THE QUALITY OF CARE IN

Salford

CQC prototype report

May 2016

Quality of care in a place

CQC is producing a number of prototype documents exploring how we might report on the quality of care in a place. The following documents are planned for the first half of 2016:

The quality of care in North Lincolnshire
Prototype report
February 2016

North Lincolnshire
Data-only report
February 2016

The quality of care in Salford (Greater Manchester)
Prototype report
May 2016

The quality of care in Salford (Greater Manchester)
Appendix
May 2016

Tameside (Greater Manchester)
Data-only report
May 2016

Contents

FOREWORD **2**

SUMMARY **4**

SYSTEMS AND THEIR IMPACT 4

POPULATIONS AND THEIR EXPERIENCES 5

THE QUALITY OF HEALTH AND SOCIAL CARE PROVIDERS 6

CONCLUSION: OPPORTUNITY AND CHALLENGE 7

INTRODUCTION **9**

OUR APPROACH IN SALFORD 11

LIMITATIONS 14

THE WAY FORWARD 15

SALFORD OVERVIEW **16**

SYSTEMS AND THEIR IMPACT **17**

POPULATIONS AND THEIR EXPERIENCES **20**

OUTCOMES 20

PROGRESS 21

INDICATORS OF COORDINATION AND INTEGRATION OF CARE 22

ACCESS 23

OLDER PEOPLE 24

PEOPLE WITH MENTAL HEALTH NEEDS 25

THE QUALITY OF HEALTH AND SOCIAL CARE PROVIDERS **27**

CONCLUSION: OPPORTUNITY AND CHALLENGE **29**

ADDRESSING IMMEDIATE CHALLENGES AND ACHIEVING LONGER TERM GOALS 29

CLEAR UNDERSTANDING OF DRIVERS OF HEALTH INEQUALITIES AND HOSPITAL USE 30

ENGAGING THE PUBLIC, THIRD SECTOR AND THE RANGE OF PROVIDERS 31

RESPONDING TO RAPID SOCIO-ECONOMIC CHANGE IN SALFORD 32

DEFINING AND MEASURING 'WHAT GOOD LOOKS LIKE' FROM PEOPLE'S PERSPECTIVE 32

FROM PARTNERSHIP WORKING TO STRUCTURAL REORGANISATION 32

COMPLEXITY AND PACE 33

INTERACTING WITH GREATER MANCHESTER DEVOLUTION 33

CONCLUSION 34

APPENDIX: COMPLETE LIST OF KEY LINES OF ENQUIRY **35**

Foreword

The Care Quality Commission's (CQC's) purpose is to make sure health and social care services provide people with safe, effective, compassionate, high-quality care and to encourage care services to improve.

This prototype report on the quality of care in Salford is one in a series of products from our programme of work to explore the role of CQC in quality regulation in a local area. Our approach tests whether going beyond the regulation of individual providers helps us to achieve our purpose.

CQC published the first report on quality of care in a local area in February 2016, which looked at North Lincolnshire. Alongside this report on the quality of care in Salford, we are also publishing reports containing data about Tameside and Greater Manchester. The reports try out different approaches.

We will evaluate this work to understand which approaches are best to take forward, and we will do this in a way that effectively balances the changing nature of health and social care provision with the need to ensure CQC continues to provide robust and transparent ratings of providers. The health and care landscape is changing rapidly, and we are working to ensure that CQC enables progress. A shared focus on the full health and care needs of individuals is vital to ensure people receive high-quality care, and we will continue to develop our understanding of how CQC can help.

The objectives of this Quality in a Place programme are to understand the extent to which we can provide evidence to support whether reporting on the quality of care in a place can be a lever for improvement. The evaluation that will be produced alongside our reports and your feedback will help inform our thinking about how to regulate new care models such as accountable care

organisations (ACOs) and whether reporting in this way has the potential to improve transparency for people living in a local area.

This is not a typical CQC report – it tells the story, but does not aim to reach a conclusion on the quality of care in Salford. Reaching a conclusion would not be appropriate at this stage in the development of this work. We are very grateful to the stakeholders in Salford for being so generous with their time.

I would welcome your thoughts and feedback on this and the other reports on quality of care in a place. We will continue to engage with stakeholders, both local and national, as we finalise and implement our 2016-21 strategy.

David Behan
Chief Executive

Summary

There is evidence of good and outstanding quality health and social care for people in Salford. This is both at the level of individual providers and in initiatives taken to innovate and integrate services. There is strong leadership and partnership, founded on commitment to making a positive change for local people.

Salford is one of the most deprived boroughs in England and people have poorer health compared with the England average. There are inequalities in health within Salford and people do not always access services in the best way. However, Salford is seeing improvements in many areas of health and wellbeing. Leaders in Salford are now embarking on transformational change in the design and usage of health and social care services.

SYSTEMS AND THEIR IMPACT

There is strong evidence that the four statutory partners in Salford (Salford Royal NHS Foundation Trust (SRFT), Salford Clinical Commissioning Group, Salford City Council and Greater Manchester West Mental Health NHS Foundation Trust) successfully work together and have a strategy for how to improve care in the area. Local leaders and partners are responsive to local need, identifying areas for improvement and taking effective action to make things better for local people. They have ambitious plans for integrating health and social care, moving care into neighbourhoods, prioritising prevention and self-care, and they are supporting the health and social care strategy for Greater Manchester. Across the health and wellbeing board (HWB) there is a recognition of the value of all agencies working together to achieve the best outcomes for people using services, and of the importance of supporting each other to do this. One of Salford's strengths is that the development of health and

social care services is linked into public health, the community and voluntary sector and the wider socio-economic development of the area.

POPULATIONS AND THEIR EXPERIENCES

There are examples where partners had worked together, pooling budgets and integrating teams, in order to improve services and outcomes for people and make the best use of resources. This includes learning disability services. It includes reconfiguring care pathways through the emergency care system, intermediate and community care and primary care, with the result that Salford is performing in line with or better than England on delays in discharging people from hospital.

Some performance measures, such as provision of NHS health checks and excess winter deaths, can be more rapidly influenced by a well-performing health system than those that are more strongly linked to socio-economic factors. Salford performs better than England on a number of these measures.

On areas where change takes longer and requires action across a range of social factors, Salford is showing positive change. However, it will take some time for the area to catch up with the national average. There is positive change in some areas of preventable mortality, although mortality remains high for long-term conditions and the range of life expectancy across the social gradient is greater in Salford than in England. These are issues that the area's locality plan aims to address.

Salford is aware that it has very high numbers of emergency admissions, even when the high level of social deprivation is taken into account. There are multiple sources of high emergency and hospital admissions. This includes for self-harm, alcohol related admissions, mental health conditions, falls in over 65s and long term conditions that should not require hospitalisation as they can be managed effectively in the community (e.g., diabetes, epilepsy and high blood pressure).

