QUALITY IN A PLACE

Salford

Appendix of evidence

CQC prototype report

Data sourced in advance of November 2015 fieldwork and supplemented with information found during the visit.
CQC ratings data refreshed in April 2016

Publication: 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

1. Evidence sources and methods

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. This section provides detailed information about each evidence source and methods used.

1.1 CQC INSPECTIONS AND RATINGS

We have summarised ratings from our inspections of providers based on our new methodology, and compared the proportion of each rating in the area with the proportion nationally. The summaries of ratings are up to date as of April 2016. We have also presented ratings of providers on maps, which can allow analysis in relation to other geographic information, such as deprivation and population density.

We analysed CQC provider inspection reports, to see if key themes emerged across providers within a sector or the local area. This was based on providers inspected and rated by August 2015. There were 28 provider reports using the new methodology available at the time of analysis, one acute hospital, 21 adult social care providers and six primary medical service providers. Analysis of findings regarding the quality of providers and sectors was focused on three of CQC's five key questions (safe, effective and responsive). This focused the analysis to those sections of the inspection reports most likely to discuss organisational performance not included within the other key questions and themes common across providers. Analysis for evidence of integration and cross-organisational working at provider level included information from all five key questions. Analysis was only completed for key questions rated as inadequate, requires improvement or outstanding. Key questions rated as Good were excluded from analysis on the basis that they were less likely to provide information about what is driving variation in performance among providers the area – what was leading to providers obtaining an outstanding, requires improvement of inadequate rating.

1.2 QUANTITATIVE DATA INDICATORS

CQC's own data on providers is instrumental to this project. However, we have also used data from other sources, to provide information on outcomes and indicators of the quality of care for local people. This is based on data available in September 2015 and has not been updated unless a substantial change in the data indicates a different view of the quality of health and social care. 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.

We have drawn on data used in other CQC studies to inform our work. Where this data has been used, we have kept the original methodology. From CQC's work on its mental health crisis review publication, this has been benchmarked against the England average using five bandings of 'much higher than expected', 'higher than expected', 'similar', 'lower than expected' or 'much lower than expected'. For Integrated care for older people, data has again been benchmarked using five bandings of 'much higher than average', 'higher than average', 'similar', 'lower than average', 'much lower than average'. It has been benchmarked against the national average, as well as region (North-West for Salford) and five statistically similar health and wellbeing boards (HWBs).

1.3 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. We attended a meeting of Salford's Health and Wellbeing Board (HWB).

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. Views and quotations are included anonymously, but with an indication of which type of stakeholder expressed the view.

1.4 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 up to 15 case studies for each group. This was seen as sufficient to generate insight alongside quantitative indicators and a manageable size for the pilot. Both of these groups include people with many different conditions. For each group we decided to focus on people with 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 to people who had experienced fracture or multiple falls.
- For people with mental health problems we spoke to people with a diagnosis of schizophrenia.

For both groups people needed to be over eighteen and able to consent. For those with mental health problems, we did not include those who were inpatients or had been in receipt of care within the last three to twelve months.

We approached services in Salford in order to identify people who met our criteria. We approached services that would enable us to find patients who are both ambulatory and non-ambulatory and those who are living both in the community and within residential care services. CQC wrote to identified care coordinators in the services and asked them to send NHS numbers of those patients meeting our criteria. CQC then randomly selected patients, (more than required to allow for those who did not want to be involved, were unavailable or drop out for other reasons). Care coordinators were contacted with the list and asked to contact identified patients to get their agreement to be involved. The final list was formulated and interviews set up with relevant people.

Interviews were undertaken by CQC Specialist Advisors and inspectors. At the start of each interview, interviewers checked that the person understood what was involved and consented to take part and the use of their information at the start of each interview. Where consent was not given, the interview was ended. Interviewees explained that they would make notes but make sure these were kept safe and secure at all times and the information would be kept confidential. They explained that if the interviewer felt there was serious risk of harm to the interviewee or others then they may need to break confidentiality, but would discuss this with the interviewee first. The interviewer asked for agreement to include a summary of the persons overall experiences in the report on the quality of care in Salford. They explained we might use their experiences as an example within the report and that any information included would be anonymous.

For each case we attempted to undertake the following, although in some cases professionals were not available to speak to us:

- Interviewed the main care coordinator, 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 patients case notes in each service if required.

The interviews were structured questions linked to the framework. These explored people's experiences of receiving and providing care and the links and movement between services. We asked about people's experiences of care over

the last year. The interviewers were provided a briefing pack and templates to use and attended a training session. Each interviewer took notes and wrote up a report on each case. This included a pen portrait of the patients tracked and a summary of care, including the views of the person using the services and those providing the care. We looked for themes and issues emerging from the cases which told us what people's experiences of care were like and how joined up the care seemed to be.

1.5 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 consultation was publicised via organisations working with older people in Salford. 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. This is a small number of respondents, which means the findings provide qualitative insight into the experiences of those who responded, but limits the extent to which they can be generalised to all older people and their carers in Salford. The demographics of respondents are shown in table 1.

Responses were also screened for safeguarding issues. Potential safeguarding concerns were identified in two responses and these were passed on to the safeguarding team.

Table 1: Demographic of respondents

	Number of respondents		
Description of respondent	**Female**	**Male**	**Total**
A person aged 75 or older responding about their own experiences	3	2	5
A person between 55 and 75 responding about their own experiences	2	3	7
A carer responding on behalf of someone aged 75 or older	4	0	4
A carer responding on behalf of someone aged between 55 and 75	1	1	2
A person responding about their own experiences and those of someone they care for who is 75 or older	8	1	9
A person responding about their own experiences and those of someone they care for who is between 55 and 75	0	2	3
Total	18	9	27

All but one of the respondents described themselves as 'White English / Welsh / Scottish / Northern Irish / British' with the remaining respondent identifying as 'Chinese'.

A coding framework was developed that was driven by both the data and the key lines of enquiry (KLOEs) and prompts within the assessment framework (see the final part of this document). The responses were coded and summarised to help draw out the main themes.

2. Salford overview

This section provides contextual information on Salford relevant to health and social care, including the area's socio-economic and demographic profile.

The city of Salford is one of the 10 boroughs of Greater Manchester, in North West England. It covers 37 square miles and the five districts of Salford, Eccles, Worsley, Irlam and Cadishead, and Swinton and Pendlebury, with a population of 242 040.[1] Salford is the 22nd most deprived local authority out of 326 in England.[2]

Salford is a city of contrasts. It is predominantly urban. Central Salford is just one minute's walk from the heart of Manchester's shopping and central business districts, across the River Irwell which runs between the two cities. However, 60% is green space, including countryside and parks, watersides and waterways. It includes areas of wealth and deprivation. Around 70% of Salford's population live in areas classified as highly deprived and disadvantaged and around 12,300 children live in poverty. In contrast, around 5% of residents are living in wards that are among the least deprived in the country.[3]

2.1 ECONOMIC AND SOCIAL CHANGE

Salford is undergoing major economic and social change. Salford is experiencing economic growth and regeneration. However, there is concern that existing communities will not have the skills or qualifications to access the new local jobs.[4] The demographic profile is changing. Currently, Salford has a higher proportion of white and lower proportion of Asian and black ethnicities (BAME) than the England average.[5] However, the BAME population trebled in size between 2001 and 2011. Ten percent of residents are now from BAME backgrounds and these communities are projected to make up one third of the population by 2021. Consequently, the proportion of the

1 Mid-2014 population estimate, Office for National Statistics

2 The English Indices of Deprivation 2015 IMD rank of average rank, Department for Communities and Local Government

3 Greater Manchester Health and Social Care Devolution, Locality Plan for Salford
Our Vision for a Healthier Salford, DRAFT, 18 December 2015, www.healthwatchsalford.co.uk/sites/default/files/locality_plan_draft_2_-_submission_18_12_2015.pdf

4 Greater Manchester Health and Social Care Devolution, Locality Plan for Salford, ibid; stakeholder interviews

5 Office of National Statistics 2011 Census data, data pack, p. 18

population made up of young adults and children is growing. The number of older people aged 65 and over dropped by 5% between 2001 and 2011 and the proportion dropped from 16% in 2001 to 14% in 2011. Although the proportion has stayed at 14%, the number of older people is increasing along with the general population. The proportion of older people in Salford is forecast to be much lower than that in England. The proportion of the population that are aged 65 and over is projected to increase by 12% (to 37,460) between 2011 and 2021, and this is half the increase of 24% forecast in England.[6] There is an established orthodox Jewish community, which also has a younger age profile through tending to have larger families and a higher proportion of children and young people.[7] Significant population growth is predicated in some areas of the city and not in others.

These changes are resulting in increased and more complex demand for health and social care, with the potential for enduring or widening inequalities within the city. A higher proportion of non-white British population in an area is associated with lower life expectancy.[8] Salford City Council is part of the national dispersal programme for asylum seekers, a vulnerable group of people. There is a risk of Salford as a whole becoming more affluent while some areas or groups of people remain excluded, as evidenced by trends in deprivation over time. 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 areas within the city that have remained consistently in the most deprived 1% of Lower-layer Super Output Areas nationally through that period.[9]

2.2 DEVOLUTION

As one of the councils making up the Greater Manchester Combined Authority (GMCA), Salford is part of the first region in England to form an agreement with national government for the transfer of some powers and responsibilities. This devolution deal includes the delegation of some powers for health and social care. This means that Salford and its plans for health and social care have the potential to benefit from the changes in the region and need to support and adapt to the developments within Greater Manchester.

Devolution in Greater Manchester includes bringing together the £6 billion budget that is currently spent on services such as hospitals, GP surgeries, mental health and social care, redesigning and improving services for the 2.8 million people

6 CAS population estimates for mid-2001 (experimental statistics); ONS: Interim 2011-based Subnational Population Projections

7 Health Needs Assessment for Orthodox Jewish Population in Salford – an analysis of Primary Care Provision, www.salford.gov.uk/needsassessments.htm

8 Inequalities in life expectancy: changes over time, August 2015, www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/inequalities-in-life-expectancy-kings-fund-aug15.pdf

9 Smith, T., Noble, M., Noble, S., Wright, G., McLennan, D. & Plunkett, E. (2015) The English Indices of Deprivation 2015, Research report, Department of Communities and Local Government

who live in the region. At the same time, these changes have to address the projected £2 billion gap in funding for health and social care in the region.[10] Priorities in the Greater Manchester strategy for health and social care are:

- coordinating services delivered across Greater Manchester
- standardisation, reduced variety and more efficient use of resources
- improving access to services (including providing GP and other primary care services seven days a week);
- better support for people living with complex long-term conditions
- better support for people suffering severe mental illness
- public health and prevention.[11]

10 As estimated by GMCA, www.gmhealthandsocialcaredevo.org.uk/devolution-what-it-means/

11 www.gmhealthandsocialcaredevo.org.uk

3. Systems and their impact

This section provides evidence on how health and social care organisations work together to deliver quality health and social care for local people, including leadership, governance and engagement with the third sector and the public.

3.1 LEADERSHIP AND PARTNERSHIP

The people we spoke to in the statutory and third sector, local and national organisations, and providers and commissioners, told us about the strength of leadership and partnerships in Salford and the passion and commitment to bringing about positive change for local people. Those who had worked in other areas or who worked across areas remarked on how Salford stood out from other places because of this.

FOUR LEADERS AND PARTNERS

There was clarity as to who the leaders in the area were for health and social care. Four statutory health and social care commissioners and providers regarded themselves and were regarded by other stakeholders as the joint leaders and were seen to work well together. These were Salford City Council, NHS Salford Clinical Commissioning Group (CCG), Salford Royal NHS Foundation Trust (SRFT) and Greater Manchester West Mental Health NHS Foundation Trust (GMWFT).

There was consistency in what people told us led to the success of the partnership between these four organisations. The partners were aware of what factors were important to their joint leadership and their efforts to integrate and improve health and social care and actively cultivated these. Many of these resonate with principles for leadership across organisational boundaries and the design of place-based and integrated care.[12]

- Commitment to the people of Salford: The partners were conscious of the differences in culture and practice between health and social care, acute and community care. However,

12 West, M., Eckert, R., Stewart, K. and Pasmore, B. (2014) Developing collective leadership for health care, The Kings Fund and Centre for Creative Leadership, May 2014, www.kingsfund.org.uk/publications/developing-collective-leadership-health-care ; Timmins, N. (2015) The practice of system leadership: being comfortable with chaos, The Kings Fund, May 2015, www.kingsfund.org.uk/publications/practice-system-leadership ; Local Government Association and NHS Clinical Commissioners (2015) Making it better together: taking action on the future of health and wellbeing boards, 30 June 2015, www.local.gov.uk/publications/-/journal_content/56/10180/7363877/PUBLICATION; Ham, C. & Alderwick, H. (2015) Place-based systems of care: A way forward for the NHS in England, The Kings Fund, November 2015, www.kingsfund.org.uk/publications/place-based-systems-care

each partner indicated their shared commitment to the people of Salford brought them together and enabled them to have challenging conversations, as they continually return to question: 'what will be best for people in Salford?' Leaders had an attachment to Salford as a place.

"Key leaders in the local economy have been here for a while. Many live or grew up and have a strong association with Salford. It's not just your job, it's your Place." (Local leader)

- Defined 'place' and 'coterminosity': Stakeholders we interviewed commented the partnership was enabled by the fact that Salford is a stable entity that has seen through a number of reorganisations that have affected other areas of the North West, with the boundaries and organisations remaining largely constant. There is one council, one CCG, one acute trust and one mental health trust serving the same population and providing for almost all of their health and social care needs.

  "This means we can't lever competition but we have relationships of strength across the four statutory organisations." (Local leader).

- Stable and strong leadership: National and local stakeholders felt there were exceptional leaders within all of the main partner organisations, currently and in the past. Key leaders in each of the four organisations have held positions for considerable periods of time. This continuity has led to the development of relationships of trust and honesty between leaders of different organisations, built over time. There is transition planning to ensure the 'Salford ethos' continues when leadership changes. We were told that the work in Salford would withstand changes in leadership.

  'There have been various changes in leadership. Recently there has been a change to the CCG Chief Accountable Officer and there will be a new elected mayor. It hasn't derailed the process. There are people in the wings with the same vision. The system is stronger than individuals." (Local senior manager)

- Partners recognise the need to work together to improve 'the system' as a whole: The local leaders we interviewed told us that it is important for all organisations to be strong and well-run for the 'system' to be effective, but that individual organisations could only succeed if other organisations and the system as a whole worked well.

  "There can be the attitude of some people of win and lose. In Salford we have focused on win-win solutions. We have distilled ways of working into core principles. If one partner screws over another we will all be screwed, if one of us is bankrupt that will bankrupt the whole system." (Local leader)

  "You have to think about organisational sustainability and also system sustainability. You can't have one organisation fall over or one organisation fighting tooth and claw for success." (Local leader)

  "You cannot have an outstanding hospital with a failing GP practice down the road." (Local leader)

- Practical shared experience: The partners were building on past experience of working together to deliver shared initiatives. This was important in enabling the partners to take on the ambitious integration and system redesign they have planned.

