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Cheshire and Merseyside Urgent and Emergency Care Improvement Update

ICB Board

24th September 2025

This update will provide the board with information on

1. How we are organising and governing our UEC Improvement Programme.

2. Our overarching UEC Improvement approach and ambition based on the NHS IMPACT principles.

3. Our UEC improvement plans and how we are monitoring improvement

4. Some of the progress we have made so far

C&M UEC Oversight & Governance

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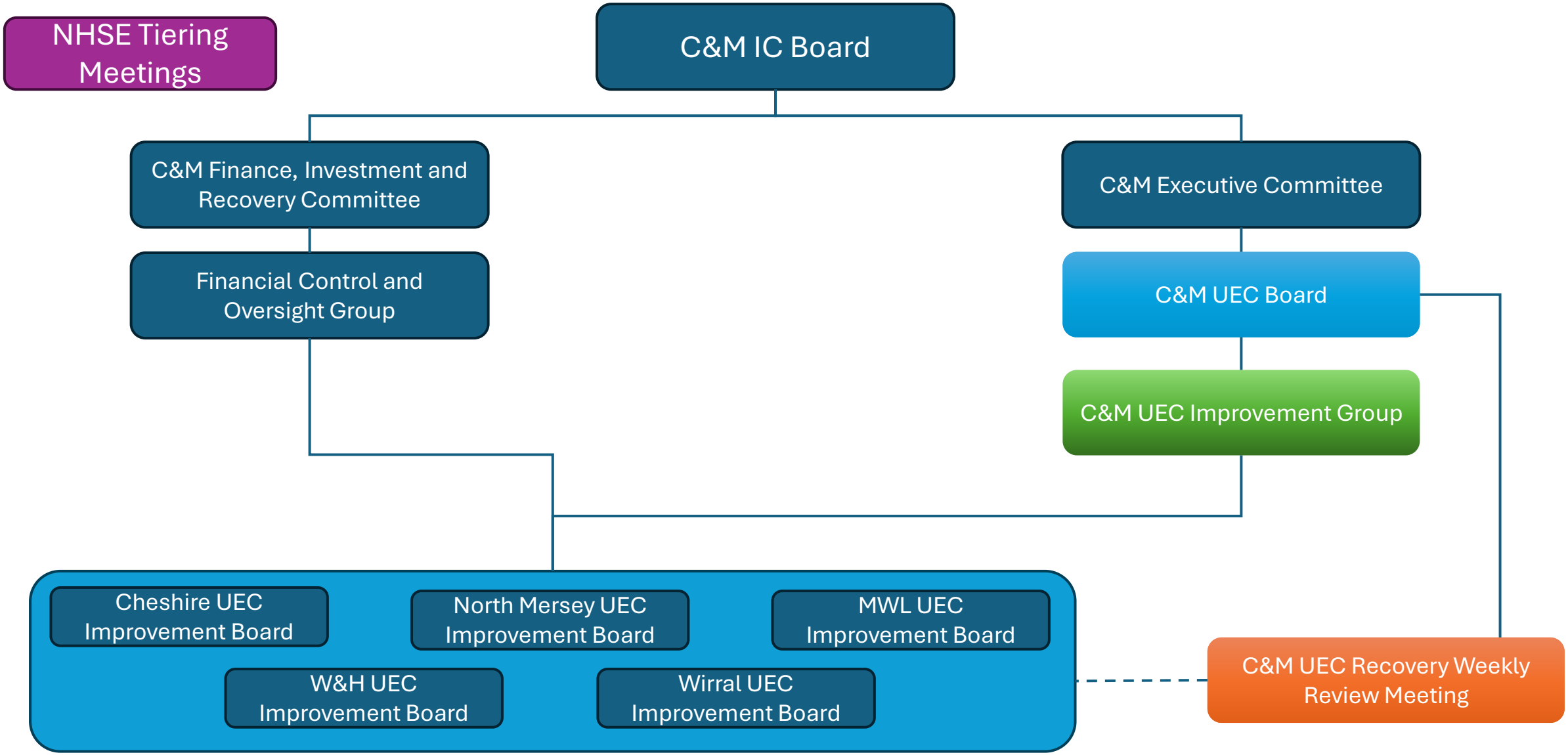

C&M UEC Oversight & Governance

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System Control Centre Lead: Claire Sanders AD of UEC operations and Improvement.
Day to day management of UEC system

Review and Recovery meeting : weekly Chair Mandy Nagra
Whole system, triumvirate attendance
Review of weekly 4 hour, 12 hour, NCTR, ambulance handover performance

UEC Improvement Group: fortnightly Chair Fiona Lemmens
Programme SROs and improvement experts
Oversight of system improvement plans
Fostering an improvement culture and driving a consistent improvement approach

UEC Board : monthly Chair Mandy Nagra
Whole system, CEO, COO, DASS and clinical attendance. All organisations represented.
Strategy, oversight & assurance

FCOG Chair Mandy Nagra
Review of financial performance and CRES plans in UEC system

Winter Planning Anthony Middleton

Working with Sam James and Performance team at NHSE NW to ensure alignment with new **National Tiering** approach and consistency of focus and concentration of improvement support.

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Aims of the UEC Improvement Group

The Urgent and Emergency Care (UEC) Improvement Group exists to bring the whole system together to:

- **Provide System Oversight** – coordinate and oversee delivery of the UEC Improvement Programme, ensuring alignment with national standards, local priorities, and the wider health and care strategy.
- **Foster an Improvement Culture** – embed continuous improvement methodology across all partners, encouraging collaborative working, innovation, and problem-solving.
- **Share Best Practice** – create a forum for learning by sharing what works across localities, providers, and sectors, reducing unwarranted variation and accelerating adoption of proven approaches.
- **Promote Consistent Improvement Approaches** support partners to use common improvement frameworks, tools, and metrics to enable comparability and collective progress.
- **Build Energy and Momentum for Change** – engage clinical, operational, and system leaders in a shared mission, creating enthusiasm, ownership, and accountability for improvement.
- **Ensure Value for Money** – maximise use of resources by aligning investments, minimising duplication, and focusing on interventions that deliver measurable impact.
- **Improve Safety and Outcomes for Patients** – ensure that all improvement efforts ultimately deliver safer, more effective, timely, and person-centred urgent and emergency care.