The emergency admission rate is an important measure of the effectiveness of care. However, it is also a consequence of inequalities and a contributor to health inequalities. People living in more deprived neighbourhoods are diagnosed at a later stage of their disease, are less likely to see a specialist and more likely to experience preventable hospital admissions.

They are also more likely to die from treatable conditions. There is some concern expressed by local stakeholders that not all residents are able to access timely care and support, including substance misuse services, occupational therapy and Care Act assessments. While primary care performs well on many indicators, care planning in general practice appears to be worse

than the England average. Salford has fewer GPs per head of population than the national average. However, we also found that the partner organisations in Salford had identified many of these problems and were taking action to address them.

OLDER PEOPLE

Salford is developing an integrated care programme for older people, which is in its early phases, with changes to people's experiences and outcomes not yet expected. When we spoke with older people, their current experiences of person-centred integrated care were mixed. This seemed partly dependent on the combination of services they used. People's better experience was associated with having positive support from a GP, good information sharing between services and not having to repeatedly tell their story. Importantly, where people indicated services were joined up and communicated well, they tended to describe a higher quality experience of care. This strongly supports the area's programme to reconfigure care for older people.

PEOPLE WITH MENTAL HEALTH NEEDS

The changes that had taken place in dementia care, through collaboration across agencies, were very positively regarded by local stakeholders. We found evidence of good quality care and crisis care for those diagnosed with severe and enduring mental health conditions and using secondary mental health services. Those we spoke with that had a diagnosis of schizophrenia described person-centred care led by a care coordinator who brought together services and support to enable them to recover. However, service user groups, primary and adult social care providers and third sector organisations told us there were problems with accessing mental health services for people experiencing low mood, without clear diagnosis or with multiple problems, such as mental health problems along with learning disabilities or drug and alcohol problems.

THE QUALITY OF HEALTH AND SOCIAL CARE PROVIDERS

CQC inspections found Salford has outstanding acute care, good community health services and that GP practices tend to be rated good or outstanding. However, of adult social care providers rated, a higher proportion are rated requires improvement or inadequate, suggesting the need for Salford to continue to focus on improving quality in this sector. These findings need to be interpreted in the context of not all providers having been inspected and rated.[1]

1 CQC anticipates rating every adult social care, primary and community mental health, acute and mental health providers by the end of 2016.

CONCLUSION: OPPORTUNITY AND CHALLENGE

Salford is improving the health and wellbeing of local people and has plans to reconfigure services in order to obtain good outcomes for all people living in the area. Our findings provide support for the plans to integrate services and strengthen primary and community care. The following challenges and opportunities were identified, which we encourage Salford to continue to consider as they implement this strategy.

- **Addressing immediate challenges and achieving longer term goals:** Salford has a clear long term strategy and takes action to address current problems in the provision of care, such as in alcohol and occupational therapy services. However, there are some areas where Salford could consider giving attention, including occupational therapy, Care Act assessments and care planning in primary care. In particular, we encourage Salford to check whether plans do address needs and gaps in provision for lower level mental health problems in the most effective way.
- **Clear understanding of drivers of health inequalities and hospital use**: Some of the data shows Salford to be an outlier. Emergency admissions, hospital use and inequalities within the area are greater than would be predicated by measures of social deprivation alone and exist despite evidence of good quality care. A clear understanding of the drivers of these patterns could enable Salford to further target and tailor initiatives in order to have the highest impact on the health and wellbeing of local people.
- **Engaging the public, third sector and the range of providers:** When talking to service user representatives, third sector organisations and the wider range of providers, there was some uncertainty about the changes taking place in health and social care, and a view that the four main partners tended to move ahead at a fast pace without always waiting to bring everyone along with them. Stakeholders also told us there needed to be changes in the way the public was engaged, so they had enough information and understanding to be meaningfully involved. We support the efforts of Salford to do more to engage all stakeholders and the public, in order to achieve reconfigured care that is responsive to local need and accountable to local people.
- **Responding to rapid socio-economic change in Salford:** Changes in health and social care are taking place at the same time as economic regeneration and growing diversity in Salford. Stakeholders identified that it is a challenge for health and social care in Salford to keep pace with the rapidly changing communities. We encourage Salford to take advantage of local diversity, by involving and responding to the needs of the full range of local people in innovative ways.

- **Defining and measuring 'what good looks like' from people's perspective:** Stakeholders felt there were limitations with existing indicators, and wanted to find ways to measure quality from the point of view of how it builds on people's strengths and enables them to live the life they want. Developing shared measures that are meaningful for local people will enable Salford to know if, five years down the line, things are better for the people in Salford.
- **From partnership working to structural reorganisation:** The Integrated Care Organisation for Adults (ICO) includes reorganisation of staff and services. These plans are supported by attention to governance and initiatives to foster leadership at all levels and workforce development. However, some people we spoke with said they were worried the new structure might result in less space for innovation, or that reorganisation might weaken relationships with those teams who were not part of formal integration, such as public health. Attention to these 'softer' issues of relationships, collaboration and innovation may support the ambition of the ICO to deliver care in new ways.
- **Complexity and pace:** Local leaders are clearly mindful of the risks that come with such large-scale change at speed, as set out in the strategy. We would encourage the local leadership to continue to ensure these risks are clearly identified and managed.
- **Interacting with Greater Manchester devolution:** Stakeholders within and outside of Salford commented that Salford was seen as a leader in Greater Manchester and that Salford leaders were well connected into developments in the region. We support Salford partners' collaboration with Greater Manchester, to influence and benefit from changes to health and social care across the region.

Introduction

The quality of care in a place project is one of several pieces of work CQC is undertaking to explore the role of CQC beyond our current provider regulation, and to understand how we should respond to changes in health and social care. We use our powers from Section 48 of the Health and Social Care Act to allow us to carry out such reviews that focus on particular themes or aspects of health and social care – including in local areas, pathways of care, groups of people or services.

To accompany CQC's business plan for 2015/16 we developed our first *Shaping the future* publication. In it, we committed to testing the value of reporting on the quality of care in a local place during 2015/16, and to explore the role of CQC beyond provider-based regulation.

This prototype report on Salford is the third output from that programme of work. It aims to inform our understanding of how CQC might build a picture of what care is like for people who use a range of different health and social care services in one area rather than looking at individual care providers, such as hospitals, care homes or GP services. We want to explore whether doing this might help to achieve an important part of our core purpose: encouraging improvement in health and adult social care.

The prototype sits in the wider work programme of CQC's Integration, Pathways and Place Board, through which we are seeking to understand what the role of CQC might be, beyond provider-based regulation.

Other projects are considering the following questions:

- What is the quality of care in North Lincolnshire and Tameside? How can we use different methodologies in order to understand the quality of care provision across an area?