  "Its evolution not revolution, without our past we wouldn't be able to look at the models we are developing." (Local leader)

- Action to address wellbeing, socio-economic factors and inequalities: Across interviews, leaders showed concern for wider social determinants of health and wellbeing and inequalities in Salford. There was a sense of the importance of bringing health and social care together, but beyond that, of linking health and social care into public health and the wider vision and socio-economic development of Salford. This was partly attributed to the strong role of the Council in the partnership, and the Council's appreciation for the importance of public health. This focus on the wider socio-economic determinants was also evident in the other partners.
- Partnership between commissioners and providers: The core partnership is a coming together of commissioners and two important providers to redesign health and social care. These providers have a core role in the development of services.

THE HEALTH AND WELLBEING BOARD

Across all of the different stakeholders we interviewed, people were clear that the Health and Wellbeing Board (HWB) is the central mechanism for bringing together the four statutory partners with a wide range of other organisations in the area. They were clear that it was within the HWB and its plans that 'shared prioritisation' took place. This was also evidenced in our reading of HWB minutes and documents.[13] A clear path could be tracked from discussions and presentations to the board through Salford's strategy and plans. The Board brings to the forum partners and initiatives from outside of health and social care and creates links and integration with initiatives tackling the social determinants of health. We attended a meeting of the HWB and witnessed constructive and open conversation and challenges within the meeting. We saw evidence of the way in which the Board made links with wider sectors, through a presentation from housing associations, which resulted in concrete actions for collaboration.

The Local Government Association peer assessment of the Health and Wellbeing Board found the same elements:

Salford enjoys trusted relationships, strong partnerships and a collegiate style of working and this is reflected in how the HWB has developed. There is recognition of the importance of the HWB and its system leadership role, and the Board has invested in its own development. There are very strong, committed and visionary system leaders in Salford and an engaging style of leadership. The HWB is leading the health

13 CQC analysis of publically available documents.

and wellbeing agenda. There is a very strong focus on the wellbeing of people as a precursor to good health.[14]

INVOLVEMENT OF THE WIDER SET OF PROVIDERS

The plans for reconfiguring health and social care include adult social care providers and primary care. However, the engagement and involvement of these providers with regard to such developments was less advanced.

- Stakeholders within and outside of primary care reflected that among GPs there were mixed views and degrees of engagement. The difficulty of obtaining partners and the pressures of growing and more complex demands on practices was leading to support for change to the organisation and delivery of primary care. However, there were also concerns about the development of 'super-sized practices' and salaried GPs.
- The views and degree of engagement of social care providers in relation to integration initiatives also appeared to be mixed. Some representatives of the sector expressed concerns about the changes and plans for commissioning social care via SRFT (see below).

  "Lots of care home providers are confused about what Salford actually wants. Is it social care or NHS?" (Social care provider)

- Some providers have a geographic footprint that extends beyond Salford, across several areas of Manchester, or even further across the North West. These providers reflected this could create difficulties in responding to the different requirements and configurations of services in different boroughs, although it also meant they could share good practice across localities.

CONTRIBUTION OF THE COMMUNITY AND VOLUNTARY SECTOR

Partners in Salford show recognition of the importance of the community and voluntary sector, through the inclusion of representatives of the third sector on key forums, investment in the third sector and the use of community assets within their redesign of care, in line with best practice for new care models.[15] However, there are challenges with providing sufficient information and time for the third sector to fully engage with new initiatives, in the context of rapid change in the statutory health and social care sector.

- Salford has a strong and varied community and voluntary sector. Salford has a well-established and well-regarded

14 Local Government Association, Health and Wellbeing Board peer challenge, 20 – 23 February 2015

15 The Five Year Forward View People and Communities Board, alongside the New Models of Care Vanguard Sites, produce a set of six principles for changing the way that health and care relate to people and communities. These 'six principles' set out the basis of good person centred, community focused health and care. A new model of partnership with people and communities: key principles, www.nationalvoices.org.uk/our-work/five-year-forward-view/five-year-forward-view

Community and Voluntary Services representative organisation, which is included on the HWB. The CCG was regarded as forward thinking in providing grants for third sector initiatives that will contribute to health. The Council was recognised for its encouragement of social enterprises.

- The third sector organisations we spoke to said the four statutory partners and the HWB showed recognition of the value of the third sector and the will to listen and engage. They said it was easy to access statutory leaders, and this was very different from other areas.
- However, they did reflect that there was an element of being 'junior' partners and that the statutory organisations tended to move ahead without 'fully bringing the third sector with'. People said it could be hard for third sector organisations to keep up with the rapid change in Salford and devolution in Greater Manchester. They were not always clear what the implications of different developments actually were. They asked for recognition that changes in statutory structures impact the third sector.

  "Every time uncertainty happens in the statutory organisations it 'spins out into the pond'." (Third sector representative)

  "This is not our everyday. It's not our day job. The health system needs to be aware we are not as intellectually involved in this as they are." (Staff member of a third sector organisation)

- They also asked for recognition that if they were being asked to represent local people or their constituency, they required time to consult. There was concern about last minute invitations to meetings and very short consultation times. They said that their responses to consultations were not always taken into consideration and that they did not always get adequate feedback from the alliance board and HWB.

  "If you invite me to a meeting without notice I am not representing anyone. We are not a single bureaucracy; it takes time to consult." (Third sector representative)

EFFECTIVENESS OF PUBLIC ENGAGEMENT

Across stakeholders we were told that more needs to be to be done, and in a different way, to engage the public. This was also a finding of the LGA HWB assessment.[16] An engagement plan has been developed to underpin the next five year strategy (Locality Plan) in order to achieve this. 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. This is not a challenge unique to Salford. However, it is important in order to achieve reconfigured care that is responsive to local need and accountable to local people, key principles for new care models.[17]

16 Local Government Association, Health and Wellbeing Board peer challenge, 20 – 23 February 2015

17 A new model of partnership with people and communities: key principles, ibid

- Several people working in health and social care spoke of the need for partnership with local people, and that individuals and communities would need to take on more responsibility for their own health. Service user and third sector representatives spoke of the need for statutory services to change the way they related to individuals and communities for a more equal and collaborative relationship. Changing the relationship between people and services is not easy but will be important to achieving change in service usage.

  "We need to change officers' behaviour to be on a more equal footing with people." (Public representative)

  "The greatest scope to influence and change is partnership with local people. Local people have to understand the need to work for their own resilience and empowerment as statutory services are not going to be there. At the moment they don't recognise this." (Health and social care leader)

- It will also be important for health and social care leaders to think about how they will be accountable to local people for the decisions they make. This is especially important as health and social care providers and commissioners work together and share responsibility for the health and wellbeing of people in Salford. Across local stakeholders people spoke about the need to have honest discussions with local people about priorities, in the context of declining resources. At the same time, they said there could be conflict between local communities and their perceptions and decisions based on evidence or economics.

- People in the third sector and representatives of service users told us it was hard to understand what abstract issues such as 'integration' and 'devolution' actually meant for local people and that unless people could see how it affected them they were unlikely to get involved. They said local people need information which clearly explains what the implications of decisions will be for them so that they can form and provide views in a meaningful way.

  "It's no good going to ask the public when they aren't informed to the same level as you and have not been thinking about the issues. That's not a conversation on an equal footing." (Third sector representative)

- It is important to engage and involve people as services are reconfigured, as there is the risk if people are not 'brought on the journey' they will be frustrated and experience services as poorer quality as they reconfigure. In interviews with third sector organisations, providers and representatives of service users there were many positive comments about the changes being made to improve health and social care. However, people also indicated that in some instances changes to services were experienced as disruptive to care.

  "You used to be able speak to the OT, now it all goes through contact team. The contact team doesn't work. We had direct link. Now they say we will take a message but we don't know if they got the message or when they will get back to you. Certain social workers don't seem to get back

to you. In the meantime, the person is still having falls." (Third sector organisation)

"The management of district nursing is a problem. They are constantly shifting services around. We used to have a good personal relationship with the district nurse, and our residents were used to her. She came in for about 18 months and you can't fault her. She's been shifted because of neighbourhood teams. Now we have to establish new relationships. It's for residents themselves. They need a familiar face. If it is a constantly changing face it is difficult for residents." (Social care provider)

"Does integration work well? No. People don't get a reply or its passed on to someone else. Integrated service means the buck gets passed round and round and round, rather than John Smith will deal with this action." (Carer)

"Single point of contact is a great idea, but it is really confusing for mental health." (Third sector organisation)

- The health and social care leaders raised engaging with all of the communities in Salford as a challenge. We were told that the local Jewish community tended to be tight-knit, with a belief in keeping things within the community and this could make it hard to engage with this group. They also spoke of the challenge of keeping pace with the rapidly evolving population of 'multi-dimensional ethnicity', younger people and children and ensuring confidence and trust in health and social care services is built in these communities.
- The way local Healthwatch organisations across Greater Manchester have come together to form thematic partnerships with representatives across the boroughs, so their working locally and across the region was viewed positively, and is important for connecting public engagement in Salford into 'Devo Manc'.
- There were delays in the establishment of Salford Healthwatch, which has limited the availability of information on the views and experiences of people who use services in Salford.[18] Healthwatch collaborates well with leaders in health and social care in Salford to gather information from the public on important initiatives. There was evidence of Healthwatch conducting its own independent projects and public engagements. However, in the context of such close collaboration, it will be important for Healthwatch to make sure it really is acting as a critical voice and representing strongly the views and priorities of local people.
- We were told that the methods used to engage the public tend to be limited, with an overreliance on community committees and Healthwatch. Newer and more innovative ways of reaching different groups could be explored.
- The partners have recognised the need for more coherence in engagement with patients and service users across the four organisations, as each have different service user representative forums or mechanisms. There are efforts to reduce this duplication, for example, the representatives of

18 CQC analysis of publically available documents.

the Council attending the CCG service user panel. A goal of the public engagement component of Salford's strategy (Locality Plan) is that information from the public will be collated and used by all organisations, regardless of which forum or mechanisms people use to share their views.

3.2 SHARED VISION, STRATEGY AND PLAN

The partners have a shared vision and strategy for Salford. This is set out in the Locality Plan for Salford being developed, within the Greater Manchester Health and Social Devolution strategy.[19] It includes 'whole system' reconfiguration and integration of health and social care to meet the needs of local people.

The Locality Plan evidences understanding of rising and changing demand, the particular challenges faced by the population in Salford and financial constraints for health and social care. It is based on the evidence in the Joint Strategic Needs Assessment, the work of research and intelligence teams established to provide evidence in priority areas and engagement with local people, including the review of the health and wellbeing strategy.[20]

The plan includes estimations of how its various initiatives will contribute to reducing the projected £157 million funding gap to £4.6 million in 2021, if they deliver their anticipated outcomes. However, it acknowledges this is optimistic and a significant proportion of the savings (£69.7 million) is based on the assumption providers will be able to achieve 2% cost improvement savings every year over the next five years.[21]

There is strong continuity between the Locality Plan and Salford's Joint Health and Wellbeing Strategy for 2013-16[22], so the area is building on work that has gone before. Salford partners are drawing on their previous experience integrating care, moving care from the hospital into the community and reducing costs.

- Examples of past success include the 2001 Health Investment for Tomorrow initiative that created an intermediate care gateway, with 'bedded facilities' in communities, and by moving provision of care into the community enabled the reduction in the number of beds in the hospital by 200 beds over a four year period. The Unscheduled Care Programme in 2010 integrated pathways between hospital and home, across primary and community (although not mental health and social care). The aim was to save £7.2 million and £5.5 million was saved. Health and social care staff have been co-located for intermediate care,

19 Greater Manchester Health and Social Care Devolution, Locality Plan for Salford, ibid

20 www.partnersinsalford.org/salfordjhwsreview.htm; www.healthwatchsalford.co.uk/locality-plan

21 Greater Manchester Health and Social Care Devolution, Locality Plan for Salford, ibid

22 Salford's Joint Health and Wellbeing Strategy: Our vision for a Healthier Salford by 2016, 2013, www.partnersinsalford.org/salfordhwbboard.htm

hospital discharge teams and in district nurse/social worker integrated teams.

- Services for those with learning disabilities are regarded nationally as an example of good practice in minimal use of inpatient services for assessment and treatment.[23] This has included transfer of employment of staff to create new health and social care provider teams under a single manager, providing and ensuring identification and appropriate support for those with learning disabilities in the range of care settings, for example, acute and primary care. The local model developed for learning disabilities of 'just enough care' is being rolled out across social care, an approach and tools which enable personalisation, independence and linking people into communities. [24]

PLANS FOR INTEGRATING HEALTH AND SOCIAL CARE AND FOCUSING CARE IN THE COMMUNITY

The plan accords with emerging best practice in designing place-based systems of care,[25] 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 reform and integration of health and social care services from the perspective of people's life course:

- **Starting well** – all children have the best start in life and continue to develop well during their early years
- **Living well** – local residents achieve and maintain a sense of wellbeing by leading a healthy lifestyle supported by resilient communities
- **Ageing well** – all local residents can access quality health and social care and use it appropriately.[26]

The plan reflects national policy imperatives, with a strong focus on movement of care from hospitals into the community.[27] This includes focusing delivery in local neighbourhoods and increasing the scale and scope of primary care by bringing together GPs, community pharmacists, opticians and community services. The reconfiguration of health and social care is linked into plans for public health and prevention and action on wider social determinants of health and wellbeing and inequalities. The Locality Plan commits to making decisions on investment in initiatives and services based on the extent to which they will address health inequalities.

Salford has been building a 'community assets' approach to integrated care. This means integrated care includes linking

23 Department of Health (2012) DH Review: Winterbourne View Hospital, Good Practice Case Studies, uploads/attachment_data/file/141593/2900171-WV-Good-Practice-Case-Studies-1-v1_0A.pdf

24 Salford City Council, Adult Social Care Market Position, www.salford.gov.uk/integratedcommissioning.htm

25 Ham, C. & Alderwick, H. (2015) Place-based systems of care: A way forward for the NHS in England, The Kings Fund, November 2015,

26 Greater Manchester Health and Social Care Devolution, Locality Plan for Salford, ibid

27 Hussain, S. & Dornhorst, A. (2016) Integrated care – taking specialist medical care beyond the hospital walls, A report to the Royal College of Physicians Future Hospital Programme, February 2016

people into community and voluntary organisations. This is intended to help address the person's wider needs and personal goals, reduce social isolation and promote health and independence. The social enterprise Inspiring Communities Together has been responsible for the 'community assets' component of the ICP, using half a million pounds from the pooled budget. A similar approach is within the plans for the Integrated Care Organisation (ICO) for Adults.