Aligned to NHS IMPACT

NHS England » NHS IMPACT

UEC Improvement Group
Meeting design and cadence

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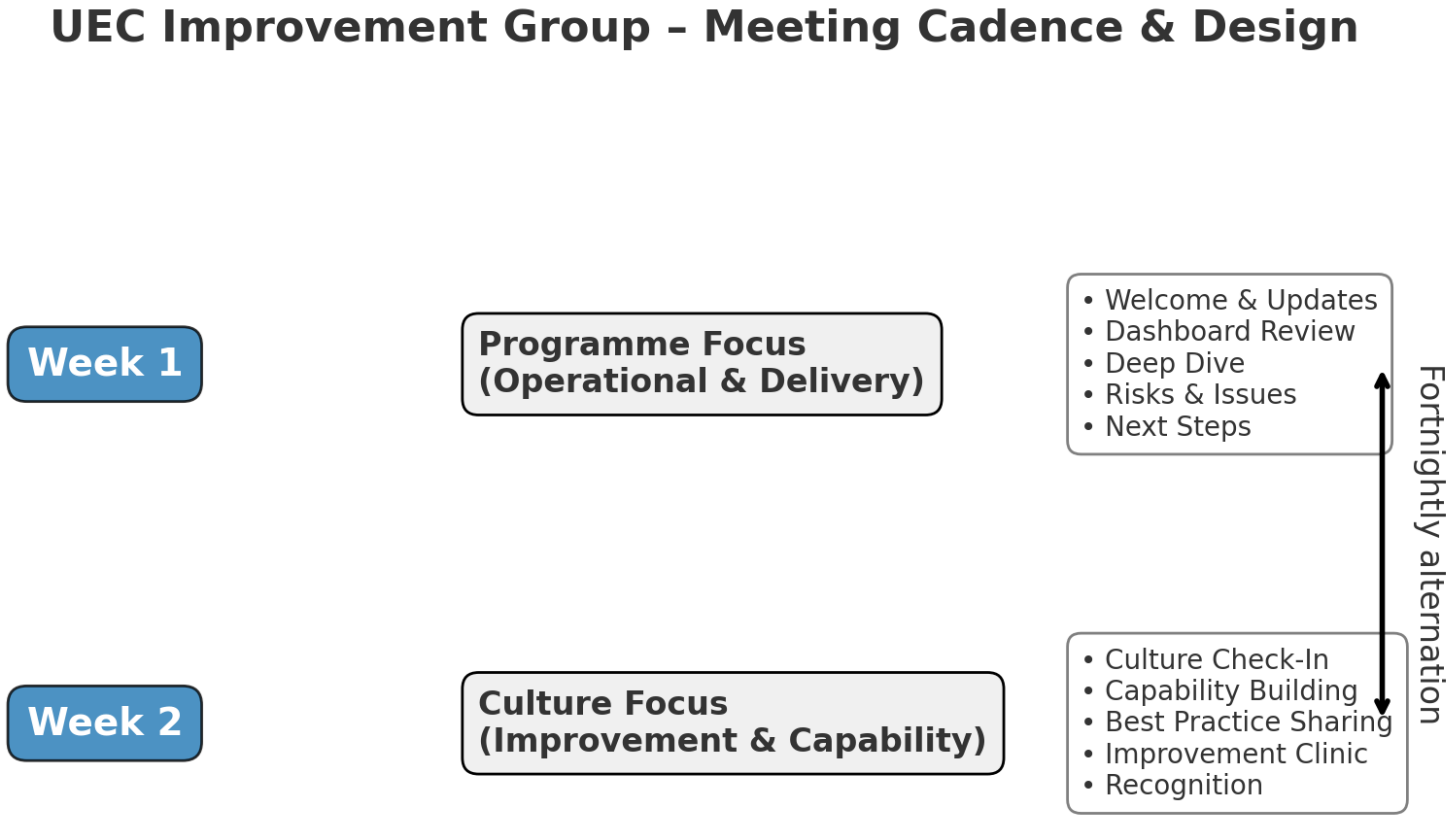
Fortnightly meetings alternating between:

- **Programme Focus** (operational delivery, performance, milestones)
- **Culture Focus** (building improvement capability, behaviours, and sustainability)



Improvement Group Ambitions: Energy-Building Activities

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Knowledge Hub / Repository

Single platform where all tools, presentations, minutes, and case studies are stored and searchable.

"What works well" case studies uploaded from each trust or locality.

Lunch & Learn Sessions

Short (30-45 min) informal sessions spotlighting:

- External SMEs (e.g., ECIST, NHSE Improvement, NWAS ops leads).
- Internal exemplars (trusts with recent HO45 or 4-hour breakthroughs).
- Broader system innovations (frailty, discharge, digital flow).

System Learning Events

Quarterly **UEC Improvement Assembly** bringing together all Places, with thematic workshops.

In reach to locality programmes to support improvement activites.

Recognition & Celebration

Regular **"Spotlight on Success"** in meetings/newsletters.

Recognition certificates for teams showing measurable improvement.

Publish **monthly "quick wins" bulletin** highlighting small but meaningful changes.

Practical QI Support

Access to a **QI toolkit** (driver diagrams, run chart templates, Lean observation guides).

Offer "Improvement Clinics" for teams to bring real problems and co-design solutions with peers.

Cross-System Mentorship

Peer-to-peer buddying between high-performing and challenged sites.

Draw upon CAMIN as a Faculty of "Improvement Fellows" drawn from across trusts and community services.

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Improvement Group Ambitions

Building improvement culture as a programme in its own right

Signal importance – it isn't an "add-on" but as critical as delivery of the UEC plan.
•**Give it structure** – with its own SRO, milestones, measures, and governance.
•**Secure resources** – programme management, faculty, time.
•**Create visibility** – colleagues see "culture change" as tangible, trackable, and celebrated.

Governance & Alignment

Establish a **dual-track structure:**

Track 1: UEC Improvement Programme (operational, performance, national standards).

Track 2: Improvement Culture Programme (capability, behaviours, sustainability).

Both programmes report into the **UEC Improvement Board** and the ICB Quality & Performance Committee.

Assign an **Improvement Culture SRO** to mirror the UEC Programme SRO.