- How could CQC assess the quality of urgent and emergency care for people within an area, and consider how care is coordinated between and within care providers with the aim of producing a seamless patient journey?
- How does the extent to which care is integrated affect older people's experiences of care?
- What are the implications of emerging new models of care (for example Vanguard sites) for how CQC should register, monitor, inspect, rate and enforce in the future?

Together with the quality of care in a place prototype reports, the intention of the programme is to understand the value of different frames for looking at quality beyond providers, in order to inform our future direction. In this first year, we are testing an approach in three areas: North Lincolnshire, Salford and Tameside. Both Salford and Tameside are part of Greater Manchester.

When selecting the locations we took a number of criteria into account. Firstly, we wanted to include places where a relatively high percentage of providers have been rated by CQC. Secondly, we wanted to include locations in two different parts of England. We chose Greater Manchester because it is the most advanced area in terms of devolution, and so our second location had to be outside the North West. Also, we wanted to include a city and a less urban location (with no major city), and to cover areas where a health and wellbeing board and clinical commissioning group (CCG) have similar boundaries (coterminous).

We chose HWBs to define our areas because they reflect local authority boundaries which people are more likely to recognise. This is also helpful because HWBs have an oversight of health and wellbeing outcomes across an area. The locations we chose share the same geographical footprint as the HWBs and CCGs but we are aware that this will not always be the case in other areas.

Questions have been asked at three levels: providers, populations/pathways and place/systems, to fully understand an area from different perspectives and to give a rounded picture of care quality. (Details of the assessment were used to form the framework we used to ask these questions and are included in the appendix to this prototype report.)

The focus of this prototype report is the overall provision of NHS care and adult social care services in Salford.

The report focuses on two population groups to help us get a better understanding of care quality in an area. We will be able to see if an additional focus on demographic or condition-based population groups within a place adds value to our assessment. In particular this prototype looks at:

- People aged 75 and over, including those who have good health and those who may have one or more long-term condition, physical or mental.
- People with mental health needs (including people with dementia), across a spectrum ranging from those with low or moderate needs to those experiencing severe and enduring mental illnesses, and exploring in more depth the experiences of people with a diagnosis of schizophrenia.

A long-term intention is that a product like this prototype report will be useful for CQC's inspection teams, and potentially to local stakeholders. This report is designed to show providers and commissioners of health and care where they can improve to serve local people better. We have also highlighted findings that show where there is good joint working.

This prototype report, alongside other work focusing on care pathways and place, including reports for Salford and Tameside, will feed into CQC's strategy for the next five years. We anticipate that feedback on this and the other reports due to publish in May will help us consider our approach to regulation and how it can reflect and potentially shape changes happening across health and social care.

OUR APPROACH IN SALFORD

This is not an inspection and there is no rating of an area. This is not a fully comprehensive review and there are a number of limitations to the evidence used, which are set out below. As this was a test of the methodology our findings should be considered indicative only.

CQC visited Salford to talk to local stakeholders and undertake case studies of patient experience during November 2015. The publically available data we used to inform our review was up to date as of August 2015. CQC ratings reported were up to date as of April 2016.

We used the same framework in each of the local areas, but we focused on different questions within the framework and different evidence sources. In North Lincolnshire we looked at commissioning, but we did not do this in Salford or Tameside. For Tameside, we produced a report of quantitative data indicators and CQC ratings only. In Salford we gathered more information from people who use services than in the other areas. We started exploring the effectiveness of our approach by focusing on a smaller number of key lines of enquiry (KLOEs) in the framework, rather than covering in detail the complete framework. (See our Salford appendix of evidence document for the KLOE list.)

To arrive at a view of the quality of care in Salford we have used a combination of existing and new evidence to address the questions in the framework. The following evidence sources were used.

CQC PROVIDER INSPECTIONS AND RATINGS

We summarised ratings from our inspections of providers based on our new methodology, compared the proportion of each rating in the area with the proportion nationally, and presented this information on maps. In addition, we qualitatively reviewed 28 reports (one acute, 21 ASC and six GPs) to see whether there were key themes among key questions rated as requires improvement, inadequate and outstanding.

QUANTITATIVE DATA INDICATORS

We used publically available data from other sources, to provide information on outcomes and indicators of the quality of care for local people. This includes data published by Public Health England (PHE), the Health and Social Care Information Centre (HSCIC) and NHS England, as well as data sourced for CQC thematic reviews. Where data has been published by external organisations, the source of the data (as noted throughout) refers to the organisation that published the data.

Data which is from a PHE publication has been benchmarked by PHE against the England average. PHE uses the system of significantly higher, significantly lower or similar. Where a comparison is similar this means that the difference is not statistically different. Occasionally it has not been appropriate to benchmark the data and this will be indicated by 'not compared'. Where we have drawn on data used in other CQC studies to inform our work, we have used the original benchmarking methodology (see section x).

STAKEHOLDER INTERVIEWS AND FOCUS GROUPS

In November 2015 we conducted 28 interviews and seven focus groups with people involved in health and social care in Salford. This included senior leaders in statutory health and social care organisations, teams of managers and staff involved in delivering care, representatives of providers, people who use services and the community and voluntary sector. It also included representatives of national Arm's Length Bodies (ALBs) for the North West. We reviewed documents which set out plans and reported on health and social care in Salford. And we attended a meeting of Salford's health and wellbeing board.

We also held a focus group with CQC inspectors who inspect providers and work with partners in Salford. This included seven people who were inspection managers or inspectors, with representatives from each CQC sector (adult social care, primary care, mental health and hospitals).

Where the report refers to stakeholder views, it is referring to content from these interviews and focus groups. Views and quotations are included anonymously, but with an indication of which type of stakeholder expressed the view.

CASE STUDIES WITH OLDER PEOPLE AND PEOPLE WITH MENTAL HEALTH PROBLEMS

In November 2015 we undertook case studies in order to understand how well services work together, from the point of view of people who use services and the professionals providing care. For this pilot, we were focusing on care for older people and care for people with mental health problems. We undertook 10 to 15 case studies for each group. This number was seen as sufficient to generate insight alongside quantitative indicators and a manageable size for the purpose of testing a methodology.

Both of these groups include people with many different conditions, so to enable us to get a clearer picture, we decided to focus on people with particular 'conditions' that were likely to require collaboration and movement between different services, across health and social care. These conditions were selected based on discussion with CQC specialists, Special Advisors and members of the Quality in a Place External Advisory Group.

- For older people (aged 75 and over) we spoke with people who had experienced fracture or multiple falls.
- For people with mental health problems we spoke with people with a diagnosis of schizophrenia.

In both groups people needed to be over eighteen and able to consent, and we ensured we met best practice regarding ethics and informed consent.

We approached services in Salford in order to identify people who met our criteria, and selected people at random based on a list provided by services. Interviews were undertaken by CQC Specialist Advisors and inspectors. For each case we attempted to speak to the following people, although in some cases professionals were not available to speak to us:

- Interviewed the main care co-ordinator, GP or community staff or person with whom we identified the patient.
- Interviewed the patient about their experiences of using several different services and whether these services were integrated.
- Interviewed those providing care in other services.
- Corroborated findings by looking at patient case notes in each service if required.