INTEGRATED CARE PROGRAMME (ICP) FOR OLDER PEOPLE

The four statutory providers and commissioners have been working in partnership to integrate health and social care for older people in Salford and move care into the community, via an alliance. Salford GP practices are involved, as well as a range of other providers and stakeholders including the voluntary and third sector. This completed the first phase of implementation in 2014/5, with plans extending over the next five years. Outcomes for the ICO include reducing emergency admissions and readmissions and permanent admissions to residential and nursing care. They have prioritised reconfiguring care for older people given the high and complex demand for care and emergency admissions in the group. 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.

INTEGRATED CARE FOR ADULTS (INTEGRATED CARE ORGANISATION AND VANGUARD)

Salford is in the process of establishing an Integrated Care Organisation (ICO) for health and social care for all adults of working age. Salford is a national 'vanguard', testing the Primary and Acute Care System model in NHS England's Five Year Forward View). SRFT is in the lead provider, and will deliver all adult hospital, community, mental health and social care through a combination of direct provision and sub-contracting arrangements with other providers, including GMW and domiciliary care private providers. This will involve the transfer of social care staff from local authority to SRFT employment. Engagement is taking place with GP practices in Salford to explore the options to change the way general practice medical services are commissioned and delivered within Salford's integrated care system.

INTEGRATED SUPPORT FOR CHILDREN, YOUNG PEOPLE & FAMILIES

In 2015 there was the initiation of 0-25 years integrated support programme for whole system transformation and public sector reform to address complex dependency, troubled families, early years, employment and skills. This includes health, social care and education commissioners, providers and other partners, such as the police.

HOSPITAL CARE RECONFIGURATION

In addition to health and social care services integration within Salford, hospital care and care for those with complex needs, in

Salford and the region, is being reconfigured within the Greater Manchester Healthier Together framework. This involves both SRFT and CCG.

3.3 GOVERNANCE

Salford is building on its experience of governance of partnership arrangements and pooled budgets and demonstrates diligence in addressing the complexities of governance for its integrated care initiatives. However, stakeholders commented that governance for integrated care 'at scale', within the parameters of current statutory arrangements, is 'untested', in Salford and nationally.

- The strategic plans of each of the four partners include objectives for integrated care and partnership.
- The Locality Plan defines shared outcomes, targets and measures, overall and against each of the stages of the life-course. Partners are in the process of developing a shared set of outcomes for the ICO. A shared set of outcomes has been developed for the ICP.
- The ICP for Older People plans are contained within a four year Service and Financial Plan (2014/5 – 2017/8). All health and social care budgets for older people services have been pooled (including the Better Care Fund allocation), into a single budget in excess of £100m. Salford's BCF Plan is aligned to the ICP and was approved by NHS England in November 2014. The pooled health and social care budget for the ICP is being managed under an Alliance Board and an Alliance Agreement between the four partners, which includes the principles of integrated working, along with a financial, governance and contractual framework.
- Salford is in the process of developing the arrangements for the ICO and report there is intensive scrutiny of governance, risk and budgets. Commissioners are proposing to establish a new pooled budget for adult services. There is particular concern about how the Council will deliver its statutory responsibilities clearly, as it relinquishes direct commissioning of adult social care and this function moves into a provider (SRFT), but the Council retains the statutory function and responsibility. This was described as: '*outside of the rule books of the clear division of commissioning and provision*'. Salford also indicated it needed to determine how savings for individual organisations from a pooled budget will be demonstrated, for example, where the Council has a reducing budget. It was reported that within the development of the ICO, mechanisms have been put in place for the partners to 'get out' if necessary.

3.4 WORKFORCE

Salford has identified workforce as critical to the success of its ambitions for integrated care and transformed services. There are concerns regarding the workforce capacity in key areas, particularly primary care, social workers and in adult social care providers. Partners have put in place initiatives to support the development of the workforce to deliver integrated care and foster leadership and shared values among staff at every level.

WORKFORCE CAPACITY

The people we spoke to at all levels tended to be of the view that Salford was a good place to work. The Council report good retention and recruitment[28]. There is a relatively stable workforce at NHS Salford and SRFT.[29]

A key challenge is the GP workforce and age profile, with insufficient GP coverage for the population in Salford. Recruitment to primary care in Salford is generally the same as in the rest of North West[30], with the challenges faced common to primary care across the country, including workforce supply, workload, changing work and roles and altered ambitions among younger GPs.

Social care providers are experiencing challenges with recruiting nurses and the stability and quality of the workforce, as is common nationally. Salford Council have sought to foster career progression opportunities for social care staff, through contracting one provider to run care homes and reablement services in each neighbourhood.

There was concern from multiple stakeholders inside and outside of the Council on the pressures on social work teams with successive reductions in Council budget.

28 Salford City Council staff turnover

Directorate	Headcount	Leavers	Turnover
Community Health & Social Care	520	77	14.81%
Salford	3782	392	10.36%

period 01/04/2015 to 31/03/2016, source: Salford City Council

29 Health and Social Care Information Centre (HSCIC), provisional monthly NHS workforce data

30 Interview of Health Education England, regional representative

DEVELOPING THE WORKFORCE FOR INTEGRATED CARE

There was appreciation that the success or failure of the delivery of integrated care ultimately depended on successfully engaging such staff at the frontline. Partners spoke of the challenges involved in transferring approximately 400 council staff into a health organisation (SRFT) and creating an integrated workforce. This included developing a common culture and values, building relationships and trust and maintaining professional standards for different professions and specialisations in integrated teams.

For the staff who will be part of the ICO, first steps have been taken to build a common culture, values and relationships, through an organisational development programme focused on 100 leaders from the different organisations, to support organisational change within the workforce. In addition, Salford is considering where to redesign and create joint roles to foster new opportunities for health and social care staff and where to keep specialisation. The core approach is developing integrated teams, which are multi-disciplinary, co-managed and co-located, but protect specialisation and professional

competencies. Importantly, Salford is taking the approach of incrementally reconfiguring services 'from within', through those working within the services, rather than leaders developing a service plan which staff are then required to implement. This reflects best practice in successful service change.[31]

LEARNING FROM FRONTLINE EXPERIENCES OF INTEGRATING SERVICES

In addition to speaking to the leaders of partner organisations, we spoke to teams involved in integrating services 'at the frontline' within the ICP. These demonstrated how much is involved in frontline integration and Salford's ambitions for integrated care, and include important lessons about 'what helps and what hinders' the actual achievement of reconfigured services.

- Much of what they said echoed what senior leaders said was important for partnership and integration at a strategic level, from an operational point of view. Teams spoke of the importance of developing relationships, leadership at every level and transcending differences through a common culture of working for the benefit of the 'whole person' using services.

  "We built assessments and planning that genuinely puts the person at the centre, that doesn't think 'is that a social care or a health need?' When we get caught in our different ways of working and processes and systems, we come back to the person. If we understand the person, we have plans for what we are going to do with them. What exactly are we doing to help this individual? What does Nigel want?"

- Teams spoke about their successes, and that sharing these and demonstrating benefits to professionals and patients helped develop support and momentum.

  "Some GPs were sceptical. They had pressing time concerns and were being asked to do more. Now six to seven months later the same GP told another GP it was the best thing they had been involved in. They can share their concerns about a patient with peers as well as other disciplines. They have seen how it has alleviated the issues of complex patients they sat and worried about. It also improves their clinical practice."

- But especially evident was the time and effort and resources required for successful reconfiguration of processes and services, and the risks involved in trying to do so rapidly and 'on top of the day job'.

  "Having a function like the MultiDisciplinary Groups (MDGs) began as a development a while ago, but were being done 'on top of the day job' with no additional resources, and so had to be put to one side."

31 Bohmer, R.M (2011). The four habits of high-value health care organisations, The New England Journal of Medicine, 365:2045-2047

"In the middle of all this, we still have to deliver a service. There hasn't been enough dedicated project management."[32]

- These teams were very clear that shared budgets, targets, management and information systems were key to integration and to the effectiveness of frontline activity. The absence of these created very significant difficulties and daily frustration for staff trying to work together.

  "We know the concept is right and you can integrate but then you start unpicking all the layers. IT and governance are daily difficulties at the moment because the organisations have different systems. The aim is to answer all calls, the ten social workers, the ten occupational therapists and district nurses. But at the moment all staff are working at different times and on different terms and conditions, with different pay for the same job."

- The anxieties about loss of jobs and professional identity were very real, and required staff to develop new ways of understanding their value as a professional.

  "If anyone in health or social care can do my job why will they need me?"

  "As a manager for integrated teams I was left thinking 'I'm not really a nurse anymore, I am not putting a bandage or plaster on it'. Nurses were asking, 'What are you doing, have you seen any patients?' I can really see now as a nurse with a clinical background you can go in a different way. If we think about people holistically, if we don't get mental health and social right, from a nurse's point of view the person will never be well.'

- There was some reflection that in some instances communication from the leadership in different organisations to their staff was inconsistent and this made efforts to bring teams together from across organisations difficult.

  "There had also been difficulties in that the leadership in the different organisations have communicated with their staff at a different pace, so some in the team are ahead of others. Because different organisations are in different spaces it has been hard to give messages to staff coherently."

CURRENT EXPERIENCES OF PROFESSIONALS DELIVERING CARE

In the case studies we did with older people, we spoke to the professionals involved in their care. These interviews tended to reflect there is a way to go to achieve joined-up services to deliver care to such a group with multiple needs. The ways in which the disconnections between services frustrated professionals and their efforts to care for patients was very evident, lending support to plans for service reconfiguration.

- There were examples of patient-centred practice by staff. Several professionals commented that care within Salford seems to be better integrated than in other areas and that this was getting better. The co-location of community

32 The need for additional project management capacity was identified and action taken to address this.

nursing and social services was seen as important, enabling staff to improve communication and build relationships. The accounts of some professionals included aspects of the ICP for older people, specifically the Multi-disciplinary Groups to coordinate care for patients with complex needs. These were positively viewed and seen to enable 'person centred coordinated care'.

- However, the more common reflections from professionals were on the discontinuities between services and inefficiencies. Overall, it appears many expensive professionals are spending time dealing with failures in systems that could be spent delivering therapeutic value to the patients.

  "Things are not smart as a system. Ages are spent on admission processes and assessments, referral pathways." (Professional)

- In many instances, interagency communication and information sharing seemed not to work well. A number of the professionals reported that they spend several hours a week 'chasing' other health care professionals. There were instances where this caused delays to care and possible risks to patients.

  "There is a problem with working on the assumption if I have written a letter, you will get it and do something about it." (Professional)

Physiotherapists in particular raised many concerns about communication between different services. It seems they experienced this challenge particularly intensely as they need to connect with multiple services and the practitioners did their own referrals. A number of professionals reported that contacting and communicating with GPs could be difficult and that there is a sometimes a lack of communication from GPs. At the same time it was emphasised that GPs themselves may not know where a patient is within the care system.

- Problems or lack of capacity in one service undermined other efforts to deliver care. Professionals raised waiting for community occupational therapy (OT) assessments as an issue, which then impacted on people's health and other care. Difficulties accessing podiatry were also raised.
- There appeared to be duplication in assessments. In particular this may be the case in relation to reablement needs, with rehabilitation teams in intermediate care undertaking assessments of what patients needed to help them be safe and well at home, and then similar assessments being undertaken by the community OT employed by the council – with the wait for community OT a long one.
- It was remarked on by professionals and also evident in the care for patients looked at in the cases that there could be confusion as to 'who owned the patient' – who was responsible for coordination and coherent decision-making and making sure they got the care required. The need for care coordinators was asserted by several staff, at all levels and in different teams.

The professionals we spoke to regarding the care of people diagnosed with schizophrenia reflected better coordination of

care across services, including through Multi-Disciplinary Teams (MDT). Although there were a couple of reports of GPs having minimal involvement with patients, most staff reported good information sharing between different services, including with GPs. Some people mentioned communication and handover techniques to ensure patient safety. These included 'traffic light' and 'zoning' handover systems for highlighting risk, use of liaison teams and support for making referrals. However, some professionals said that some services were better at communicating than others and there were a couple of examples of where poor communication has been to the patients' detriment. We were told that some services had different ways of working which could make things difficult.

3.5 INFORMATION MANAGEMENT AND TECHNOLOGY

A predominant issue raised by professionals was the difficulties caused by disconnected information systems. The Locality Plan includes plans for a single electronic record for each citizen, shared across all services, with all staff able to input information, and mobile access for workers in the community. This sits within wider plans for information management and technology in Greater Manchester, a 'digitally enabled' Salford and use of data to understand population health and predict risk.

Salford began the Salford Integrated Record Programme in 2009 which enables record sharing between primary care and secondary care. However, there continues to be separate different patient records and systems across the 47 general practices, secondary and community care delivered by SRFT and mental health delivered by GMW. The Council social care also has a system which enables assessments, payments and packages of care to be recorded. Salford is aware these systems do not easily link at present and do not include information from services people access beyond Salford.

The teams we spoke to reflected on progress in sharing information. For example, the learning disabilities team reported they are responsible for a single list of people in Salford with learning disabilities, shared across GPs and SRFT. SRFT have a system which flags up if a person with a learning disability plan comes into the hospital, which enables staff to interact with and support them in a way that meets their individual needs. Developments within the MDGs flags those still attending at A&E despite having a care plan and enables GPs to see for the first time what care people are receiving in their homes.

In our case studies of older people, there were repeated calls from professionals for joined up information systems, eradication of paper based information and a single electronic care record for each patient. In addition to shared patient records, several staff also asked for an up to date directory of professionals and means to make and manage referrals. There were also more basic problems of slow systems and IT access.

"The current IT systems actively promote discontinuity of care." (Inspector)

"A huge amount of time could be saved by having data sharing and electronic data communication." (Professional)

A particular problem seemed to be dependence on paper records when working in the community. Some reported that they had iPads, but as patient records are still paper based, they are currently only used for patient contact details. There could be multiple separate paper care records across teams. One patient had two lots of paper care records in their home, one for the district nurses and one for the home care team and the GP was not using a care plan. It was commented that teams rarely look at others' notes. For paper records there could be no effective audit trail. There was an instance where written records for the community nursing team at a patient's house had 'gone missing' with no back up copy, either paper or electronic. It was remarked that it was 'not unusual' for this to happen. For another patient, when interviewing both the community rehabilitation technician (CRT) and the community nurse (CN) it was found that there was no electronic record and that paper records were missing for both teams. This meant that there was no auditable evidence that they ever visited the patient and had to rely on memory to recall details about the patient's care. The Rapid Response Team was also using paper notes when visiting patients, which they reported was ineffective.

The accounts of physiotherapy staff provided a particularly strong demonstration of the problems caused by information systems. Discharge summaries are made on iSoft. However, physiotherapy input is recorded on paper, and while they can see iSoft entries, staff cannot enter data into this. Physiotherapy staff had difficulty reconciling hospital electronic records with care home's paper records. Physiotherapy rehabilitation plans are not always noted in community nursing team notes. Orthopaedic (fracture) clinic letters take 1-2 weeks to get back to the physiotherapists, which is time lost from rehabilitation as the physiotherapists are not able to modify their strategies in response to the consultant's advice. Physiotherapists commented that the records kept did not fully support the therapist's work and that documentation 'can take twice as long as actual patient contact'. Network strength varied and there were more staff than available computers.