Once established this can be a blueprint for improvement approach in other / all ICB programmes

C&M UEC Improvement Programme Plans

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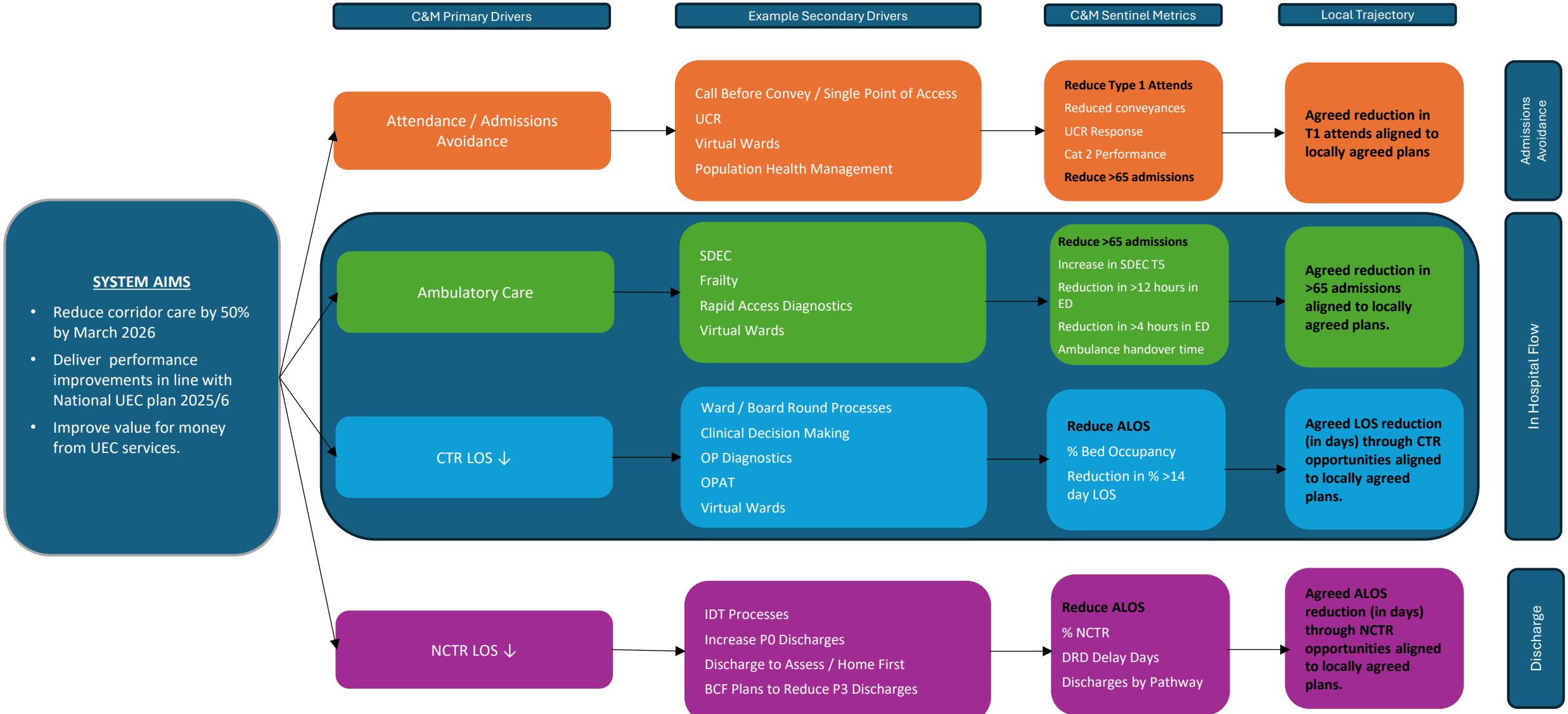

Mental Health System Plan

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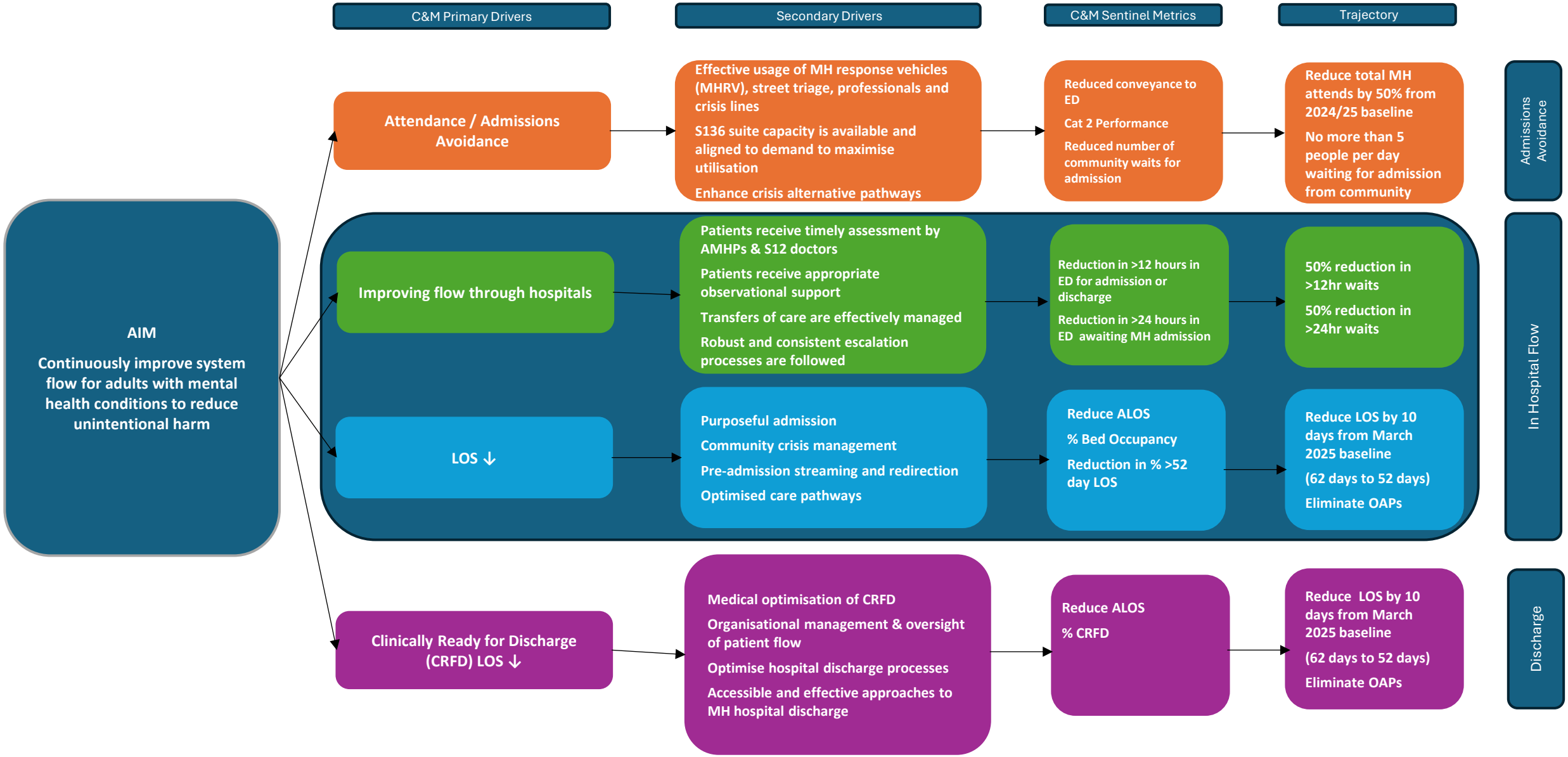