ONLINE CONSULTATION WITH OLDER PEOPLE AND THEIR CARERS

The public online consultation was designed to capture people's experience of the quality of care across providers in a place and how well care is coordinated. We asked for responses from older people and/or their carer. The online form

was available to complete between 12 and 23 October 2015. The findings cover views from the 27 older people and/or their carers who responded to the consultation.

LIMITATIONS

There are limitations to the methods and evidence sources we used for this pilot, which should be kept in mind when reading the report.

- A selection of documents, and discussions with a specific set of stakeholders, were analysed. Although we have been able to corroborate our findings between different stakeholder discussions, this should not be read as a fully comprehensive review.
- Before we conducted the site visit, a data report was compiled to inform the discussions with stakeholders. The quantitative information that we have used is based on data publically available in August 2015. This means that some of the data we have used will be out of date. However, for consistency we have presented the data available in August 2015. Outside of a pilot, we would hope that the time that elapses between production of a data report and the final report would be shorter and consequently this problem would be less pronounced. We are aware that local data may show a different picture.
- Ratings of providers in Salford are up to date as of the date of publication (May 2016). However, we have not yet rated all local or national providers. As a result, we are limited as to any conclusions we can make across all local providers and compared nationally. We anticipate that all providers will be rated by the end of 2016. Ratings of specialist services used by Salford residents which are outside of Salford are not included.
- It should be noted that the intention was to focus on people aged 75 and over when exploring the experiences of older people. However, data for this age group was not always available or there was a need to increase sample size. As a result, the evidence for older people refers to different age brackets: aged 65 and over; or 75 and over.
- The online consultation with older people and the case studies with older people and those with schizophrenia included only a small number of respondents. While this evidence is designed to provide insight to people's experiences of care alongside quantitative and other sources of evidence, the size of the sample presents a risk to the findings and how widely they can be generalised.
- Online methods may not be the most effective way of reaching and engaging with older people. There was a short lead-in time to the consultation, meaning the length of time the online form was open to the public was less than two weeks. Whilst the form was distributed to a wide

range of stakeholders (see appendix 1 for the full distribution list), the time constraints may have restricted people's opportunity to be involved.
- The assessment has focused on adult services.

THE WAY FORWARD

While this project is designed to test methodology, we hope that our findings will be helpful. Salford commissioners, providers of health and care and those who lead the system locally may identify potential gaps in the system where improvements can be made. The project is linked to CQC's strategy for 2016 to 21 (scheduled for publication in May 2016).

Salford overview

The city of Salford is one of ten boroughs in Greater Manchester, in North West England. It has a population of 242 040. Salford is the 22nd most deprived local authority out of 326 in England. It includes areas of wealth and poverty; although most of the city is highly deprived, around 5% of residents are living in wards that are among the least deprived in the country.

Salford is changing. There is strong economic growth which is bringing in new people, but there is concern that some existing communities will not have the skills or qualifications to take up new local jobs. The city of Salford is one of the few local authorities that have shown a continuous decrease in deprivation relative to other local authorities over the last ten years. However, there are three small areas within the city that have remained consistently in the most deprived one per cent of such areas nationally through that period.[2] Currently Salford has a high proportion of white residents. However, the proportion of the population from Black and Minority Ethnic (BAME) groups is growing rapidly. The proportion of people aged 65 is significantly lower than the England average.

Greater Manchester is the first region in England to form an agreement with national government for the transfer of powers and responsibilities. This devolution deal includes changes to the delivery of health and social care across Greater Manchester, including Salford.

2 Lower-layer Super Output Areas map to postcodes and contain a minimum of 1000 people, with the average being 1500 people, http://www.datadictionary.nhs.uk/data_dictionary/nhs_business_definitions/l/lower_layer_super_output_area_de.asp?shownav=1

Systems and their impact

The stakeholders we spoke with nationally, locally, and those who worked across areas from the statutory and third sector told us about the strength of leadership and partnerships in Salford and the commitment to making a positive difference for local people, as this was borne out in evidence. The four statutory health and social care commissioners and providers (Salford Royal Foundation Trust, Salford Clinical Commissioning Group, Salford City Council and Greater Manchester West Mental Health Trust) recognised that individual organisations could only succeed if other partners and the 'system' as a whole worked well. The commissioners and main providers were coming together to change health and social care in Salford. As might be expected in an ambitious programme moving at pace, there were some concerns that these four partners were moving ahead rapidly, and more needed to be done to bring other providers, the third sector and the public with them. To address this, a new approach and plan for engagement has been developed.

Partners in Salford are very aware of the poor health and quality of life outcomes for local people and high levels of emergency and unplanned admissions and hospital use. They have ambitious plans to deliver better care and outcomes for the people of Salford. The partners have a shared vision, strategy and objectives for Salford, which evidences awareness of rising and changing demand, financial constraints and includes plans for making savings. They have prioritised developing an Integrated Care Programme for Older People (ICP), given the high demand for care and emergency admissions in the group. The programme was piloted and rolled out during 2014/15 and 2015/16, with plans extending over the next five years. They have invested in a city-wide initiative to change the lived experience and health and care of people with dementia, as a group overrepresented in hospital admissions. Partners are drawing on previous experience of integrating care, moving care from the

hospital into the community and reducing costs. This includes development of intermediate care and integrating pathways between hospital and home, across primary and community care. The integrated learning disabilities services are regarded nationally as an example of good practice in minimal use of inpatient services for assessment and treatment.

Partners are now working on ambitious plans for whole system reconfiguration and integration of health and social care. This includes an integrated care organisation (ICO) providing care for all adults, with Salford Royal NHS Foundation Trust (SRFT) as the main provider. The intention is social workers from the council will transfer into SRFT, which will provide adult social care and subcontract health services (from Greater Manchester West Mental Health NHS Foundation Trust - GMW). The role of GPs within the integrated care system is being developed. Salford is also beginning to plan integrated support for children, young people and families. They have placed the goal of driving up quality across the 'system' at the centre of these plans and have developed mechanisms to support the achievement of this goal.

The plans for the development of integrated health and social care include movement of care from the hospital into the community and harnessing the voluntary sector and community assets. The plans for care sit within a broader plan for action on the wider social determinants of health, including alcohol misuse. Salford's plans accord with emerging best practice in designing place-based systems of care, by focusing on the whole of the population in Salford, rather than a group or medical condition in isolation. It takes account of different needs by organising health and social care services reform and integration from the perspective of people's life course.

The partners are demonstrating diligence in addressing the complexities of governance that integrating health and social care entails. Salford has identified workforce as critical to the success of its ambitions for integrated care and transformation, and is investing in the development of leaders at every level in all organisations. However, concerns remain regarding workforce capacity in key areas, particularly primary care, social workers and in adult social care providers.