3.6 SYSTEM-WIDE INNOVATION AND QUALITY IMPROVEMENT

Salford's Locality Plan sets out the ambition to be the highest quality and safest health and social care economy in England. The intention is to build quality into the ICO. Salford has put in place initiatives for system-wide innovation and improvement, as opposed to improvement mechanisms that work within single organisations. There is evidence in the plans and processes used by partners of best practice in innovation and improvement and managing organisational change.

The stakeholders spoke of the challenges and opportunities involved in achieving their ambition for system-wide quality. There was recognition of the significant work entailed in moving some of the commissioned provision to 'the right level' in quality and safety. Integration within the ICO was seen as an important opportunity to drive quality improvement and attain a high level of quality across all parts of the system.

"Part of due diligence in the transition will be around how to bring care home provision up to standard of quality expected of in SRFT. As areas of provision move into the ICO we will have to tighten up monitoring and performance across the whole piece."

The Making Safety Visible initiative is establishing safety as a foundation of the ICO. This is funded by The Health Foundation.

"We were the only health economy to include the council there, rather than focus on safety in acute. We felt system wide approach was important as quality in the hospital is affected by quality in community."

Different cultures within different parts of health and in social care had different understandings of quality, risk and safety. This meant partners had to work through and develop a standard approach to quality, but one which took into account differences between different settings.

"There are very big differences between acute and social care in the understanding around quality. Acute and social care and even GPs have different views of what quality looks like and how to achieve it, and even within directorates in organisations there are different views. For some it is being seen on time and type of treatment, and there was no adverse risk extending to whether people feel valued and listened to and able to express views. We don't have a clear standard approach to quality in Salford."

'There is a need to work through how to manage risks when you are moving between a hospital, which is highly controlled and risk averse, to the community, where there has to be the ability to take healthy risks 'otherwise people can't live'. It is important not to imposing hospital risks standards on the community, but also to challenge community practices to be better.'

Stakeholders reflected that the way improvement and innovation has been supported historically has been inside an organisation rather than locally or regionally, to serve a population at a scale and build services and quality across a 'system'. When the alliance partners came together as a board one of the initial challenges was how the 'system' leaders came together to work through the aspects of services that they needed to change together. The HWB identifying strategic priorities and partners came together to talk about assurances, governance and finances. However, there was no mechanism for partners to work together to redesign and improve services across organisations.

Salford has put in place a facility for system-wide improvement and innovation, Haelo Innovation and Improvement Centre. This is a joint venture partners across Salford, led by the four partners (SRFT, GMW, Council and CG) and Salford University. It also works with partners in Greater Manchester and contracts to national partners (e.g., it is developing the Safety Thermometer for NHS England). In this way the improvements in Salford are linked into regional and national developments of strategic importance. Haelo has no 'content expertise'. Instead

it brings in a broad range of stakeholders across the system in a 'neutral' and open forum, with everyone as equal partners. The stakeholders 'look at the facts', patient journeys and hard data, and work together to redesign care. It was remarked:

"The differentiator between successful vanguards and projects in Devo Manc and those that are not will be having a vehicle to deliver change together".

Partners also explained that they used best practice in innovation and improvement. This included:

- Use of clinicians and frontline professionals in the design of new models of care and ways of working.
- Use of Institute for Health Improvement 'test to change' methodology for improvement.
- Robust programme management 'through the whole system' through a single project management office and plan, in SRFT, accountable to the board of four partners.
- A focus on monitoring and measurement to identify the impact of changes and identify early any need to adjust course.
- Investment in evaluation. For example, the ICP will be evaluated as part of a National Institute for Health Research (NIHR) funded research project.

3.7 STRATEGIC RISKS

Salford is the early stages of this major programme of transformation. The partners and stakeholders spoke to us of the many risks to Salford's transformation of health and social care. There was the need for the four main partners to bring other providers, the third sector and the public with them. Partners needed to respond to the rapid socio-economic change in the area. There were concerns about ensuring integration delivered 'from the perspective of local people' and to define meaningful shared outcomes. There were anxieties about the movement from partnership working to structural reorganisation within the ICO and the disruption this would bring to the workforce and existing frontline relationships and processes. There was the need to be looking 'in two directions', both transforming care in Salford and being part of the changes in health and social care within Greater Manchester devolution. Overall there was anxiety about the pressures of money, demand, complexity and pace.

"Nowhere in world has this. There are only bits of examples of success. Will this save money and improve quality of care?" (Local leader)

These challenges are examined in more detail in the report conclusions.

4. Populations and their experiences

This section provides evidence on health and wellbeing outcomes, access and coordination and integration of care for people living in Salford. It looks at the population as a whole.

4.1 POPULATION OUTCOMES

SOCIAL CARE

- For those obtaining adult social care services, the level of satisfaction with services in Salford is in line with the national average. The proportion of people in England who answered 'I am extremely satisfied' or 'I am very satisfied' in 2013/14 was 64.8 and in Salford 65.3% of responses were positive.[33]
- There is some indication of unmet need in Salford for those using social care, based on the quality of life score calculated from the Adult Social Care Survey. Eight questions are scored based on whether there are no unmet needs, needs adequately met, some unmet needs and no needs met. The domains to which the questions relate are control, dignity, personal care, food and nutrition, safety, occupation, social participation and accommodation. The average score in England is 19 (range 17.8-20.6) and the score for Salford is 18.2. [34] The higher the score the more needs that are met.
- Salford scores better than the England average in some domains of quality of life, specifically accommodation, but worse on employment and social contact. The proportion of adults with a learning disability in employment is significantly lower than the England average. However, the proportion of adults with a learning disability in settled accommodation is significantly higher than the England average (see table 16 for measures for those with mental health difficulties). The proportion of people who use services and their carers reporting that they had as much social contact as they would like is significantly lower than the England average.

33 Adult Social Care Survey, http://fingertips.phe.org.uk/profile/adultsocialcare/data#gid/1000101/pat/6/ati/102/page/1/nn//par/E12000002/are/E08000006/iid/90582/age/168/sex/4

34 http://fingertips.phe.org.uk/profile/adultsocialcare/data#gid/1000101/pat/6/ati/102/page/1/nn//par/E12000002/are/E08000006/iid/90582/age/168/sex/4

Table 2: Adult Social Care User's Quality of Life, England and Salford

Measures of quality of life	Time period	Salford	England	Compared to England
Proportion of adults with a learning disability in employment	2013/14	2.3%	6.7%	Significantly worse
Proportion of adults with a learning disability who are in settled accommodation	2013/14	92.2%	74.9%	Significantly better
Proportion of people who use services and their carers, who reported that they had as much social contact as they would like	2013/14	38%	44.5%	Significantly worse

Source: Public Health England Adult Social Care Fingertips tool

- Salford scores better or in line with the England average in relation to support for carers accessing social care services. With regard to satisfaction from services, Salford's score is marginally more positive than England. The 2012/13 Carers Survey asks 'Overall, how satisfied or dissatisfied are you with the support or services you and the person you care for have received from Social Services in the last 12 months?' The proportion of people in England who answered 'I am extremely satisfied' or 'I am very satisfied', in 2012/13 was 42.7% and in Salford it was 45.4%.[35]
- The carer reported quality of life score is similar to England. This is derived from 2012/13 Carers Survey and represents the respondents' self-reported quality of life. Six questions are scored based on whether there are no unmet needs, some unmet needs and no needs met. The domains to which the questions relate are occupation, control, personal care, safety, social participation and encouragement and support. The average score in England is 8.1 (range 6.5-9.3) and the score for Salford is 8.0.[36] The higher the score the more needs that are met.
- There is a more positive experience of involvement in care by carers in Salford than in England. The Carers Survey also asks 'In the last 12 months, do you feel you have been involved or consulted as much as you wanted to be, in discussions about the support or services provided to the person you care for?' The average score in England is 72.9% and the score for Salford is 79.8%, which is significantly better.[37] Carers' involvement in decisions can have a positive impact on the outcomes for both the patient and carer and can reduce the risk of a breakdown in care.

HEALTH

- Life expectancy is worse in Salford than in England for both men and women at birth and at age 65. Healthy life expectancy is also worse.

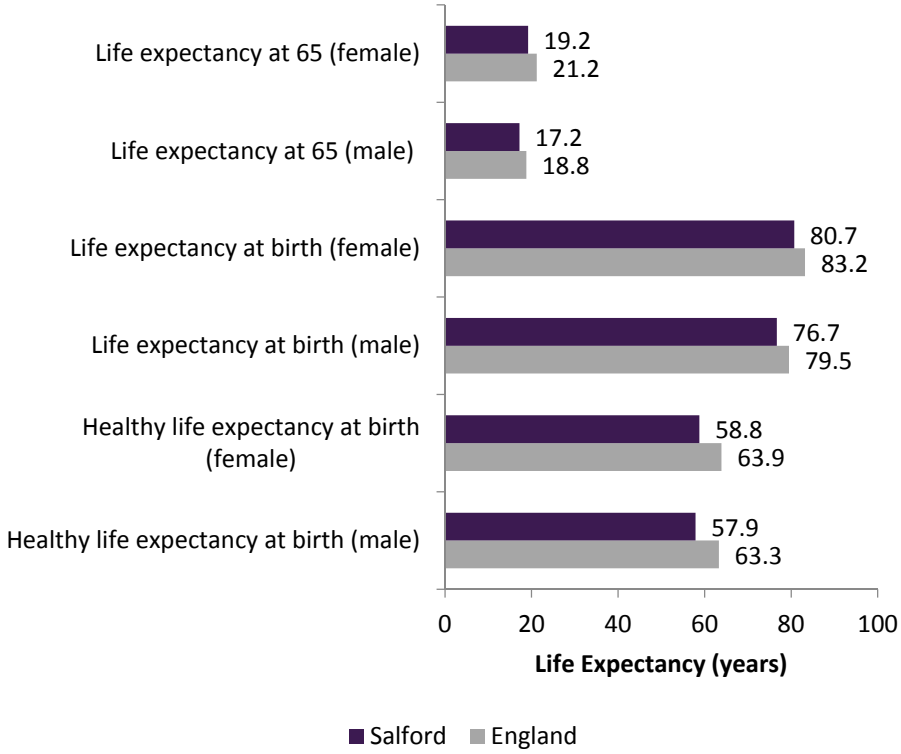
35 Public Health England Adult Social Care Fingertips tool, data for 2012/13

36 Public Health England Adult Social Care Fingertips tool, data for 2012/13

37 Public Health England Adult Social Care Fingertips tool, data for 2012/13

- Life expectancy is 10.6 years lower for men and 10.3 years lower for women in the most deprived areas of Salford than in the least deprived areas. There is greater inequality in health between the affluent and poorer people in Salford than would be expected based on the levels of deprivation.[38] In other words, the range in life expectancy across the social gradient is greater in Salford than in England. In particular, women in Salford have a much greater range in life expectancy than the England average and life expectancy for women is among the worst in the country and deteriorating.
- There has been a decline in mortality rates since 2001, which has now reached what was the rate for England in 2001. In Salford, both male and female age-standardised mortality rate (ASMR) are ranked in the top ten for England and Wales. The ASMR describes the number of deaths in an area that would occur if it had the same age structure as the standard population.[39]

Figure 1: Life expectancy in years, 2012-2014 and healthy life expectancy in years 2011-2013, Salford and England



Source: PHE Public Health Outcomes Framework Fingertips tool (using ONS Data)

38 Using the 2011 Index of Multiple Deprivation (IMD scores) the slope index of inequality in life expectancy at birth based on national deprivation deciles within England show that the range in life expectancy across the social gradient is greater in Salford than in England.

39 Office for National Statistics, Age Standardised Mortality Rates, Salford and England and Wales, 2001-2013

Figure 2: Range in years of life expectancy across the social gradient, from most to least deprived, Salford and England, 2012-2014

Source: Data from PHE Public Health Outcomes Framework Fingertips tool using ONS and Department for Communities and Local Government data

- Because Salford is an area of high deprivation, the health of local people is starting from a low base. Salford has experienced many of the factors that contribute to poor health in Manchester and the North-West but historically has not benefited from factors that could contribute to better health and wellbeing, such as employment. Between 2001 and 2006, health indicators tended to be worse than areas with similar characteristics and deteriorating. However, local leadership and partnerships, supported by national investment, has resulted in reversal of these trends and good progress for the health and wellbeing of local people.
- The Salford Joint Strategic Needs Assessment Health and Wellbeing Overview in 2015 analysed 35 indicators through comparison of both averages and rates of improvement for Salford, Greater Manchester, North West and England. This shows good progress for health and wellbeing for the Salford population. However, the analysis does not look at inequalities between areas within Salford in these changes over time or inequalities within or between demographic groups (e.g. older or younger people or different ethnicities). [40]
- Salford is significantly better than England for 9/35 indicators assessed. For many indicators there has been a gap between Salford and England averages for many years. To close the gap the rate of improvement in Salford needs to be higher than the rate of improvement for England. The percentage change of improvement in Salford has been greater than for England for 19 of the areas assessed and for the indicators worsening the decline is not as great in Salford as England for two of the eight areas (excess weight

40 Data from the Public Health Outcomes Framework benchmarking tool, Salford Joint Strategic Needs Assessment, Health and Wellbeing Overview, A Comparative Report of Public Health Outcomes, June 2015, www.salford.gov.uk/d/Health_and_wellbeing_comparative_performance_June_2015.pdf

at 10/11 and emergency readmissions within 30 days). Gaps remain between Salford and England for 18 indicators, with Salford performing worse than the national average (see table 4). [41]

- The rate of eligible people being offered and receiving an NHS Health check in Salford has risen from 18.4% in 2011/12 to 52.2% in 2014/15 and the rate is now significantly higher than England. For the period 2010/13 Salford is the second lowest (best) area in the country for excess winter deaths (all ages). The rate has fallen by 58.9% and this is almost 16 times greater than the change in rate for England.[42]
- In Salford the potential years of life lost per 100,000 registered patients from causes considered amenable to healthcare is higher than the England rate. Potential years of life lost (PYLL) from causes considered amenable to healthcare calculates the number of additional years a person might have been expected to live with timely and effective healthcare had they not died of a cause considered to be avoidable (see figure 3). When looking at rates of avoidable and excess deaths, Salford performs significantly worse than England for measures of preventable mortality from long term conditions, including from cardiovascular, liver and respiratory disease and cancer. Circulatory diseases (including coronary heart disease and stroke), cancer and respiratory disease are the greatest contributors to the difference in life expectancy between Salford and England and between the most and least deprived areas in Salford, for men and women.[43]
- There are improvements for some causes of mortality considered preventable, but mortality from long-term conditions remains high. For mortality from cancer considered preventable, the rate of improvement is better than England, but the rate in Salford is fourth highest in the country. Salford had a reduction in under 75 mortality from liver disease from 2001/3 to 2011/13, which is opposite to the national trend. The rate of decline in cardio-vascular mortality is very similar to England. For respiratory mortality considered preventable the rate in Salford is significantly higher than England from 2001/3 to 2011/13 but has shown a fall since 2008/10. This reduction is around a third of the reduction seen in England.[44]