Cheshire & Merseyside UEC Improvement Plan: FRAILTY

***draft in progress**

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This plan outlines a coordinated, system-wide approach for Cheshire and Merseyside to enhance outcomes for people living with frailty. It is aligned with the national FRAIL strategy and supports local system priorities, focusing on:

Prevention – reducing the risk and impact of frailty through proactive population health measures.
Early intervention – identifying and supporting individuals at the earliest opportunity to maintain independence.
Reversing frailty – proactively identify people whose frailty symptoms have the potential to be reversed and putting interventions in place to achieve reversal
Timely crisis response – ensuring rapid access to appropriate care and support during episodes of deterioration.
Rehabilitation – promoting recovery and restoring functional ability following illness or injury.
Long-term support – enabling sustained wellbeing through coordinated, person-centred care.

The plan sets out actions across three-time horizons:
Short-term – measures to address winter pressures and immediate service demands.
Medium-term – service transformation to strengthen pathways and integrate care delivery.
Long-term – building a sustainable, community-based model that fully integrates with wider health and care services

OBJECTIVES Short Term (0–6 months – Winter Pressures)

1. Boost front-door frailty capacity
- Maximise Frailty SDEC utilisation
- Achieve frailty screening within 30 minutes of ED arrival.

2. Prevent avoidable admissions
- Maximise *Call Before Convey* (CB4C) and *Single Point of Access* (SPOA) redirection of patients to frailty pathways without ED conveyance.
- Ensure all SPOAs include access to frailty pathways.
- Fully utilise front-door frailty streaming to trigger early comprehensive geriatric assessment.

3. Targeted prevention blitz
- Undertake rapid polypharmacy reviews for the top 200 high-risk patients per Place (To be agreed with Meds management lead)
- Deliver multifactorial falls assessments with direct access to intervention.

4. Strengthen discharge-to-assess
- Prioritise frailty cases with reablement needs.
- Embed discharge planning across the whole patient journey from earliest opportunity, engaging patients and families to reduce length of stay.
- Refresh existing deconditioning prevention programmes across acute trusts.
- Utilise discharge comms toolkit for winter

5. Asset mapping

- Map out frailty services across NHS Community and Acute providers, including (but not limited to) falls pick-up services, frailty-at-the-front-door / frailty SDEC services and care home services
- Collect quantitative and qualitative evidence about the impact of existing services
- Develop target operating model for system frailty services

OBJECTIVES Medium Term (Aligned to planning round 2025/26)

1. Embed frailty identification system-wide
- Implement standardised frailty screening in primary care, community, ambulance, and acute settings.
- Introduce a frailty 'flag' in the shared care record, accessible to all providers.

2. Scale Urgent Community Response (UCR)
- Embed standard UCR service specification, with a focus on increasing consistency in offer and in the rate of accepted referrals per weighted population.
- Link UCR provision to care home in-reach and GP rapid access services.

3. Integrated rehabilitation & reablement model
- Enable seamless transfers from hospital to community rehab beds or home-based therapy.

4. Workforce development
- Provide frailty training for 100% of front-line staff in ED, ambulance, primary care, and community teams.

5. Cancer pathway integration
- Develop, agree, and commence implementation of frailty assessment and management guidance for patients with suspected or diagnosed cancer.

6. End of life pathway integration
- Improve identification of people who may be in their last year of life
- Increase the number of end-of-life patients who have care plans in place, using EPACCS and / or Advanced Care Planning

Proposed metrics Once finalised, metrics trajectories and associated financial benefits will be developed.

Metric Type	Metric	Target
Process	% patients screened for frailty within 30 mins of arrival	≥ 90%
Process	% polypharmacy reviews completed for high-risk cohort	≥ 80%
Process	% of people who die who had an end-of-life care plan in place (EPACCS or ACP)	+15%
Outcome	Reduction in non-elective admissions for patients with frailty	-10% from baseline
Outcome	Reduction in average length of stay for frailty admissions	-15% from baseline
Outcome	Reduction in non-elective admissions for patients on gold standards framework (GSF)	-5% from baseline
Outcome	Reduction in average length of stay for patients on GSF	-15% from baseline
Outcome	Reduction in people aged 65+ being discharged onto pathway 3 after an acute hospital stay	Achieve target of <5%
Outcome	Bed days as a result of a fall for people aged 65+, 75+ and 85+	Move from upper quartile to mean
Balancing	Readmission rate within 30 days	≤ 10%
Balancing	Community service caseload growth rate	Monitor

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Example of Provider Trust Improvement monitoring

Each Provider Trust has a monthly improvement trajectory for 4 hour and 12 hour performance with key enabling actions. Each organisation has been assessed for delivery confidence alongside the national UEC tiering rating which determines the levels of support and scrutiny applied.
This is the focus of weekly ICB recovery meeting and NHSE tiering conversations
Example shown below

TRUST	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
4 HR	70.82	70.89	70.96	71.02	71.09	71.23	71.22	71.3	71.34	71.4	71.47	71.53
Actual	78.1%	77.7%	77.1%	77.0%								
12 HR	16.43	15.93	16.67	16.63	18.02	16.68	15.96	15.74	16.38	16.31	16.24	16.17
Actual	17.7%	17.5%	18.4%	18.7%								

Key enabling actions

Delivery Confidence: HIGH / MED/ LOW

- Continuation of call Before Convey approach initiated in Q4 2024/5 supported by NWAS
- Development of SDEC models with focus on extending access 12/24, 7/7.
- Multi-agency ‘front door’ SDUCU with focus on identification of complex needs at point of attendance to start holistic care planning.
- Adopt recommendations from recent AtED audit
- Focus on ward-based processes and regular point prevalence audits through Valuing Patient Time Collaborative.
- Review of diagnostic capacity aligned to IP demand to reduce delays for IP diagnostics.
- Development of internal flow performance dashboard to provide real time management insight into internal flow KPIs down to ward-level.