Salford is in the early stages of this major programme of transformation. Teams working at the frontline of the integration of services emphasised the time and effort involved in reconfiguring services and overcoming barriers of separate cultures, budgets, information systems, management, pay and conditions.

In particular, the current experiences of professionals delivering care for older people show there is further to go to achieve joined-up care across services for this group with multiple needs, as is the case across England. This evidence provides strong support for the plans for integration, already underway. The professionals' accounts of providing care demonstrate how much frustration, inefficiency and potential for impairment to quality the discontinuities between services and systems cause for staff trying to care for patients. Staff reflected on problems with handovers, breaks in communication between teams, duplicated work, multiple different paper and computer records and a lack of clarity as to who was responsible for coordinating the patient's care. The importance of agencies coming together to plan the overall design and operate services to create a 'system' that works for patients and staff was evident.

The existence of dedicated care coordinators for those with serious mental health problems appeared to make a difference to the ability of services to coordinate and collaborate. However, staff also reflected on the difficulties and inefficiencies created through lack of shared information systems between services.

Salford has made initial steps in developing a single integrated care plan and record across services, and has plans to achieve this over the next five years. However, at present, this is an area causing challenge for frontline staff.

Populations and their experiences

OUTCOMES

The overall satisfaction of people who use adult social care services is in line with the England average. Salford has mixed performance in how well social care meets the needs and contributes to the quality of life of people using services. Based on peoples' views of the extent to which their needs are met by the social care services they use, Salford scores lower than the England average. Salford tends to score significantly better on the proportion of adults in settled accommodation, but significantly worse on the proportion in employment or with as much social contact as they would like, which may be linked to levels of deprivation. Salford performs well for carers using social services, based on data indicators. On indicators of quality of life for carers accessing social services, Salford scores in line with, or slightly better than, the England average. In common with areas of high deprivation, people in Salford have poorer health compared to the England average. Both men and women can expect to live, on average, three years less than the national average and have fewer years of healthy life. Almost one quarter of people in Salford report a health condition or disability that limits their day-to-day activity. The prevalence of mental health conditions, dementia and learning disabilities is significantly higher than the England average. There are marked health inequalities in Salford. Both men and women in the most deprived areas have a life expectancy around a decade shorter than those in the least deprived areas. The range of life expectancy across the social gradient is greater in Salford than in England.

There are high rates of early death from cancer, respiratory and cardiovascular disease, and these are the most significant contributors to the life expectancy gap between Salford and England and between areas within Salford. Smoking, drug and alcohol-related harm and lack of physical activity are key factors for poor health in Salford, along with other factors related to deprivation, such as low educational attainment.

PROGRESS

There are indications of good progress for health and wellbeing for the Salford population. In 2015, the Salford joint strategic needs assessment health and wellbeing overview (2015) analysed 35 public health outcome indicators of relevance to the health and wellbeing strategy. This included comparison of both averages and rates of improvement for Salford and England. The percentage change of improvement in Salford has been greater than in England for 19 of the areas assessed - and for the indicators worsening, the decline is not as great in Salford as in England for two of the eight areas. This suggests the health and wellbeing strategy and initiatives in public health and health and social care are having an impact. It is important to note that the analysis does not look at inequalities between areas within Salford in these changes over time, or inequalities between or within particular demographic groups or communities (e.g. older people, different ethnicities). There would be merit in further investigation to assess to what extent benefits are being realised across different groups.

There is strong progress on indicators more susceptible to rapid improvement through provision of care, as they are less linked to socio-economic and behavioural influences across the life-course. This includes a substantial increase of eligible people being offered and receiving an NHS health check since 2011. The rate in Salford is now significantly higher than England. Salford is the second lowest (best) area in the country for excess winter deaths (all ages) and the rate has fallen by 58.9% since 2006, which is almost 16 times greater than the change in rate for England.

However, for many indicators there has been a gap between Salford and England averages for many years, and this relates to conditions where it takes time to improve population health (and where it will take time for the area to catch up). Salford has seen a decrease in deaths from cancer that is considered preventable, and a reduction in deaths from liver disease for those under 75, which is faster than the national rate of decrease. The rate of decline in cardiovascular mortality is similar to England, and for respiratory mortality it is slower. However, mortality remains high for long-term conditions. There are also some indicators, such as falls in older people and female life expectancy,

which are deteriorating. The needs assessment recommends further investigation of the causes of this deterioration.

INDICATORS OF COORDINATION AND INTEGRATION OF CARE

Patterns of care usage provide indications of how well an area is coordinating and integrating services in order to delay and reduce the need for care and support, provide care in the most appropriate place and enable people to recover.

Salford successfully manages movement of people from hospital, performing better or in line with England on delayed transfers of care. This is because of the initiatives to manage care pathways through the emergency care system, intermediate and community care. For emergency readmissions within 14 days of discharge from hospital, SFRT is better than the England average - and within the group of top performing acute trusts in England. Emergency readmissions after 30 days are slightly higher than England, although the rate is not deteriorating as quickly the England average. This suggests effective treatment and that services are enabling people's recovery.

However, despite evidence of good quality community and primary care and integration, the most notable pattern in Salford is high hospital usage. Salford has very high emergency admissions, even when the high level of social deprivation is taken into account. Hospital usage for conditions that would not usually require hospitalisation is higher in Salford than in England for conditions such as epilepsy, diabetes or high blood pressure. There are also high admissions in Salford compared to England for instances of intentional self-harm for all ages, alcohol related harm, falls in over 65s and several mental health conditions.

The emergency admission rate is an important measure of the effectiveness of preventative strategies, primary care, previous hospital admissions, community care arrangements and hospital discharge arrangements, and how well services are working together. For example, inadequate treatment and management of long-term conditions in primary care may lead to unnecessary emergency admissions. However, emergency and preventable hospital admissions are also a consequence of inequalities - and a contributor to health inequalities. People living in more deprived neighbourhoods are diagnosed at a later stage of their disease, are less likely to see a specialist, more likely to experience preventable hospital admissions and are more likely to die from treatable conditions. High levels of hospital use may be influenced by the ways services are configured, high levels of need and effective identification of need in the community, or usage from neighbouring areas.

The high level of emergency admissions and hospital use supports Salford's plans for investment in community and primary care, reconfiguring services and investment in public health, community and individual resilience. It is important for Salford to ensure these plans are informed by a detailed understanding of the drivers of emergency admissions and hospital use, including inequalities, and that they monitor closely the impact of the investment on the outcomes for people using services.

ACCESS

This report does not provide a comprehensive assessment of access to care in Salford in comparison with other areas in England. There are indications of good access to care, and also that Salford identifies areas where there are access difficulties and that it acts to address these. In general, there was a concern across statutory and third sector stakeholders regarding the likelihood of declining access, eligibility and types of services available due to declining resources, and the implications for local people. Salford is seeking to address this, partly through more efficient and effective care and use of resources, and also through supporting people and communities to use and develop the resources they have.