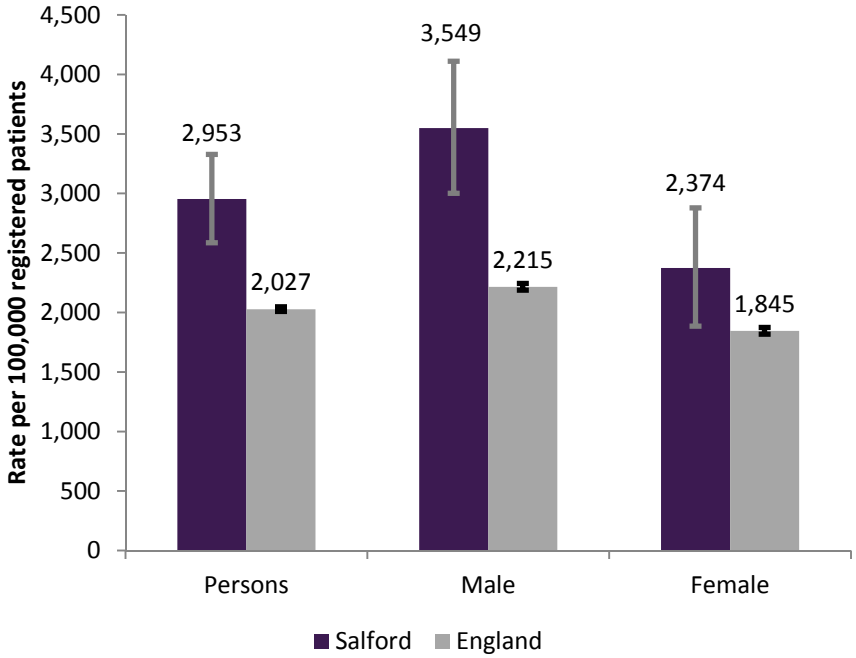
41 Salford Joint Strategic Needs Assessment, Health and Wellbeing Overview, A Comparative Report of Public Health Outcomes, ibid.

42 Salford Joint Strategic Needs Assessment, Health and Wellbeing Overview, A Comparative Report of Public Health Outcomes, ibid.

43 Smith, T., Noble, M., Noble, S., Wright, G., McLennan, D. & Plunkett, E. (2015) The English Indices of Deprivation 2015, Research report, Department of Communities and Local Government

44 Salford Joint Strategic Needs Assessment, Health and Wellbeing Overview, A Comparative Report of Public Health Outcomes, ibid.

Figure 3: Potential years of life lost (PYLL) from causes considered amenable to healthcare in Salford and England, 2013



Source: Health and Social Care Information Centre NHS Outcomes Framework Indicator Portal

Table 3: Avoidable and excess deaths in Salford and in England

Measures of avoidable/excess mortality	Time period	Salford	England	Compared to England
Mortality rate per 100,000 from causes considered preventable (Persons)	2012-14	277.7	182.7	Significantly worse
Under 75 mortality rate per 100,000 from cardiovascular diseases considered preventable (Persons)	2012-14	79.9	49.2	Significantly worse
Under 75 mortality rate per 100,000 from cancer considered preventable (Persons)	2012-14	122.5	83	Significantly worse
Under 75 mortality rate per 100,000 from liver disease considered preventable (Persons)	2012-14	27.8	15.7	Significantly worse
Under 75 mortality rate per 100,000 from respiratory disease considered preventable (Persons)	2012-14	31.8	17.8	Significantly worse
Mortality per 100,000 from communicable diseases (Persons)	2012-14	83.8	63.2	Significantly worse
Excess Winter Deaths Index (Single year, all ages)	Aug 2013 – Jul 2014	5.9	11.6	Similar

Measures of avoidable/excess mortality	Time period	Salford	England	Compared to England
Excess Winter Deaths Index (3 years, all ages)	Aug 2011 – Jul 2014	9.1	15.6	Significantly better
Infant mortality - Rate of deaths in infants aged under 1 year per 1,000 live births	2011 - 13	3.9	4	Similar

Source: PHE Public Health Outcomes Framework Fingertips tool

- Smoking, drug and alcohol-related harm and lack of physical activity are key factors for poor health in Salford. The proportion of children and adults classified as obese, levels of adult physical activity, estimated levels of adult smoking and smoking related deaths and alcohol-related hospital stays for adults and those under 18 are all worse than the average for England.[45] The prevalence of mental health conditions, dementia and learning disabilities is significantly higher than the England average.[46] There is progress in addressing health related behaviour. Rates of smoking prevalence and physical activity are improving faster than the England average, although Salford continues to face challenges with child poverty and childhood obesity.[47]

45 Public Health England, Salford Unitary Authority, Health Profile 2015, 2 June 2015, www.apho.org.uk/resource/view.aspx?RID=50215&SEARCH=Salford&SPEA

46 PHE Adult Social Care and Health Profile Fingertips tools

47 Salford Joint Strategic Needs Assessment, Health and Wellbeing Overview, A Comparative Report of Public Health Outcomes, ibid.

Table 4: Progress on indicators of health and wellbeing

	Indicator	Rate of improvement of the indicator over the timeframe selected is: (based on percentage change)			
		Better than England	Better than North West	Better than Greater Manchester	Better than GM statistical neighbours
Indicators performing better than England averages	Excess winter deaths (all ages)	Yes	Yes	Yes	Yes
	Excess winter deaths (85+)	Yes	Yes	Yes	Yes
	Population vaccination coverage MMR two doses *	N/A	N/A	N/A	N/A
	Successful completion of treatment opiate users	Yes	Yes	Yes	Yes
	Successful completion of treatment non opiate users	Yes	Yes	Yes	Yes
	People presenting with late stage HIV	Yes	Yes	Yes	Yes
	Low birth weight	Yes	-	Yes	-
	Cumulative percentage of the eligible population offered and received an NHS health check	Yes	-	-	-
	Infant mortality, deaths aged under 1 yr	Yes	Yes	Yes	Yes
Indicators that are improving but are worse than England overall	Children in poverty (age under 16)	No	Yes	No	
	Mortality from cardio vascular diseases considered preventable – aged under 75	No	No	-	Yes
	Mortality to cancer considered preventable	Yes	Yes	-	-
	Mortality to liver disease considered preventable	Yes	Yes	-	-
	Mortality to respiratory disease considered preventable	No	No	-	-
	Mortality to communicable diseases	No	Yes	-	-

	Indicator	Rate of improvement of the indicator over the timeframe selected is: (based on percentage change)			
		Better than England	Better than North West	Better than Greater Manchester	Better than GM statistical neighbours
	Life expectancy at birth (males)	Same	Same	-	-
	Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-14)	Yes	Yes	Yes	Yes
	Chlamydia detection rate **	N/A	N/A	N/A	N/A
	Smoking at time of delivery	Yes	Yes	Yes	Yes
	Smoking prevalence (survey data)	Yes	Yes	-	-
	Smoking prevalence routine and manual (survey data)	Yes	No	-	-
	Excess weight in 4-5 year olds	Yes	Yes	Yes	Yes
	Hospital admissions due to falls in persons aged 65-79	Yes	No	-	-
	Physical activity - active adults (survey data)	Yes	Yes	-	-
	Conceptions to under 18s	Yes	Yes	Yes	-
	Conceptions to under 16s	No	No	No	-
	Emergency admissions for intentional self-harm (all ages, Persons)	Yes	Yes	Yes	-
Indicators that are not improving/ declining and are worse than England overall	Life expectancy (females)	Yes	Yes	-	-
	Utilisation of outside space	Yes	Yes	-	-
	Breastfeeding at initiation	Yes	Yes	Yes	Yes
	Emergency readmissions within 30 days	No	No	-	-

	Indicator	Rate of improvement of the indicator over the timeframe selected is: (based on percentage change)			
		Better than England	Better than North West	Better than Greater Manchester	Better than GM statistical neighbours
	Excess weight in children aged 10/11	No	No	No	No
	Alcohol related admissions (narrow definition)	Yes	Yes	-	-
	Hospital admissions due to falls in persons aged over 65	Yes	Yes	-	-
	Hospital admissions due to falls in persons aged over 80	Yes	Yes	-	-

*= unable to calculate

** = Marked as N/A as Salford is not able to improve at a similar rate as other areas as the baseline is too high from 2010/11

Key		Number of indicators
	Rate of improvement better than England (or worsening less)	21
	Rate of improvement better than North West (but not England)	2
	Rate of improvement worse than England and North West	9
	Same or undetermined or NA	3

Source: Data from the Public Health Outcomes Framework benchmarking tool, Salford Joint Strategic Needs Assessment, Health and Wellbeing Overview, A Comparative Report of Public Health Outcomes, June 2015[48]

48 www.salford.gov.uk/d/Health_and_wellbeing_comparative_performance_June_2015.pdf

4.2 INDICATORS OF COORDINATION AND INTEGRATION OF HEALTH AND SOCIAL CARE

- As indicated in table 5, Salford performs in line with or better than England on delayed transfers of care, reflecting management of movement of people from hospital. This is because of the initiatives to manage care pathways through the emergency care system, intermediate and community care[49] (see below). Salford is lower than the England average and within the group of top performing acute trusts in England with regards to emergency admissions within 14 days of discharge from hospital. However, the percentage[50] of emergency admissions occurring within 30 days of discharge is slightly higher in **Salford (12.8%)** compared to **England (11.8%),** with the England range 7.9%-14.5%. This rate is deteriorating over time, although at a slower rate than the England average.[51]

Table 5: Delayed transfers of care, Salford and England

	Time period	Salford	England	Compared to England
Rate per 100,000 of total delayed transfers of care aged 18+	2013/14	8.0	9.6	Similar
Rate per 100,000 of delayed transfers of care attributable to adult social care aged 18+	2013/14	0.5	3.1	Significantly better

Source: Public Health England Adult Social Care Fingertips tool

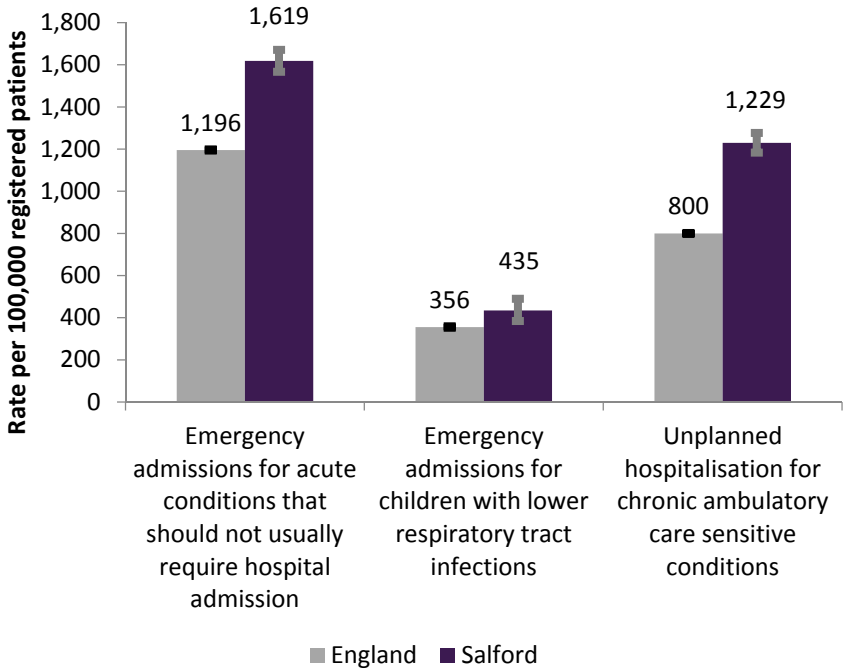
- Salford has a higher rate of emergency unplanned admissions and unplanned hospitalisation than the overall England rate, for long-term conditions that should not usually require hospitalisation and can be effectively managed in the community, such as, diabetes, epilepsy and high blood pressure.

49 NHSE

50 2011/12 data from the HSCIC Indicator Portal

51 Data from the Public Health Outcomes Framework benchmarking tool, Salford Joint Strategic Needs Assessment, Health and Wellbeing Overview, A Comparative Report of Public Health Outcomes, June 2015, www.salford.gov.uk/d/Health_and_wellbeing_comparative_performance_June_2015.pdf

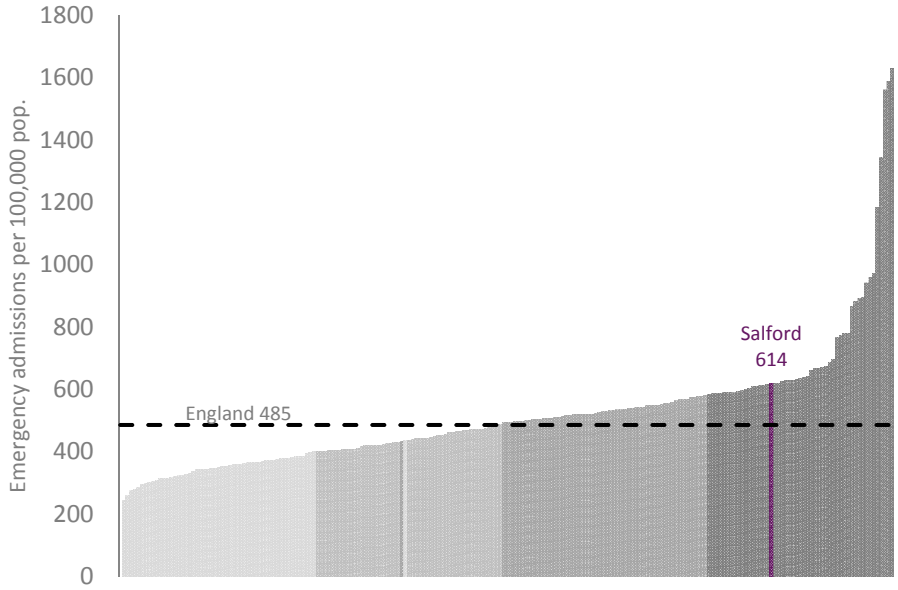
Figure 4: Rate per 100,000 registered patients who have an emergency admission/unplanned hospitalisation for a condition which would not usually require it, Salford and England, 2013/14



Source: Health and Social Care Information Centre NHS Outcomes Framework Indicator Portal

- Figure 4 shows the rate of admission for 19 ambulatory care sensitive conditions per 100,000 population. These conditions have been identified as ones where community care can avoid the need for hospitalisation. In general, the lower the rate of emergency admissions for these conditions the better - both for patients and the NHS. In quarter 4 2014/15 Salford's rate was 614 emergency admissions per 100,000 population, whereas the overall England rate was much lower at 485 emergency admissions per 100,000 population.