Cheshire & Merseyside UEC Improvement Plan
Monitoring performance and improvement trajectories

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For providers that are off trajectory for achieving 4 hour and 12 hour performance a detailed recovery plan outlining the “what by when” has been requested.

On the right is an example of a plan to recovery a Trust’s 12 hour performance

Local UEC recovery teams and the UEC improvement group will work with providers to support their recovery efforts.

Breaches prior to intervention	Timescale	
Current Position		**56.4**
DDU Phase 1	Aug-25	-3
Continuous flow and direct access to specialty beds	Aug-25	-2
Housekeeping/ quick wins (e.g. transfers on chairs not beds, real-time movement of patients, real time discharging of patients)	Aug-25	-1
Validation of 12-13 hour breaches	Aug-25	-0.5
Afternoon Discharge huddles, pharmacy support for flow and early discharges	Sep-25	-1.5
ED Triage	Sep-25	-1
DDU Phase 2	Sep-25	-4
Specialty reponse/Hot clinics	01-Oct	-1
Criteria Led Discharge/OOH Medical Cover	Oct-25	-1
Wait to be seen	01-Nov	-4
Loss of current EAU function		4.7
Breaches following intervention		42.1
Target		42

Cheshire & Merseyside UEC Improvement Plan
Examples of Progress : Corridor Care

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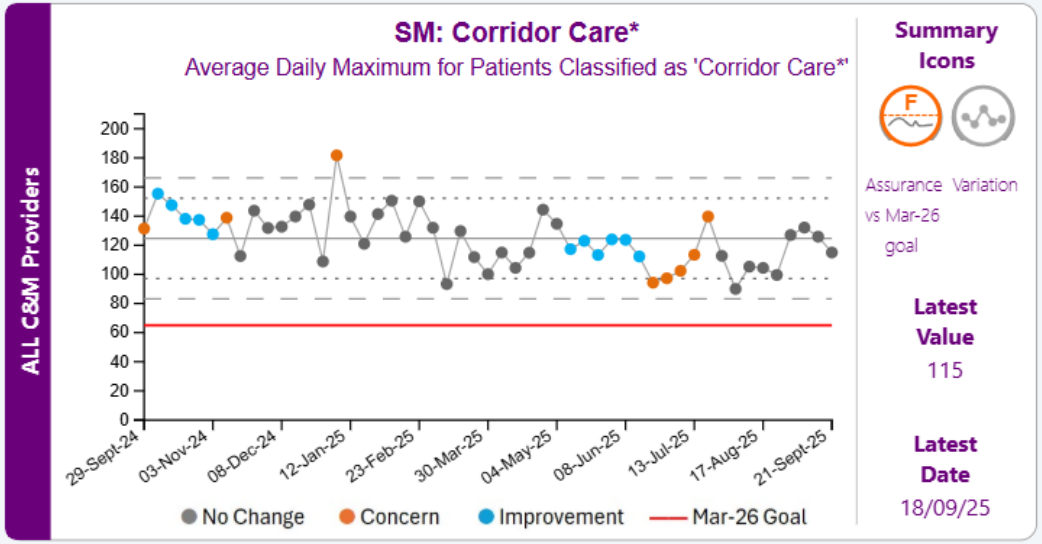
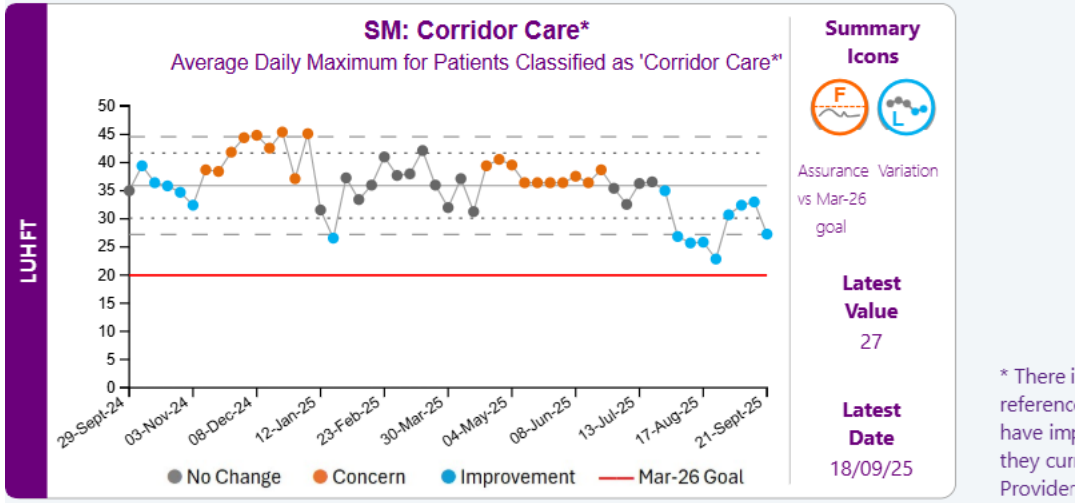
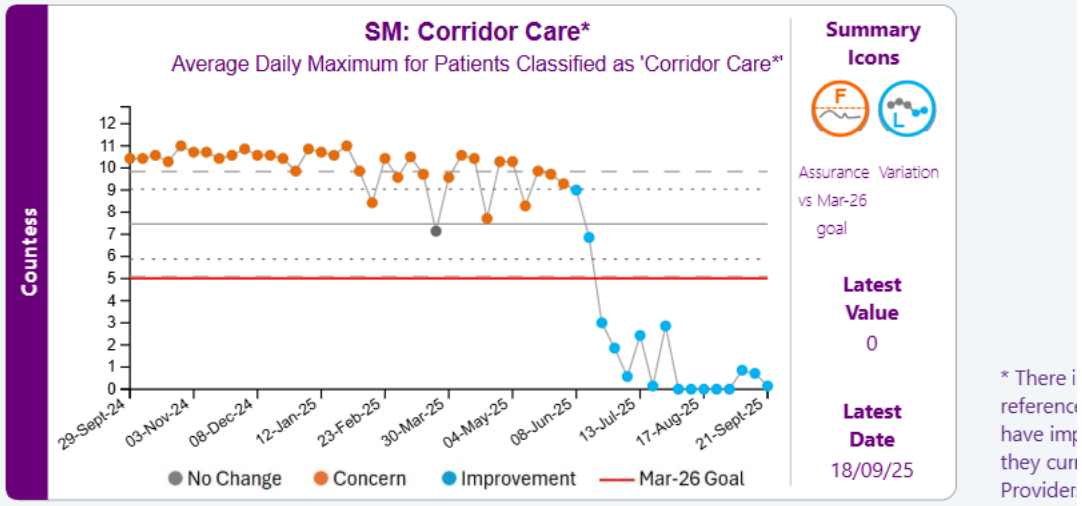
Corridor Care: C&M Provider-Specific Indicators



Corridor Care: C&M Provider-Specific Indicators



Corridor Care: C&M Provider-Specific Indicators



In past 12 months there has been progress on our overarching aim of reducing corridor care by 50% which suggests that the actions being taken are the right ones.