- The problem most evident in interviews and evidence was obtaining community occupational therapy assessments, which then delayed modification to homes and the ability of people to stay well and safe in their homes. Salford has identified that community occupational therapy is creating difficulties in several 'care pathways' and there are 'test to change' initiatives underway to address these.
- The other common concern was the implementation of Care Act 2014 provisions since April 2015, including delays obtaining assessments under the Care Act and delays in carers' assessments, resulting in delays to obtaining support.
- Access to primary care is important for prevention and can address health inequalities. On patients' responses to the GP survey, Salford performs in line with the England average on access to GPs, and considerably better than England on patient experiences of GP out-of-hours services. GP appointments emerged as a concern for local people. Salford is comparatively under-doctored, with fewer GPs per head of population than the national average. 'Upscaling' primary care is core to the plans for reconfiguring care.

- Compared to the England average in 2013/14, a higher proportion of patients in Salford had to wait longer than three weeks to start treatment for drug or alcohol dependence. This was of particular relevance given the high rates of alcohol-related hospital stays in Salford. This was a result of a restructure of treatment services, which integrated drug and alcohol treatment. The 2014/15 data on waiting times for treatment show Salford is now performing better than England on waiting times for alcohol treatment.
- A significant concern was problems with availability and access to assessments and services for those with common mental health problems or without a clear diagnosis, but who needed more than is available through the Improving Access to Psychological Therapies (IAPT) programme.
- Healthwatch and our explorations of older people's experiences indicated there could be issues with support post-discharge from SRFT and other hospitals, primarily with information not received or sent, and the need for the team undertaking follow-up to chase discharge information. This was particularly when people were being discharged to a different area from the location of the hospital - and where specialist services were in the process of being rationalised across hospitals.

OLDER PEOPLE

Older people often experience many different health conditions and tend to experience several health conditions at the same time. Many use the full range of health and social care services.

Salford has begun to reconfigure care for older people to deliver care in an integrated way in the community, and to reduce unplanned demand for hospital care and expensive packages of social care. This includes identifying the various levels of support needed by older people and tailoring services that are most relevant to them. This shows responsiveness to local need and challenges. From the evidence we used, it is not possible to assess initial impact of the first phase of the ICP on older people's experiences of care. The partners indicate they are not yet expecting to see changes in outcomes, as the implementation of the first phase has only recently finished.

Currently, older people in Salford tend to experience poorer health than the England average, and there are higher than average permanent admissions to residential care, instead of people being able to stay in their own homes.

When we spoke with older people, their experiences of person-centred integrated care were mixed. This seemed partly dependent on the combination of services they used. A better experience was associated with having positive support from a GP, good information sharing between services and not having

to repeatedly tell their story. Where people indicated services were joined up and communicated well, they tended to describe a higher quality experience of care.

In terms of access to services, many of the concerns older people raised were the same as those for local people in general. There were also general concerns with getting care into older people's homes, including agencies not providing regular carers, the cutting of care packages and declining eligibility. The podiatry service frequently came up as something people found difficult to access. Some older people reported services which were no longer available to them, such as the diabetes centre and reduced services offered by the Stroke Association.

The data[3] for 2014-15 shows that in Salford, 9.4% of older people receive reablement services after leaving hospital. This compares to an England average of 3.1%, a North West average of 3.2% and similar local authorities with 3.6%. However, in Salford 75.4% of older people are at home 91 days after leaving hospital into reablement. This is compared to an England average of 82.1%, a North West average of 80.9% and similar local authorities with 80.1%. So the data implies that Salford has higher coverage but performs slightly worse on quality. The measure includes social care-only placements, and excludes people who were only assessed by the NHS.

Despite a largely positive performance on indicators of primary care and discharge, a particular problem lies with emergency admission and readmissions, which are much worse than the national average and worse than statistically similar health and wellbeing boards; there has also been deterioration between 2012/13 and 2014/15. And there are high emergency admissions in the last 100 days of life.

PEOPLE WITH MENTAL HEALTH NEEDS

Salford has a high prevalence of mental health conditions, with more deprived parts of Salford tending to have higher level of mental health needs. Salford's strategies and plans evidence a holistic understanding of health and wellbeing and its links to work, community and physical health. The Locality Plan includes promotion of wellbeing and inclusion of mental health into the integration of care for each phase of the life course. Salford has been focusing on improving mental health services for older people, as the programme for integrated care for this group is the most advanced. The work to improve the lives of those with dementia and their carers was mentioned very frequently and very positively by providers, third sector and representatives of service users.

3 HSCIC Adult Social Care Outcomes

Care for adults with severe and enduring mental health conditions appears to be good. There is rapid access to specialist services for this group. In order to understand experiences in more depth, we undertook case studies with people diagnosed with schizophrenia. The people we spoke with mainly described person-centred care, led by a care coordinator. Overall, they described care that supported them to recover and addressed wider social, employment and physical health needs and personal goals. Most family and carers were appropriately involved. People said they could get support quickly in a crisis. Mostly, the care coordinator seemed to enable good links with other services, including GPs, social services and community and voluntary services. There is also good use of intensive crisis support in the community.

With regard to support for those with lower level or moderate needs, there is evidence of mixed performance. The services within the IAPT programme in Salford were performing in line with the national average in terms of access and recovery. However, stakeholders told us that there were problems with accessing mental health services for people experiencing low mood. This was often associated with life problems where people did not fit into a diagnostic category or pathway, and where people were experiencing other conditions. For those not yet receiving services, people spoke about delays in obtaining assessments and bouncing between social work and community health teams, long waiting times (12 months) for psychological services, delays in social care occupational therapy assessments and lack of clarity among GPs about pathways or how to access services for patients. Stakeholders did also mention initiatives to address this, such as the piloting of ‘step up’ psychology services and improved availability of community crisis services taking self-referrals.

Salford’s most recent mental wellbeing needs assessment is from 2010. This found a range of positive community-based initiatives targeting the most vulnerable groups and good examples of partnership working. However, it also found gaps and areas for Salford to strengthen. Mental wellbeing services need to be clearly joined up with the specialist services, care pathways need to be more clearly defined and possible gaps in provision addressed.

Evidence suggests some of these difficulties may persist, and this may be contributing to high levels of emergency admissions and hospital usage in Salford.

Salford should consider updating this needs assessment, in order to understand to what extent the strategies coming to a close have been successful. This is important as Salford’s consultation with local people in 2015 to review the health and wellbeing strategy indicates one of the priorities for people in Salford is ‘mental health across the life course’.

The quality of health and social care providers

CQC inspections found Salford has outstanding acute care, good community health services and that GP practices tend to be rated good or outstanding. However, of adult social care providers rated, a higher proportion are requires improvement or inadequate, suggesting the need for Salford to continue to focus on improving quality in this sector. These findings need to be interpreted in the context of not all providers being inspected and rated. General practice and care home inspection reports showed some evidence of good practice in collaboration and coordination between providers.