Figure 5: Directly standardised rate of emergency admissions by CCG, Q4 2014/15



Source: NHS Better Care, Better Value Indicators

- There are many sources of high hospital admissions in Salford. In 2013/14 admissions for intentional self-harm (all ages) was worse in Salford (390.7) than England (203.19), and increased by 5.3% from 2012/13, although at a slower rate than England change (8.1%). Alcohol related admissions in Salford have remained significantly higher

than England (967.9 per 100,000 in 2012/13 compared to 636.9) and has shown an overall increase from 2008/09, and the deterioration is greater than England overall (6.7% increase in Salford and 3.5% change in England). The rate of falls in people over 65 has increased from 3,137.2 per 100,000 in 2010/11 to 3,316 per 100,000 in 2013/14. The rate has remained significantly higher than England over the same time period and Salford is the second highest (worst) in the country for this indicator.[52] Rates of emergency admission and hospital admission for those with a mental health need are also a contributor (see section 7 for data with people with mental health needs).

Table 6: Hospital admissions for alcohol specific conditions, Salford and England, 2011/12 and 2013/14

	Time period	Salford	England	Compared to England
Rate per 100,000 hospital admissions for alcohol specific conditions in Salford	2013/14	1,074	374	Significantly worse
Rate per 100,000 hospital admissions for alcohol specific conditions under 18 in Salford	2011/12 to 2013/14	87.3	40.1	Significantly worse

Source: PHE Alcohol Profiles

4.3 ACCESS

This report does not provide a comprehensive account of access to care in Salford, compared to other areas. In some areas, Salford provides good access to care and acts to address access issues. Some examples of this are included below. 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 are seeking to address this in part through integrating health and social care, moving care into the community, harnessing community assets and enabling community and individual resilience.

52 Data from the Public Health Outcomes Framework benchmarking tool, Salford Joint Strategic Needs Assessment, Health and Wellbeing Overview, A Comparative Report of Public Health Outcomes, June 2015, www.salford.gov.uk/d/Health_and_wellbeing_comparative_performance_June_2015.pdf

ALCOHOL AND DRUG TREATMENT

Short waiting times are important to help people recover from dependencies. Data from 2013/14 the National Drug Treatment Monitoring System indicate that Salford had a much higher proportion of the patients having to wait longer to commence treatment for dependencies than the England average, of particular concern given the rates of alcohol-related hospital stays in Salford. This occurred as a consequence of a restructure of treatment services, which integrated drug and alcohol treatment. The process of restructuring had the consequence of increasing the reported waiting times for alcohol clients. The 2014/15 data for waiting times for treatment show Salford is now performing better than England on waiting times for alcohol treatment. Salford performs as well or better than England in successful completion of substance misuse treatments.

Table 7: Measures of health improvement, Salford and England, 2013/14

Measures of health improvement	Time period	Salford	England	Compared to England
Successful completion of drug treatment, opiate users (% of adults in treatment)	2013	10.7%	7.8%	Significantly better
Successful completion of drug treatment non opiate users (% of adults in treatment)	2013	39.3%	37.7%	Similar
Successful completion of alcohol treatment (% of adults in treatment)	2013	65.6%	42.5%	Significantly higher

Source: PHE Public Health Outcomes Framework Fingertips tool and PHE Alcohol Profiles

GP APPOINTMENTS

In terms of access to primary care, Salford is performing in line with the England average, as assessed by patients' responses to the GP survey. Salford performs considerably better than England on patient experiences of GP out-of-hours services. 74.7% of patients described these services as 'very good' or 'fairly good' compared to 66.2% for England.[53] However, access to GP appointments emerged as a concern for local people, stakeholders we interviewed, and patients. This

53 GP Patient Survey, Salford and England, 2013-14, Health and Social Care Information Centre NHS Outcomes Framework Indicator Portal

included the time it took to get an appointment and the time of day when appointments were available, with particular challenges for people who are working. CQC inspection reports showed evidence of both good and poor access to primary care for people in Salford and for different patient groups.[54] Although performing in line with England, Salford is taking action to address this concern, with Healthwatch running a consultation on the issue of GP appointments and Salford seeking to address the lack of capacity in primary care.

Table 8: Access to GP services, responses from the GP survey 2013/14, Salford and England

Access to GPs	Time period	Salford	England
% who would recommend practice	2013/14	78.6%	78.7%
% satisfied with phone access	2013/14	77.4%	75.5%
% satisfied with opening hours	2013/14	79.4%	76.9%
% who saw/spoke to nurse or GP same or next day	2013/14	52.1%	50.7%
% reporting good overall experience of making appointment	2013/14	75.4%	74.6%
% who know how to contact an out-of-hours GP service	2013/14	51.6%	55.8%

Source: Public Health England GP Profiles using the GP Patient Survey Results

COMMUNITY OCCUPATIONAL THERAPY AND CARE ACT ASSESSMENTS

The problem raised most repeatedly in interviews with stakeholders and in the evidence from patients related to obtaining community occupational therapy assessments, which then delayed modification to homes and ability of people to stay well and safe in their homes. Salford identified community occupational therapy is involved in multiple care pathways and has 'test to change' projects underway to address this issue.

The other common concern was the implementation of Care Act 2014 provisions since April 2015, including delays obtaining

54 Care Quality Commission, Qualitative analysis of CQC inspection reports, Salford, 15 October 2015. Twenty-one Adult Social Care provider reports for providers rated inadequate, requires improvement and outstanding were included (those obtaining a rating of good were not analysed). Analysis looked only at the key questions 'safe, effective and response'.

assessments under Care Act, confusion regarding the relationship between Mental Health Act and Care Act assessments and delays in carers' assessments. Salford has commissioned Mind to run advocacy services for the Care Act.

DISCHARGE AND TRAVEL FOR SPECIALIST SERVICES

There were issues with support post discharge from SRFT, primarily with information not received or sent and the need for the team undertaking follow-up to chase discharge information.

Concerns were raised regarding problems with discharge communication and support for specialist services discharging out of area, both into Salford and from Salford into other areas. Some of this related to the process of reconfiguring of services across hospitals in Greater Manchester.

In Salford people had raised the issue of travel for specialist services out of area, in the context of reconfiguration of specialist services in Greater Manchester. People recognised the necessity for travel for specialist services, but want support in planning routes and information on how to get there cheaply. This is an area were people tend not to have cars, and taxis are expensive.

5. Older people

This section provides evidence on health and wellbeing outcomes, access and coordination and integration of care for older people in Salford.

This is a group which experiences many different health conditions and use many different services. The majority of older people we spoke to in our case studies experienced multiple health difficulties (e.g., diabetes, cardiovascular disease, cancer, mental ill-health, physical disability, infection, stroke, frailty). In our online consultation with older people and their carers, people identified a variety of different health and social care services that they regularly used in Salford. By far the most frequently accessed service was the GP, with Dentists and hospitals also regularly attended. Other services referred to were community mental health teams, health centre nurses, domiciliary care agencies, care homes and the podiatry service.

5.1 INTEGRATED CARE PROGRAMME FOR OLDER PEOPLE

Salford has begun to reconfigure care for older people, as high uses of health and social care with multiple needs, and to improve experience and outcomes from care for this group.

“The vision is for a radically changed health and social care system, where older people are enabled to retain their independence and take a much more active role in their own care. The plan is for GPs, community and social care staff, working with communities and third sector providers, to deliver care in an increasingly integrated way, with single needs assessments and rapid and effective joint responses. More care is to be delivered in a community setting, largely in people's homes, with a corresponding reduction in unplanned demand for hospital care and expensive packages of social care.”[55]

The population has been stratified according to need, personified in the figure of ‘Sally Ford’ and her family and friends. The implementation of the first phase of the new model of care was completed in 2015, with plans extending over five years. The first phase includes:

- Multidisciplinary Groups in neighbourhoods, providing targeted support to people who are most at risk and have a population focus on screening, primary prevention and signposting to community support.
- Centre of Contact which acts as a central health and social care hub, supporting MultiDisciplinary Groups (MDGs) and

55 Locality plan

helping people to navigate services and support mechanisms and coordinating telecare monitoring.

- Linking people with local community assets enabling people to remain independent, with greater confidence to manage their own care.

There are also initiatives to improve end of life care, including supporting older people and their families to plan for end of life and for all care plans to include plans for end of life. There is a major initiative across the city to enable people with dementia to 'live well', which is discussed in the section on mental health).

A set of outcomes has been developed for the ICP. These include:

- reducing emergency admission and readmissions
- reducing permanent admissions to residential and nursing care
- increase in the proportion of older people that are able to die in their preferred place
- increase in the proportion of people that feel supported to manage their own condition
- increase in quality of life for users and carers
- increase satisfaction with the care and support provided
- increase flu vaccine uptake.

5.2 OUTCOMES

- Health related quality of life for older people is significantly worse in Salford than overall in England. This indicator is derived from the GP Patient's Survey, which asks people to describe their mobility, self-care, usual activities, pain/discomfort/anxiety/depression. The range of scores in England is 0.64-0.79, the higher the score, the better the quality of life.[56]
- Suffering from a hip fracture is a debilitating condition as only one in three sufferers return to their former levels of independence and one in three ends up leaving their own home and moving to long-term care.[57] Salford's rate of hip fractures per 100,000 population is significantly worse than the England rate.[58]
- The rate of hospital admissions due to falls in persons aged 65-79 begun to increase from 2012/13. There is still a fall of almost 5% over the period, which is a greater percentage change than in England but the rate has remained significantly higher than England and the North West. Salford is second highest (worst) in the country for this indicator. The rate of hospital admissions due to falls in persons aged over 80 has shown an increase which follows

56 2012/13, PHE Public Health Outcomes Framework Fingertips tool

57 National Institute for Health and Clinical Excellence (2015), Quality standard for hip fracture. Available at: www.nice.org.uk/guidance/QS16/chapter/introduction-and-overview

58 2013/14, Public Health Outcomes Framework Fingertips tool

the pattern in England. The rate has increased to 8211 per 100,000 in 2013/14; this is a 12.8% rise over the time frame. The rate has remained significantly higher than England and Salford is second highest (worst) in the country for this indicator.[59]

- Excess winter deaths can result from health inequalities or a lack of appropriate health promotion or emergency planning. Excess winter deaths for those over 85 are not statistically different from the England average.[60]

- Research suggests where possible people prefer to stay in their own home rather than move into residential care.[61] Permanent admissions to care are significantly higher in Salford than the England average.[62]

59 Data from the Public Health Outcomes Framework benchmarking tool, Salford Joint Strategic Needs Assessment, Health and Wellbeing Overview, A Comparative Report of Public Health Outcomes, June 2015, www.salford.gov.uk/d/Health_and_wellbeing_comparative_performance_June_2015.pdf

60 Public Health Outcomes Framework Fingertips tool

61 About the facts you see on NHS Choices, www.nhs.uk/Scorecard/Pages/IndicatorFacts.aspx?MetricId=8068

62 2013/14, PHE Public Health Outcomes Framework Fingertips tool

Table 9: Outcomes for older people, Salford and England

Outcomes for older people	Time period	Salford	England	Compared to England
Excess Winter Deaths Index (1 year, ages 85+) (Persons)	August 2012-July 2013	12.0	28.2	Similar
Excess Winter Deaths Index (3 years, ages 85+) (Persons)	August 2010-July 2013	15.5	24.1	Similar
Health related quality of life for older people (survey score)	2012/13	0.686	0.726	Significantly worse
Rate per 100,000 hip fractures in people aged 65 and over (Persons)	2013/14	770	580	Significantly worse
Rate per 100,000 hip fractures in people aged 65 and over - aged 65-79 (Persons)	2013/14	368	240	Significantly worse
Rate per 100,000 hip fractures in people aged 65 and over - aged 80+ (Persons)	2013/14	1,938	1,566	Significantly worse
Permanent admissions to residential and nursing care homes, per 100,000 population aged 65+	2013/14	888	651	Significantly worse

Source: PHE Public Health Outcomes Framework Fingertips tool

5.3 EXPERIENCE OF PERSON CENTRED COORDINATED CARE

Based on the case studies with older people and online consultation with older people and their carers, it appears that older people's experiences of person centred coordinated care is genuinely mixed. Importantly, where people indicated services were joined up and communicated well, they tended to describe a higher quality experience of care. However, when people were asked about how well services worked together, they tended to respond by taking about the quality of care from individual services. Patients still seem to think of and experience their care as interactions with lots of separate professionals and services, with some experiences of these good and some less good.

GOOD AND POORER EXPERIENCES OF SERVICES

Overall, the older people we interviewed seemed happy with the treatment they received and believed that their health and social care needs were largely being met. There were many examples of patients commending professionals and the area for the care they were provided. However, good and bad experiences of care were reported across all of the different services people had used. In the online consultation, no one service type had a higher level of dissatisfaction, with people reporting issues with the care they received across services. In the case studies, most of the older people made reference to at least one or two negative experiences with individual professionals or services.

INVOLVEMENT IN CARE

Generally, older people seemed to feel involved in the decisions about their care and that their carers' views were also included.

"Yes I was involved and happy with the plan." (Older person, responding about their own experiences - online consultation)

In the online consultation, the majority of people who responded on the issue of care plans were carers. The majority of carers felt they had been actively involved and kept informed.

"[I was] fully involved in the care planning and decision making process for my relative to ensure the best care was given." (Carer responding on behalf of an older person, online consultation)

However, there were also instances where older people were not aware of their care plan. Some carers felt limited in how much influence they could have regarding the care of their relative. There were a few exceptions, where carers said they were not involved at all.

"When looking after my mother in law we were hampered by bureaucracy and red tape all the way. The help was too slow. We met many people who visited her home but most visits were to fulfil paperwork expectations. I feel that without our interventions she would have suffered more." (Carer responding about their own experiences, and those of an older person they care for, online consultation)

"I do not think I have been involved in all treatment at all… I am completely in the dark with regards to her physical condition and medication." (Carer responding on behalf of an older person, online consultation)

The vast majority of respondents had never tried to access personal information or medical records about themselves or the person they care for. In the online consultation, of the few who had tried to access their records, only one had been successful. Those who had not been able to access patient information reported that this information is not readily available to them. Some indicated they understood they knew how to access their records, and a few respondents stated they had never tried to formally access their records but that they felt informed.

MOVING BETWEEN SERVICES

In both the online consultation and case studies, where respondents discussed moving between services, almost equal numbers of people reported a positive experience as those who reported a negative or mixed experience. It seems that moving between services is an area where there is a mixed experience depending on the services people are accessing. Experiences with hospital admissions and discharge were discussed, also with both positive and negative experiences.

"It all seems well joined up to me." (An older person on their care, online consultation)

"He gave the GP surgery 50 out of 100. He had been promised a phone call back by the GP, but he never received it and

described his GP as 'elusive'. The social workers were variable, sometimes efficient, sometimes not. He has adaptations to his house but it took many, many phone calls before the job got done. The hospital was good but his medication was missing on discharge." (Interviewer reporting on older person who was talking about his care - case study.)