On the right are examples of strong improvement in some of our organisations but there is variation across C&M.

There is still more to do to be confident that improvement will be sustained and to increase pace of improvement ahead of winter.

Cheshire & Merseyside UEC Improvement Plan
Examples of Progress: Ambulance Handover 45

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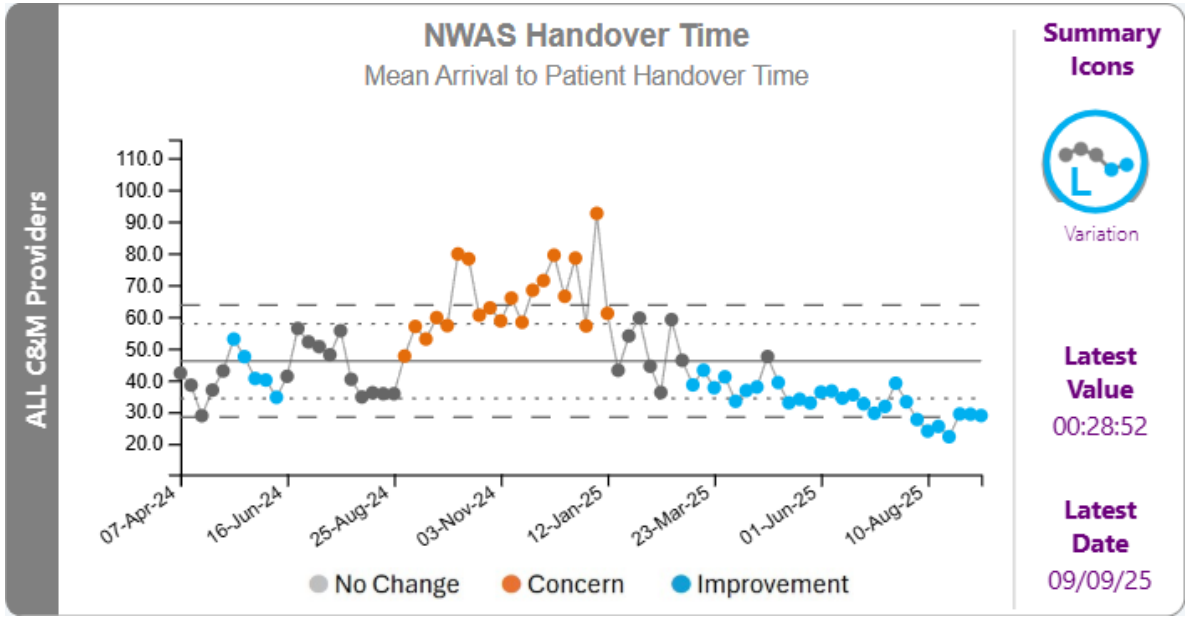

Latest variation shows consistent improvement for the C&M aggregate position since Mar-25. Mean handover time for all C&M Providers is 00:28:52.

● Countess, LUHFT, MWL and Wirral are consistent with the C&M trend, ie statistically significant improvement since Mar-25.
Mid Cheshire and Warrington have both shown statistically significant improvement over the last 11 weeks.

● East Cheshire are currently reporting no recent statistically significant change to handover time.

Handover 45 implementation

Since launch on 1st August, HO45 has:

- Set a clear operational standard — maximum 45 minutes from arrival to handover.
- Introduced real-time monitoring and rapid escalation for breaches.
- Driven shared ownership between NWAS crews and ED teams for patient flow.
- Triggered downstream improvements in discharge before noon, SDEC utilisation, and inpatient flow.
- Data can now be seen in real time around handovers taken over 15,30 and 45 minutes on SHREWD allowing teams to target actions and review.

A comparison of the 6 weeks since HO45 implementation vs the same period in 2024 shows there have been notable improvements in emergency ambulance response and handover times:

- Category 1 mean response – 58 seconds faster
- Category 2 mean response – 1:31 minutes faster
- Category 2 long waits >60 minutes – reduced by 3%
- Average handover – 16 minutes faster per incident
- HAS compliance – improved to 99%
- Handovers > 45 minutes – reduced by 57%

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Examples of Progress: Virtual Wards

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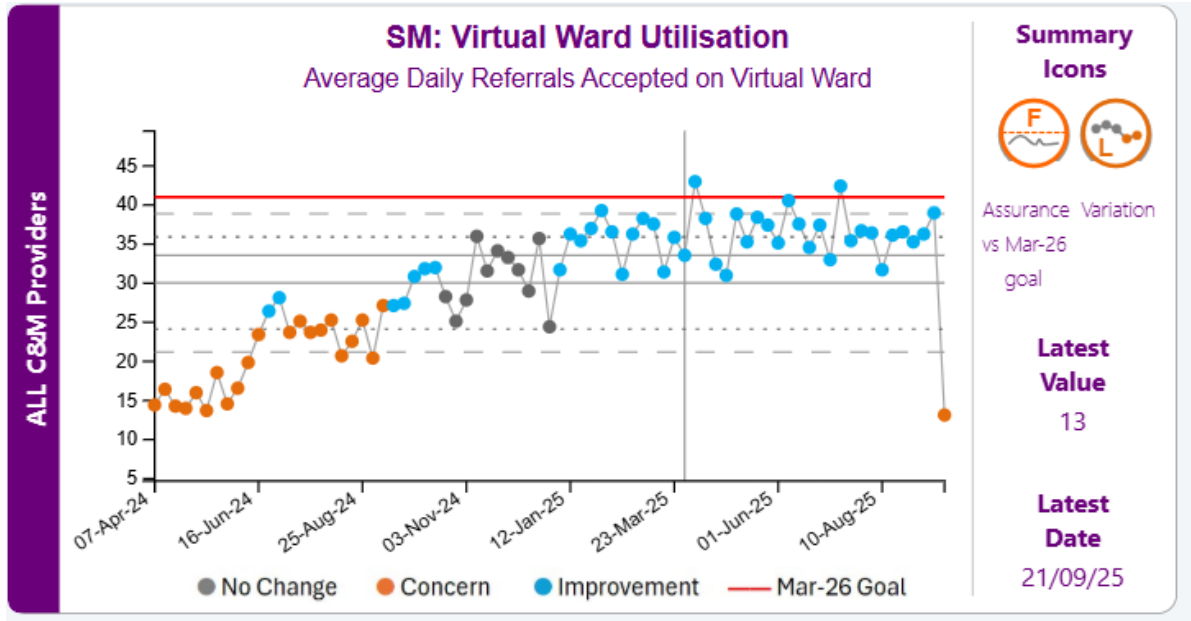

