansion of activity levels via widening the referral criteria
- Addressing discrepancies in out-of-hours provision in some localities – some services such as UCR teams, or rapid response teams, finish at 8pm so the model is unable to refer to them outside of these hours and instead has to use emergency services.

There is commitment across the GM ICB to expand the model to incorporate more functions of a full ICC beyond the current care coordination taking place. This is likely to include:

- Wider NHS 111 code set inclusion

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- Category two 999 work
- Primary care direct referral
- SDEC direct flow
- UCR direct booking
- Integrated EPR booking

There are also plans to extend the 'call before you convey' model across GM, incorporating the four remaining GM localities which do not currently offer it.

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