INFORMATION SHARING

In both online consultation and case studies, effective information sharing seem to be key to people experiencing well-managed joined up care, and this seemed to contribute to people feeling the quality of care was good. People described situations where care plans were known by practitioners and delivered as agreed and that information was shared across services.

The following is an example of a positive experience. The gentleman had a long-term condition and approached his GP, where he got the necessary referral to Salford Royal. He described his experience with both the hospital and GP as *"always positive".* Both he and his GP received a copy of any letters regarding his assessments and appointments. He appreciated this communication and it was a practice not automatically carried out by other hospitals he had attended outside of the Salford area. He thought that communication systems are working well and that information was shared. He said, *"I don't have to explain I am deaf each time which is very helpful."* He also reported feeling well informed and involved in decisions about his care. (65-year old man responding about his own experiences, online consultation with older people)

Where the experience was negative or mixed, a clear theme to emerge was that people did not think information was effectively shared between services. This was the case in both case studies and the online consultation. Respondents described situations where they had to repeatedly give the same information, were asked the same questions and felt responsible for making sure their information was passed on. There was an expectation amongst some respondents that as most things are computerised this would be more automatic. Sharing of information and coordination between hospitals as well as between hospital and social or community care was important for people.

"I think that all of the teams could speak to each other clearly." (Carer responding about their own experiences, and those of an older person they care for)

"She has two separate lots of records in her home, one for carers and one for district nurses. She feels 'people in charge don't communicate well'. For example, the doctor wanted her to have a cream applied and the carer wouldn't do it as they hadn't been told to do it." (Interviewer reporting on older person talking about her care - case study.)

One respondent felt her daughter had to repeatedly give the history of her illness and hospital visits and that there was *"no link up between hospitals".* The daughter also felt information was not shared locally either. *"We have to give all her info every time we see anyone. Mum has a dossette for her tablets, we give this info to the ambulance, then the nurse then the*

doctor asks for it too." (Experiences of an older woman and her daughter)

RESPONSIBILITY FOR COORDINATION

For some, it was not clear who was responsible for co-ordinating care, with one carer in the online consultation remarking, *"nothing is joined up".* There were examples of people having to deal with many different staff e.g., community health staff and social workers, with impact on the continuity of care.

"It's a bit confusing for patients due to the number of therapists with similar roles involved in care and making decisions." (Older person talking about their care, case study)

The following case study illustrates difficult experiences with coordination, information sharing and care planning. The respondents described not feeling sufficiently informed or involved and that the mother was discharged from hospital with insufficient information*. "I do not feel that they explain the condition clearly and have been left to [go] home with my mother feeling very concerned that myself and her family will not be able to look after her properly."* As well as concerns with the hospital discharge the carer described a situation where their mother's services stopped upon admission to hospital, and that it could take up to six weeks to get them up and running again when she returned home. Then services were often provided by different people, affecting the continuity of care she received. Whilst the carer and her mother were involved in the care plan they described having to be *"very strong in your opinion"* to get what they needed. It was felt that services need to speak to each other more and that they often had to give the same information more than once to different people involved in her mother's care. (Carer responding on behalf of their elderly mother)

GENERAL PRACTICE

A caring and supportive service from their GP seemed to be key to people having a good experience, and GPs seemed to have a key role in helping people 'through the system'.

"I feel all my health care needs are met effectively by my GP and hospital consultants." (Older person, responding about their own experiences.)

"The patient felt well looked after at her doctor's surgery, had great confidence in her GP and valued their long term relationship. He, and the optician, had intervened very quickly with a health problem. She liked her time on Barton Brook having initially been nervous about going there. The staff were a cheerful, happy, close team and worked well together. This nice atmosphere rubbed off onto patients. Her carers were 'mostly good'. She commented, 'Coordination between parts is mostly good. Salford is a good city to live in - please give it credit." (Older person case study)

5.4 ACCESS

Many of the concerns regarding access for older people were the same as those for local people in general, although there were also some specific concerns.

- In the online consultation and case studies we were told about some problems with discharge practices from hospitals (in and out of area) and being able to access their GP.
- In the case studies and interviews with third sector organisations, concerns were raised about aspects of getting care into older people's homes, in order for them to stay well and at home.
- As with other groups, there was evidence of delays in community occupational therapy. The consequence of these problems was people not obtaining the OT, modifications or the care needed to enable them to stay in their homes. Delays in obtaining an OT appointment could also cause delays in discharge from hospital. Salford is acting to address this problem.
- Third sector organisations told us about problems with obtaining assessments under the Care Act. They also told us that elderly people could dislike the assessment process, resulting in them leaving the assessment. We were also told that Salford was aware of this and acting to change this. Where older people have requested assessment, intermediate home care is a given over a period with four visits a day. We were told elderly people tended to dislike this because it is intrusive, *'someone coming in to look at how things are done'* (third sector representative).
- Service user representatives and third sector organisations raised general concerns with getting care into older people's homes, including agencies not providing regular carers, 'task and time' care and *'cutting care all the time, from 20 hours to five, with 15 minute drop-ins, it doesn't work'.* Salford is implementing a model of 'just enough care', which is seeking to promote self-care, independence and harness community assets.
- In the case studies and online consultation, the podiatry service came up as an area older people found difficult to access. In the online consultation, some older people reported services which were no longer available to them, such as reduced services offered by the Stroke Association.

5.5 INDICATORS OF COORDINATION AND INTEGRATION OF HEALTH AND SOCIAL CARE

TREATMENT AND CARE IN PRIMARY MEDICAL SERVICES AND THE COMMUNITY

- The indicators below have been selected to show how well older people are being cared for and treated in primary care and in the community. Salford performs similarly to the national average on these indicators, as well as to the North West as a whole and as well as statistically similar HWBs.
- There has been significant improvement in the use of self-directed payments in adult social care (between 2012/13 47.0; 2013/14 50.2).
- As urinary tract infections (UTIs) are easily prevented and treatable outside of the hospital setting, they should represent a small fraction of non-elective admissions. Regular reviews of care plans for people diagnosed with dementia are essential to ensure physical, mental, social

and other needs of the patient are met by all services, working together, as opposed to just treating health related incidents. Personalisation is priority in social care. Research has indicated that personal budgets have a positive effect on wellbeing, increased choice and control, cost implications and improving outcomes.[63] The percentage of self-directed payments shows the extent to which the area is enabling patients to take more control over their care through a more personalised care plan and direct payments are the purest form of personalisation.

Table 10: Indicators of treatment and care in primary medical services and community, 2013/14

	Salford	National	National comparison
The percentage of the population that had avoidable emergency admissions for UTIs out of the total admissions ages 75+	2.2	1.7	Similar to average
The percentage of patients diagnosed with dementia whose care has been reviewed in a face-to-face review in the preceding 12 months, all ages	80.4	77.9	Similar to average
The percentage who receive self-directed support out of the total population of people receiving community based services, ages 65+	50.2	63.9	Similar to average
The percentage receiving direct payments out of the total population of people receiving community based services, ages 65+	4.7	9.2	Similar to average

Source: Integrated Care for Older People (using Hospital Episode Statistics, QOF and ASCOF publication December 2014)

ADMISSIONS AND HOSPITAL USE

- Emergency admissions and readmissions to hospital in Salford for older people are much worse than national average, worse than North West region and Salford is the poorest performer when compared to statistically similar HWBs.
- In addition, there has been significant deterioration in A&E attendances and discharged patients with emergency readmissions.
- Emergency admissions and readmissions can be an indicator of unmet need and inequalities, as well as of problems in primary or preventative provisions or integration and communication of services for appropriate treatment and management of conditions.

63 References; Vision for adult social care and Think Local, Act Personal

Table 11: Admission and hospital use in older people, 2013/14

	Salford	National	National comparison
The percentage of the population that had A&E attendances, ages 75+	68.8	46.9	Much worse than average
The percentage of the population that had emergency admissions with an overnight stay, ages 75+	24.1	19.5	Much worse than average
The percentage of all discharged patients that have emergency readmissions, ages 75+	12.9	9.5	Worse than average
The percentage of the population that had multiple emergency admissions per year, ages 75+	3.4	2.1	Much worse than average

Source: Integrated Care for Older People (using Hospital Episode Statistics)

Table 12: Changes in admission and hospital use in older people

	2012-13 %	2013-14 %	Change over time
The percentage of the population that had A&E attendances, ages 75+	67.1	68.8	Significant deterioration
The percentage of the population that had emergency admissions with an overnight stay, ages 75+	24.4	24.1	No significant change
The percentage of all discharged patients that have emergency readmissions, ages 75+	12.1	12.9	Significant deterioration
The percentage of the population that had multiple emergency admissions per year, ages 75+	3.0	3.4	No significant change

Source: Integrated Care for Older People (using Hospital Episode Statistics)

DISCHARGE, RECOVERY AND RETURN TO NORMAL PLACE OF RESIDENCE

- The following indicators have been selected to show how well the area is performing in communication between acute, community and adult social care services and preparing for an older person's discharge and rehabilitation

needs following a time in hospital, and reducing the risk of the patient being readmitted to hospital.

- Salford performs at a similar level to the national average on number of delayed transfers of care per 100,000 resident population, ages 18+ (Salford: 7.8; England: 8.9)[64]
- 2014-15 data[65] 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%. Therefore, 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.

END OF LIFE CARE

- These indicators are of effective planning and care for older people at the end of life.
- In Salford, the extent people are able to die at home is similar to the national average.
- However, Salford is much worse than average in emergency admissions in the last 100 days of life, and there has been no significant change in this indicator over time.

Table 13: Indicators of end of life care, 2013/14

	Salford	National	National comparison
The percentage of all deaths which occur at usual place of residence out of the total number of deaths, ages 75+	37.4	44.0	Similar to average
The percentage of patients admitted to hospital (emergency admissions) in last 100 days of life out of the total population, ages 75+	6.2	4.8	Much worse than average

Source: Integrated Care for Older People (using data requested from PHE and Hospital Episode Statistics)

64 Integrated Care for Older People (using ASCOF publication December 2014)

65 HSCIC Adult Social Care Outcomes

6. People with mental health needs

This section looks at care for people with mental health needs, including those experiencing common mental health problems and severe and enduring mental health conditions.

6.1 STRATEGY AND PLANS

Strategies for mental health and wellbeing[66], the Health and Wellbeing Strategy and Locality Plan evidence a holistic understanding of mental health and wellbeing, taking into account the relationships between work, family, community, deprivation, physical and mental health and wellbeing. The vision of the Locality Plan is 'that citizens will achieve and maintain a sense of wellbeing, feeling they are valued and have a purpose in society'. The plan includes harnessing individual and community assets to promote mental wellbeing, objectives for mental health in each phase of the 'life-course', and the aim that 'all residents of the city will have access to high quality, compassionate world-class mental health services'. In addition, Salford's plan is part of wider Greater Manchester's mental health strategy and initiatives regarding mental health and crisis and employment.

INTEGRATION AND INNOVATION

Mental health support and services are within the integrated care being developed for the different age groups, so mental health care for adults will be within the ICO. The initial focus has been addressing the mental health needs of older people, within the integrated care programme for this group. This includes:

- Older Adults Community Mental Health Teams (CMHTs) which provide support seven days a week offering up to three visits per day, to prevent the need for admission, support early discharge and promote care at home.
- Mental health professionals participate in the integrated multi-disciplinary group's for older adults, with other agencies.
- Significant capital investment in the older adults inpatient and outpatient hospital facility, creating a centre of excellence for older adult care and a 'dementia friendly' environment.

66 Emotional Health and Wellbeing Strategy for Children and Young People in Salford 2013-2015; Salford Mental Wellbeing Strategy 2011-2015.

There is a major initiative to enable people with dementia to 'live well' and for Salford to become a 'dementia friendly city'. This is led through Salford's Dementia Action Alliance, including a wide range of statutory, provider, community and voluntary and private sector organisations.[67] An aim of this is addressing the very high rates of admission for people with dementia to acute wards. It included changes in commissioning, specifying what is required from providers regarding dementia; putting in place key workers to help people navigate support after diagnosis; addressing inefficiencies in the way services are coordinated and delivered; and connecting people into communities and addressing social isolation.

Improvements to dementia care were mentioned very frequently and very positively by providers, third sector and service user representatives. They mentioned various aspects of this comprehensive programme, including: activities that care homes can access for people with dementia, such as 'singing for the brain'; older age psychiatry, initiatives with IAPT to develop communication and other skills for those who care for people with dementia, including staff in care homes; and use of 'blue butterfly' badge and signs for those with dementia in SRFT.

"There has been improvement dementia care. That is where attention has focused." (Service user representative)

"Dementia services had a review. It's been a remarkable improvement." (Third sector organisation)

67 www.dementiaaction.org.uk

"For our clients the level of satisfaction with dementia support is good. The services are really quite good." (Third sector organisation)

Salford's memory assessment treatment service has achieved accreditation as excellent in the Memory Services National Accreditation Programme and was given an outstanding achievement award by the Royal College of Psychiatry. Salford's Memory Assessment and Treatment and Learning Disability services were shortlisted for innovation in dementia care at the National Dementia congress.

6.2 OUTCOMES

- Salford has a higher prevalence of mental health conditions than other parts of the UK. Around 36,500 adults and 6,000 children are estimated to have a mental wellbeing need, with need higher in more deprived areas.[68]
- Population level outcomes for people with mental health needs are mixed. The excess under 75 mortality rate per 100,000 adults with serious mental illness is higher in Salford than in England but the significance has not been calculated. The suicide rate in Salford is slightly higher but the difference is not significant. The rate of recovering from

68 Peck, C & Tocque, K (2010) Salford Mental Wellbeing Assessment, April; Greater Manchester Health and Social Care Devolution, Locality Plan for Salford
Our Vision for a Healthier Salford, DRAFT, 18 December 2015, www.healthwatchsalford.co.uk/sites/default/files/locality_plan_draft_2_-_submission_18_12_2015.pdf

psychological therapies is slightly lower in Salford, but the difference is not significant.

- In terms of measures of quality of life from those using adult social care, the proportion of adults in contact with secondary mental health services in employment is significantly lower than the England average. However, the proportion in settled accommodation is significantly higher than the England average.