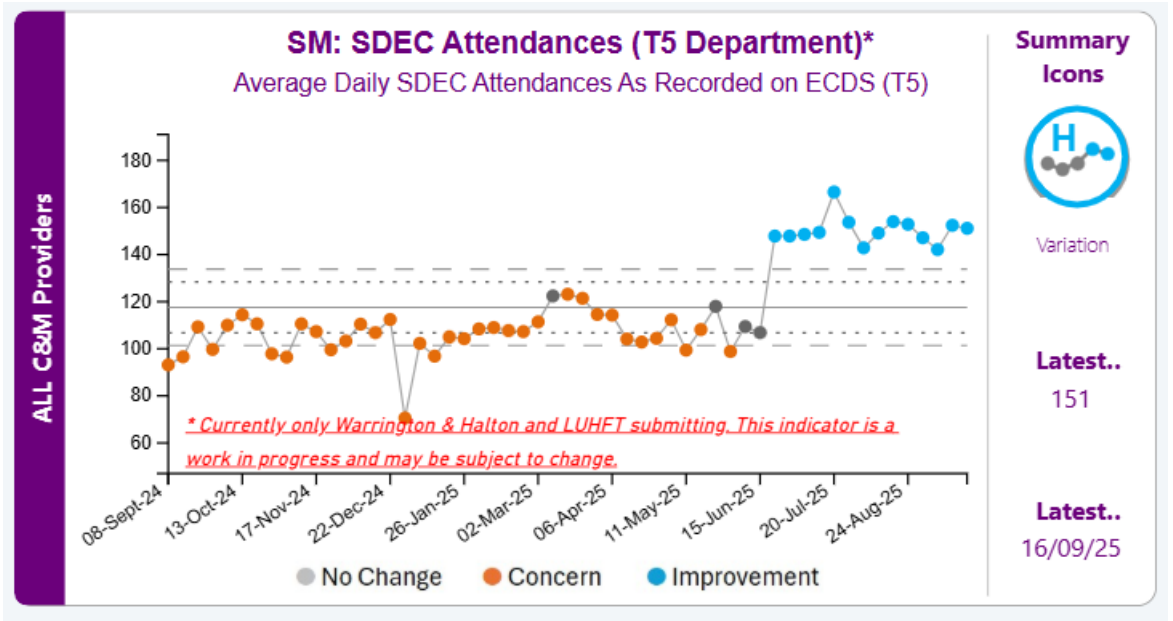

The provider collaborative has led this improvement by

1. Moving from condition specific pathways to less restrictive criteria based on the right patient rather than the right condition
2. Establishing lead provider model
3. Actively sharing the learning between teams

Same Day Emergency Care pathways allow patients to bypass ED and avoid admission

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Examples of Progress: Single Point of Access

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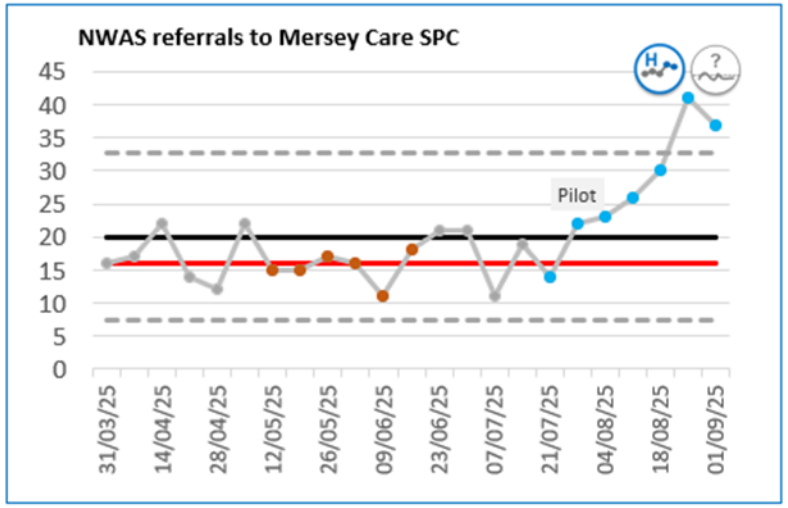
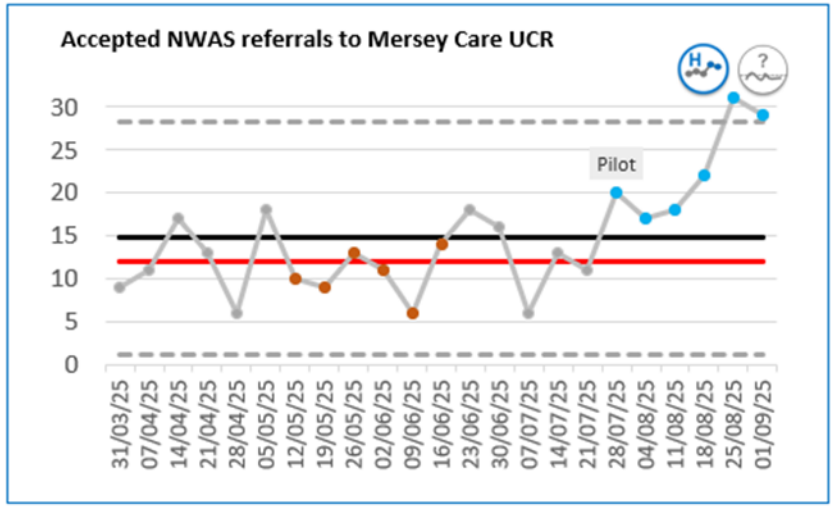
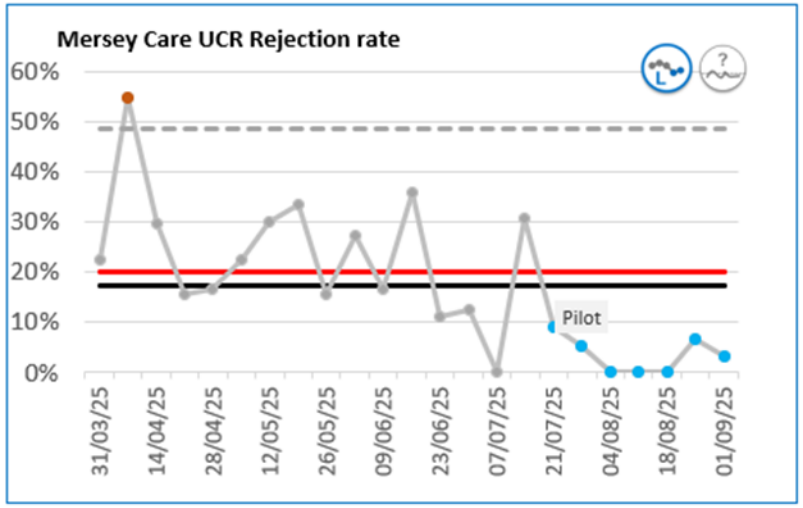
The C&M Provider Collaborative has put a Single Point Of Access (SPOA) in place for NWAS crews to refer to when they have a patient who they feel could be actively managed at home rather than being admitted to hospital. The SPOA can then refer the patient into the Urgent Care Response (UCR) service in the community. The work is aligned to another piece of work that is standardising the UCR response across C&M.