SRFT, which provides both acute and community services, has been rated as outstanding by CQC. The Salford Royal Hospital was rated as outstanding overall, with urgent and emergency services, medical care and end of life care outstanding, critical care and services for young people and children good and surgery and diagnostic imaging requires improvement. Community health services were rated good overall, with services for adults and end of life care rated outstanding and services for children, young people and families and inpatients rated as good.

At the time of drafting, CQC had rated 31 out of the 54 GPs in Salford. The proportion of GPs obtaining a good or outstanding rating is higher than England overall. Good practice of working with deprived communities and vulnerable groups was found in outstanding GPs.

At the time of drafting, CQC had rated 46 out of the 77 adult social care providers in Salford. Salford has a smaller proportion of Adult Social Care providers rated good or outstanding and a greater proportion rated requires

improvement or inadequate by CQC compared to England. Problems in adult social care included care planning and record keeping, care homes with insufficient opportunity for residents to engage in meaningful social activities, management of risk and medication and insufficient staffing levels.

Accident and emergency ambulance services are provided by North West Ambulance Service NHS Trust. As the first ambulance trust inspected under CQC new methodology, CQC did not provide ratings for this trust. In our report published in December 2014, we found areas of outstanding practice, and also poor practice where the trust must improve. Notably, given the high emergency admissions in Salford, the trust was at that time the worst performing nationally in taking a high number of patients to hospital when alternative services may have been more appropriate.

- Specialist mental health services are provided mainly by Greater Manchester West Mental Health NHS Foundation Trust, which was inspected in February 2016.

Conclusion: opportunity and challenge

The evidence presented above shows good work and ambition and plans to do more in order to ensure the people of Salford experience high quality care and have better outcomes. As health and care leaders told us: 'This is not a finished job'. There is commitment and opportunity to transform health and social care for the benefit of local people. However, the partners and wider stakeholders reflected on the many risks to Salford's ambitions. The section below discusses the opportunities and challenges identified.

ADDRESSING IMMEDIATE CHALLENGES AND ACHIEVING LONGER TERM GOALS

Salford has a clear vision, strategy and plans in order to better meet local needs in the future. In addition, there is evidence of identifying and taking action to address current challenges. For example, delays in access to substance misuse services were identified and services were reconfigured. Test to change initiatives are in place to address the delays in occupational therapy, which are affecting many different groups of people and pathways.

There are some challenges identified in our review which Salford may consider giving attention to. This includes indications of some decline in provision of rehabilitation (occupational health provision by SCC) and delays in Care Act assessments, which may be undermining the ability of people to be safe and well in their own homes. Data indicators suggest there may be insufficient use of care planning in primary care. This emerged as an issue for both older people and those with serious mental health problems, where the issue related

to GP use of care plans for those patients not in receipt of specialist mental health services from GMW. Salford may also want to explore whether the practice of the ambulance trust (North West Ambulance Service NHS Trust) of taking a high number of patients to hospital when alternative services may have been more appropriate has been addressed since CQC's inspection of the trust in December 2014.

The problems with access and unmet need for the high level of more general mental health and wellbeing needs in the community are concerning. Some initiatives to address this are being piloted and mental health is being integrated within Salford's reconfiguration of care. However, our evidence suggests a continuation of many of the gaps identified in the 2010 health and wellbeing needs assessment. An update of this needs assessment may help Salford decide where best to focus resources to address these issues.

CLEAR UNDERSTANDING OF DRIVERS OF HEALTH INEQUALITIES AND HOSPITAL USE

Social factors are likely to be a driver of poorer health, health inequalities, emergency admissions and higher than expected hospital use in Salford. Evidence shows that the reasons for differences in health within and between places are complex, influenced by demographic make-up and the particular pattern of deprivation and health-related behaviour. For example, having a higher proportion of men, BAME populations, a deprived older population, employment and housing deprivation, binge drinking and poor diet are related to poorer life expectancy in England.[4] However, access to and effective provision of health and social care plays a very important role, and is one of the most immediate ways of addressing the health consequences of inequalities.

Inequalities and deprivation impact on patterns of service usage, and these patterns in turn contribute to health inequalities. People living in deprived areas are diagnosed later, are more likely to experience preventable hospital admissions and more likely to die from treatable conditions. Evidence indicates that nearly half of emergency admissions arise from social inequality. People living in the most deprived fifth of neighbourhoods in England have nearly two and a half times as many preventable emergency hospitalisations as people living in the least deprived fifth, allowing for age and sex. [5] In addition, some of the current issues in health and social care in Salford outlined above may be contributing to the pattern of high hospital usage.

4 Buck, D. & Maguire, D. (2015) Inequalities in life expectancy: changes over time and implications for policy, The Kings Fund, http://www.kingsfund.org.uk/publications/inequalities-life-expectancy

5 Centre for Health Economics, University of York (2016) Health Equity Indicators for the NHS, research funded by National Institute for Health Research, http://www.york.ac.uk/che/research/equity/monitoring/

Investigating the particular combination of factors driving health inequalities and hospital use is outside the scope of this report. In general, Salford's strategy of integrating services, focusing on those with complex needs, harnessing community assets and action on wider social determinants is likely to address these issues. Further detailed analysis of the impact of specific social factors, aspects of care configuration or delivery on health inequalities and hospital use would support this strategy. This may enable innovative and targeted initiatives tailored to the specific needs of Salford.

ENGAGING THE PUBLIC, THIRD SECTOR AND THE RANGE OF PROVIDERS

There is very strong collaboration between the four main partners (Salford Council, Salford Royal Foundation Trust, Greater Manchester West and Salford CCG). There are initiatives in place to make sure frontline staff are at the centre of change. However, wider stakeholders perceived that the four partners could be so focused on their efforts to transform care at pace, there was not always enough engagement and time to bring the third sector, wider providers and the public along with them. There was recognition across the range of stakeholders that more needs to be to be done, and in a different way, to engage the public. An engagement plan has been developed to underpin the Locality Plan in order to achieve this.

Among the representatives of the third sector, providers and service users we spoke with, there seemed to be some confusion or anxiety regarding the plans for reconfiguring care and what this would actually mean for them. Some also told us that the process of changing services within the integrated care programme for older people was resulting in difficulties for them. For example, for some it meant they were losing relationships with professionals they trusted as staff moved into integrated care teams; or the process of reconfiguration into the single contact centre for health and social care was perceived as causing difficulties in accessing services. Bringing these stakeholders along on the journey will support the planned changes and identify where problems with the quality of care may be occurring during the transition.

Effectively involving the public and changing the relationship between communities and services is very difficult, and made more difficult by the rapidity of developments in Salford and Greater Manchester and pressure on resources. We support the efforts of Salford to do more in this regard, in order to achieve reconfigured care that is responsive to local need and accountable to local people.