Since commencing the pilot NWAS conveyance rates have dropped below 50 % for the first time and ED arrivals for 65 year + from care homes has shown a statistically significant reduction.







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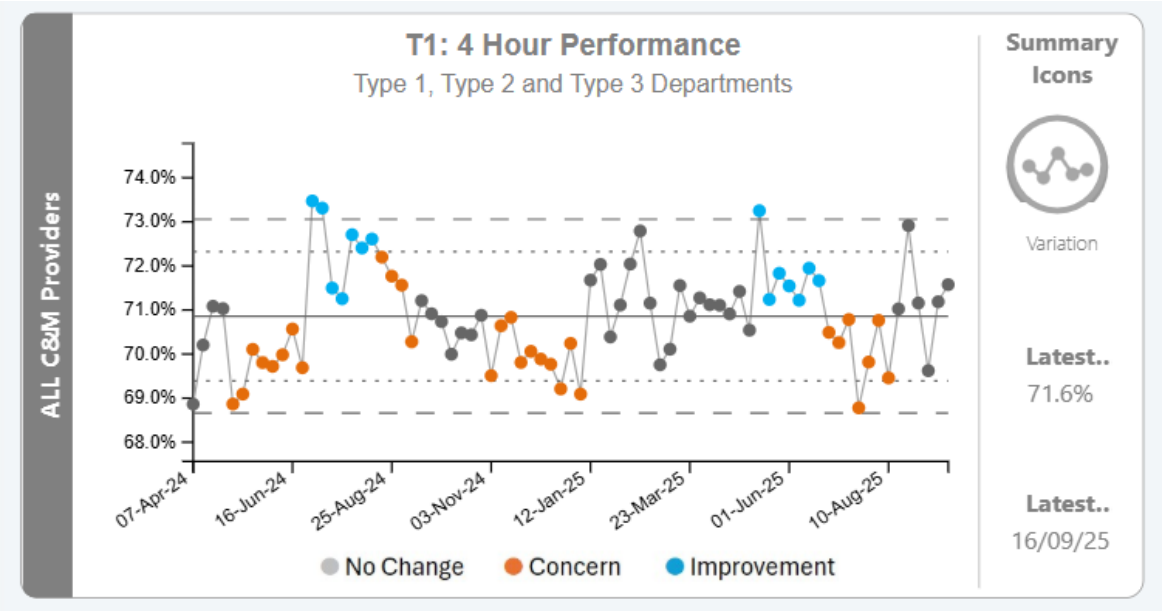

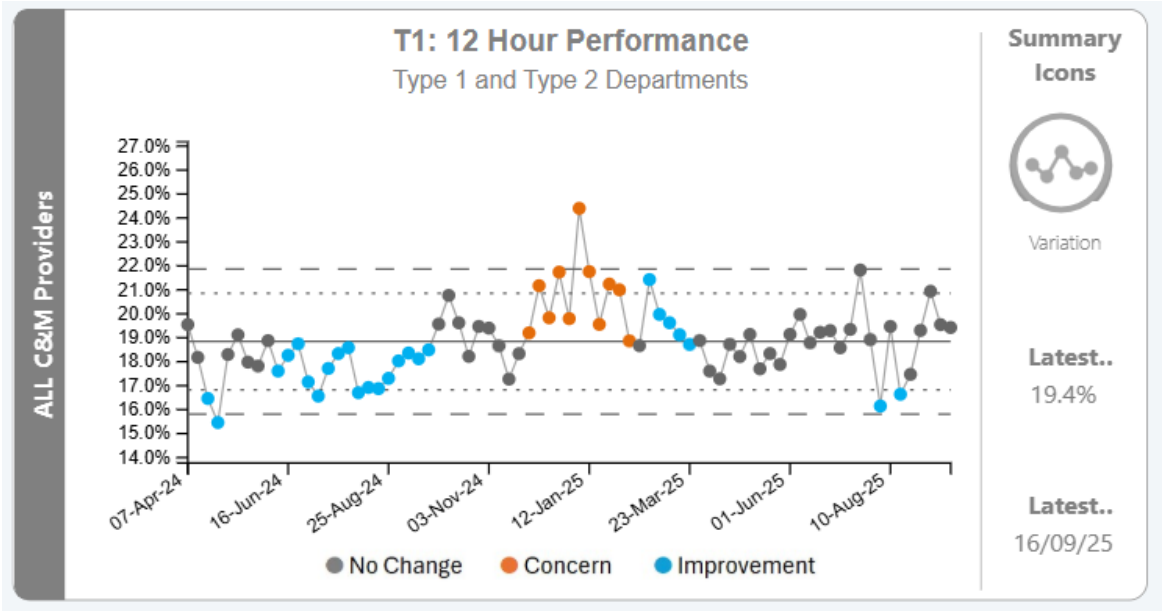

Although we are seeing statistically significant improvement in some of our projects, we are still to see a sustained improvement in the 4 hour and 12 hour performance measures.

This is the focus of the weekly recovery meetings and the NHSE NW tiering meetings.