RESPONDING TO RAPID SOCIO-ECONOMIC CHANGE IN SALFORD

In Salford there is strong recognition of social-determinants of health, commitment to addressing health inequalities and the integration of health and social care into public health and the wider development of the city. However, an important challenge, and one which many stakeholders spoke of, is keeping pace with the socio-economic changes now underway in Salford. Salford is undergoing rapid economic regeneration and this is attracting a new community of affluent middle class people, which in itself is likely to change the public health profile of the population. There is concern that the existing more deprived population may not have the education and skills to benefit from new local jobs. At the same time the BAME population is growing and becoming more diverse. There was recognition that more needs to be done to develop trust in services within these communities. There was also awareness of the importance of building cohesion between existing and new communities.

It is a challenge for health and social care to respond to the different care needs in rapidly evolving communities, at the same time as undergoing major change – but this is also an opportunity for Salford to take advantage of local diversity, involving and responding to the needs of the full range of local people in innovative ways.

DEFINING AND MEASURING 'WHAT GOOD LOOKS LIKE' FROM PEOPLE'S PERSPECTIVE

Salford is defining 'outcomes' for integrated care and the Locality Plan. There was a view that to some extent, currently available measures were limited in 'getting at' what really matters in the context of place based and integrated care. Stakeholders told us about the need for new indicators that showed 'what good looks like as patient and service user'. They spoke of the need to measure quality in terms of 'how it feels in people's lives', 'if care builds on people's strengths and enables them to live the lives they want' and the 'integration of physical and mental health'. Developing shared measures that are meaningful for local people, will enable Salford to know if five years down line the line, things are better for the people of Salford.

FROM PARTNERSHIP WORKING TO STRUCTURAL REORGANISATION

Salford has experience of pooling budgets, integrating teams and developing an integrated care programme for older people (ICP) via an alliance. While the ICP is in its early stages, Salford is creating an integrated care organisation (ICO) for adults, which involves structural change, with significant reorganisation of staff and services. Stakeholders reflected that they did not have all the answers

currently as to how the ICO would work in actuality, but the area was on a journey together with an emerging concept.

People spoke of the importance of ensuring that the result of the ICO was not a new organisation that simply delivered traditional services. There was reflection that the partnership work and collaboration in the ICP had enabled testing, innovation and 'organic growth'. There was some concern that if innovative work, such as that on community assets, was formally incorporated as a commissioned service within the new organisation, this might result in less space for innovation. There were also questions as to the implications of the ICO for staff and teams currently working closely together, but who were also outside of formal integration, such as public health. This came from the experience of past reorganisations in which structural change and co-location broke and strengthened relationships between different parts of the 'system' and teams.

The partners are managing the risks related to finance and formal accountability in the ICO through governance processes. Attention to these 'softer' issues of relationships, collaboration and innovation may support the ambition of the ICO to deliver care in new ways.

COMPLEXITY AND PACE

A repeatedly voiced concern in Salford was the pressures of declining resources and increasing demand and expectation, forcing complex change at pace. At the same time, there was enthusiasm and energy for change and the opportunity to make a difference to local people. People spoke of an urgency to act, but also worry about not having time and resources to fully consider and build change, manage delivery of safe and quality services through change and the number of complex initiatives underway. While there is a sense that the changes will improve quality and patient experience, there is not yet consistent confidence that they will realise savings or reduce demand, at least in the short to medium term. There was reflection from a range of stakeholders that delivery of more care in the community may not necessarily reduce demand, but could rather move demand, uncover unmet need or create different demand. We encourage Salford to continue to manage these risks within the health and wellbeing board.

INTERACTING WITH GREATER MANCHESTER DEVOLUTION

Stakeholders reflected on the interaction of developments in Salford with wider developments in health and social care in Greater Manchester. In general, the view was that the vision for Greater Manchester and the vision for Salford were well-aligned, and that devolution was building on a long history of the boroughs

working together. Collaboration and region-wide initiatives were seen as providing important opportunities to improve health and social care. However, there was also recognition that some local plans and initiatives may need to adapt in the context of developments across the region. In particular, people reflected on the implications for the collaboration built between partners in Salford if in future the boundaries of the council and/or the CCG change or merge across boroughs. Devolution was also noted as an additional driver of pace and complexity of change for Salford.

Stakeholders within and outside of Salford commented that Salford was seen as a leader within GM and that Salford leaders were well connected into developments. Continuing this will enable Salford to manage any risks and harness the benefits offered by the region-wide strategy for health and social care.

CONCLUSION

Salford is driving forward rapid and ambitious change to health and social care. There are risks and challenges to this, but also great opportunity to innovate and improve care, health and wellbeing for all local people. We hope that this report supports Salford to achieve its vision.

Appendix: Complete list of key lines of enquiry

Provider KLOE: What is the overall quality of providers in a place?	
P1	What is the quality of acute care in a place?
P2	What is the quality of primary care in a place (including community, GPs and out-of-hours, urgent care and dentists)?
P3	What is the quality of adult social care in a place?
P4	What is the quality of mental health care in a place?
P5	What is the quality of care from providers for people with mental health conditions?
P6	What is the quality of care from providers for older people
Populations KLOE: What are the health and wellbeing outcomes for people?	
O1	What are the health and wellbeing outcomes for different population groups?
O2	What are the health and wellbeing outcomes for different population groups which are amenable to health and social care?
O3	Are there inequalities in health and wellbeing outcomes for different population groups?
Populations KLOE: Do people experience person-centred, coordinated care?	
C1	Do people experience coordinated health and social care informed by what is important to them?
C2	Is there evidence that health and social care is integrated for population groups?
C3	Is there evidence of inequities in the provision of person-centred, coordinated care between different groups?
Populations KLOE: Are needs identified and addressed across population groups?	
N1	Do people think their health and social care needs are met?
N2	Are the needs of different population groups met?
N3	Are there inequalities in access to health and social care for different population groups?

Appendix: Complete list of key lines of enquiry

Systems KLOE: Is leadership having on impact on quality of care across the health and care system?	
L1	Is there effective partnership and joint working across the system? Is there evidence of having an impact through acting to achieve a shared vision?
L2	How are providers and the civil society groups contributing to local leadership and innovation?
L3	Do partners work well together to ensure children and adults are protected from harm and abuse?
L4	Is there effective public engagement?
L5	What is the direction of travel for the system – is there capacity to improve?
Systems KLOE: Is governance having an impact on quality of care across the system?	
G1	Are governance arrangements across the system supporting partners to drive quality of care across the system?
Systems KLOE: Is workforce capacity and capability having an impact	
W1	Is there a joined up approach to workforce considerations across the area?
W2	Is there a strategy for ensuring sufficient health and care skills in the local health economy?

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THE QUALITY OF CARE IN SALFORD– PROTOTYPE REPORT