Table 14: Outcomes for individuals in contact with mental health services, Salford and England

Outcomes for individuals in contact with mental health services	Time period	Salford	England	Compared to England
Excess under 75 mortality rate in adults with serious mental illness	2012/13	442.4	347.2	Not compared
Suicide rate per 100,000 (Persons)	2011-13	9.2	8.8	Similar
Rate of recovery from IAPT treatment (% recovering from treatment)	2012/13	43.8%	45.9%	Similar
Proportion of adults in contact with secondary mental health services in employment	2012/13	7.0%	8.8%	Significantly worse
Proportion of adults in contact with secondary mental health services who are in settled accommodation	2012/13	78.2%	58.5%	Significantly better

Source: PHE Public Health Outcomes Framework Fingertips tool/PHE community mental health Fingertips tool

Table 15: Adult Social Care User's Quality of Life, England and Salford

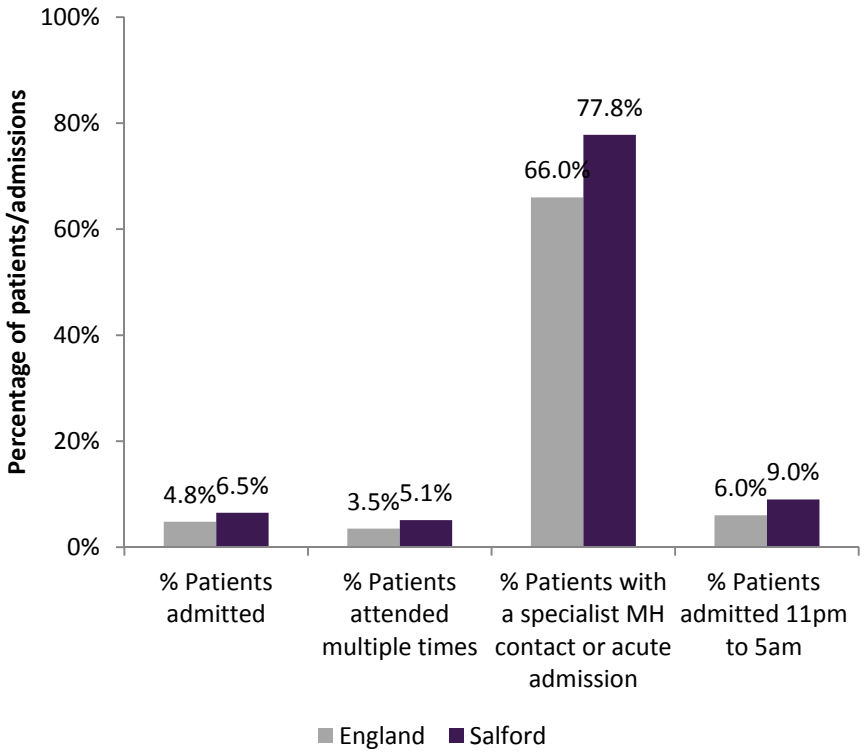
Measures of quality of life	Time period	Salford	England	Compared to England

Source: Public Health England Adult Social Care Fingertips tool

6.3 INDICATORS OF COORDINATION AND INTEGRATION

- Salford has higher usage of A&E and acute hospital admissions for people with mental health conditions than England, across all indicators. As shown in figure 6, the proportion of patients admitted to an acute hospital via A&E for a mental health condition is statistically higher than expected in Salford. Further, the proportion of patients in Salford admitted for a mental health condition who had attended A&E multiple times in the preceding 5 years is also statistically higher than expected. The proportion of patients with a specialist mental health contact attending A&E multiple times is also statistically higher than expected in Salford.
- The proportion of patients admitted between 11pm-5am is statistically higher than expected in Salford.
- Emergency readmissions within 30 days of discharge are also significantly higher in Salford than in England.

Figure 6: Admissions to A&E for mental Health conditions, Salford and England, 2012-13



Source: Mental Health Crisis Review, HES and MHMDS linked data

Table 16: Hospital readmissions, Salford and England

Hospital re-admissions	Time period	Salford	England	Compared to England
% of emergency admissions via A&E for a MH condition (for patients with a history of previous MH contact) that returned to A&E within 30 days (for any reason)	2012/13	29.4%	25.0%	Higher than expected
% of emergency admissions via A&E for a MH condition (for patients with NO history of previous MH contact) that returned to A&E within 30 days (for any reason)	2012/13	16.2%	13.5%	Higher than expected

Source: CQC Mental Health Crisis Review using HES and MHMDS

- The tables below show which specific mental health conditions have higher than expected emergency and acute hospital admissions compared to England. There are more hospital admissions for young people with mental health conditions and self-harm than the England average. Admissions for schizophrenia are in line with what is expected, appearing to support that there is generally good care for people with this diagnosis. However, admissions for organic forms of dementia and mental health conditions related to alcohol misuse are significantly higher than expected.

Table 17: Indicators of unmet need, Salford and England

Indicators of unmet need	Time period	Salford	England	Compared to England
Rate per 100,000 hospital admissions for unipolar depressive disorders per 100,000 aged 15 and over	2009/10-2011/12	46.9	32.1	Significantly higher
Rate per 100,000 emergency admissions for neuroses	2011/12	29.5	16.8	Significantly higher
Rate per 100,000 hospital admissions for mental health conditions, 0-17 year olds in Salford	2013/14	116.7	87.2	Significantly higher
Rate per 100,000 hospital admissions as a result of self-harm, 10-24 year olds in Salford	2010/11 to 2012/13	534.4	352.3	Significantly higher

Source: PHE Common Mental Health Disorders Profile

- In terms of emergency admissions and readmissions for older people with mental health problems, including for physical conditions, Salford performs much worse than national average, worse than the North West region and worse than statistically similar HWBs.

Table 18: Emergency admissions for older people with mental health problems, Salford and England

	Salford	National	National Comparison
The percentage of the population that had avoidable emergency admissions for UTIs out of the total admissions ages 75+, MH PATIENTS	0.92	0.58	Worse than average
The percentage of the population that had A&E Attendances, ages 75+, MH PATIENTS	19.79	10.64	Much worse than average
The percentage of the population that had emergency admissions with an overnight stay, ages 75+, MH PATIENTS	6.88	4.28	Much worse than average
The percentage of discharges that have emergency readmissions, ages 75+, MH PATIENTS	20.42	14.42	Much worse than average
The percentage of the population that have multiple emergency admissions per year, ages 75+, MH PATIENTS	1.17	0.53	Much worse than average
The percentage of patients admitted to hospital (emergency admissions) in last 100 days of life out of the total population, ages 75+, MH PATIENTS	2.00	1.25	Much worse than average

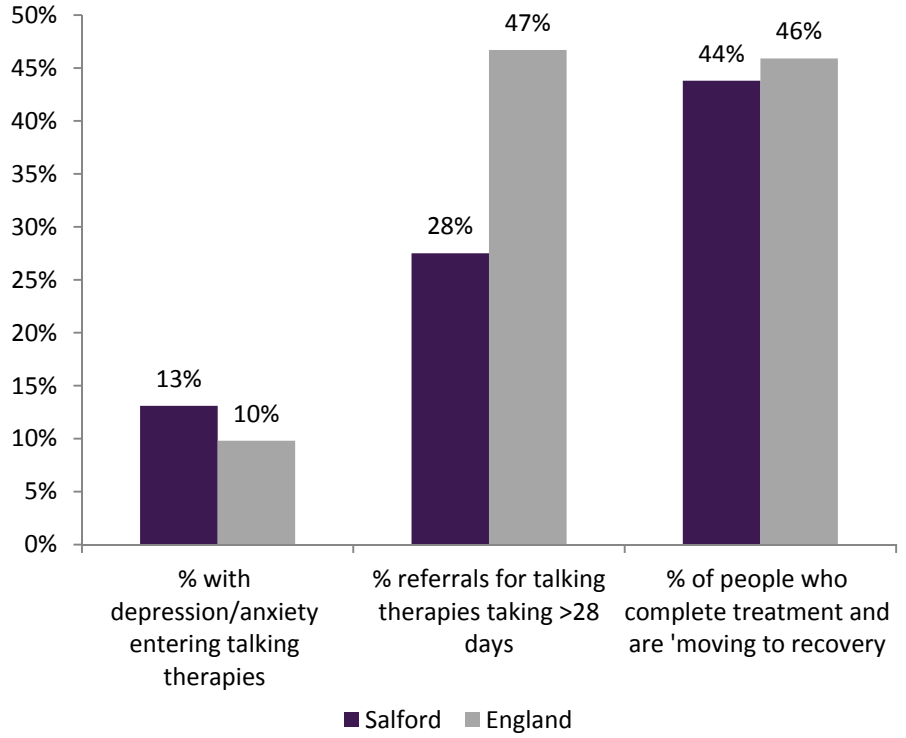
Source: Integrated Care for Older People (using Hospital Episode Statistics)

6.4 PEOPLE WITH MILD TO MODERATE MENTAL HEALTH NEEDS: IMPROVING ACCESS TO PYSCHOLOGICAL THERAPIES

The Improving Access to Psychological Therapies (IAPT) programme provides first-line treatment for people suffering from depression and anxiety disorders. Step 2 IAPT services in Salford are provided by Six Degrees, a social enterprise, and were well regarded by stakeholders, as 'innovative' and 'exemplar' IAPT services. GPs and third sector organisations commented that people tended to be happy with the help they received. GMW provides step 3 and 4 IAPT services.

Salford has a similar performance to the England average for the overall ratio of the number of people entering talking therapies to the estimated number of people with depression and/or anxiety disorders. Salford is also similar for the proportion of people who complete treatment and are 'moving to recovery'. The number of referrals for talking therapies that have waited more than 28 days from referral to treatment is lower in Salford, although this is statistically similar to the England average.

Figure 7: Access to psychological treatments, Salford and England, 2012-13



Source: CQC Mental Health Crisis Review using HSCIC Improving Access to Psychological Therapies (IAPT)

6.5 ACCESS AND UNMET NEED

The third sector, service user and primary care representatives we spoke to told us about difficulties with access and unmet need for the many people with lower level mental health needs in Salford, where they did not fit into a clear 'diagnostic category', had multiple needs, or were in need of something beyond IAPT. Here it was difficult to obtain an assessment, find a 'pathway' or the right kind of support. We were also told about some initiatives to address gaps in provision. The mental health and wellbeing needs assessment last completed in 2010 found good practice, but gaps and areas for Salford to strengthen, and these are similar to the concerns raised by stakeholders in our review. Our evidence suggests some of these difficulties may persist. This suggests it is important for Salford to assess progress in these areas and areas for focus through an updated needs assessment. This is important as Salford's consultation with local people indicates one of the priorities for people in Salford is 'mental health across the life course'.[69]

- We were told about people falling between services. This included where they had co-morbidities, people falling between learning disability and mental health services, treatment for substance misuse, transitions from children's to adult services and between mental health and physical health care.

"Lots of patients have drug and alcohol problems as well as mental health difficulties and they fall between two stools. Drug and alcohol services are not able to support them and if they are actively using drugs or alcohol the mental health team find it hard to deal with them." (GP representative)

- The point of assessments is to identify need and how it can be met. However, we were told it was difficult obtaining assessments and the right assessment for people with lower level needs. The result could be people disengaging or not getting the support they needed to avoid crisis. The experience was if there was a physical health need there was a single contact centre to use for help with a referral, but that this was not working well for mental health. We were told for people with low level mental health needs or multiple needs, GPs may not be clear how to respond; people may not obtain a care plan (CPA) with the community mental health team (CMHT), in which case they may qualify for an assessment under the Care Act; but there are problems with the implementation of this aspect of the Care Act at present.

"There is a big game of ping pong between community mental health and social work teams in obtaining assessments and services." (Third sector organisation)

"There was a young adult with mild learning disabilities and mental health problems who left children's services with no transition plan. Despite a suicide attempt and other presentations, the GP refused refer to mental services, as they felt the mental health problems were 'not enduring

69 Greater Manchester Health and Social Care Devolution, Locality Plan for Salford, ibid, p.21; HealthWatch Salford, www.healthwatchsalford.co.uk/projects

enough'. The CMHT refused to assess as there was no diagnosis. When they were finally assessed, they were found eligible and referred into IAPT. The person disengaged over the course of all that." (Third sector organisation)

- The view from representatives of GPs was that GPs struggle to know how and what to access for their patients experiencing mental health difficulties, especially for the majority of their patients who were experiencing low mood, frequently linked to circumstances such as financial difficulty and alcohol misuse, as opposed to psychiatric illness.

  "The work on dementia has been great. The rest of mental health services need a shake-up. Communication and navigation around system is difficult." (GP representative)

  "The way [mental health services] are structured it is impossible to work out what tiering [patients] are." (GP representative)

GPs questioned why if a patient was assessed by the liaison psychiatrist and crisis team in A&E and was found to not require admission, letters were sent to the GP to suggest referral into primary medical services, as opposed to referring indirectly and informing the GP.

- We were given examples of where failures to obtain assessments or meet thresholds in order to obtain support had resulted in people entering crisis.

  "We had a client with mental health issues causing problems with daily living tasks and impacting on their wellbeing. We tried referral into adult social care, they were refused assess and referred into mental health, where they did not meet the threshold. This exacerbated the mental health difficulties and the person ended up in crisis at Meadowbrook. It was at that point the CMHT then got involved and the psychiatrist and they got a mental health assessment." (Third sector organisation)

  "There has been a big investment in mental health liaison service at SRT in order to assess people in crisis. But people just need an assessment before crisis". (Third sector organisation)

- Emergency services expressed that mental health was the one area in Salford where it was unclear to them what the pathway or services were.

  "Salford is a good borough and excellent at moving people into and through A&E. But the one thing would be mental health. If we are called to a mental health incident – that is the one where we are not sure where to take people or what the pathway is and where they are most likely to end up in A&E."

- Some third sector organisations and service user representatives raised concerns about a lack of alternatives to admissions and non-hospital based crisis services in the community, or crisis services for those not already in contact with mental health services. However, they did indicate there were initiatives underway to improve this. They mentioned Sanctuary as a 'self-help' service for those

approaching anxiety and crisis which provided 24/7 drop in and took self-referrals.

- While the IAPT services were well regarded across stakeholders and performed well (see above), several people told us about long waiting lists for psychology services. Waits could be up to 12 months, and people could be moved from one waiting list to another waiting list, resulting in waits of up to 18 months. We were told this could have a very detrimental effect on people and their lives. GPs also reflected on the fact that while IAPT services were good, it was where patients needed a different psychological service or step up that the problem occurred. Stakeholders did also tell us about a 'step up' pilot in several neighbourhoods with GMW as an alternate to IAPT.
- A GP commented that practitioners were forced to fall back on prescribing or would tend to refer into IAPT even if this did not seem the right service, as it was better for patients to get some support within six weeks rather than waiting 12 months. While the ratio of the number of people entering talking therapies to the number of people with depression and/or anxiety disorders is similar to the national average (see above), the total volumes of antidepressants prescribed compared to expected levels in primary care is higher than average in Salford.[70]

70 CQC Mental Health Crisis Review, initial data review, last updated 23/01/2015 www.cqc.org.uk/content/thematic-review-mental-health-crisis-care-initial-data-review

- Regarding other local people, delays obtaining occupational therapy assessments and assessments under the Care Act were a concern.

  "There are real problems in how long occupational therapy assessments take. We have someone who has waited since July for assessment. They cannot get out of the house and are washing in the sink. There is at least a four month wait time for OT." (Third sector organisation providing services for people with mental health problems)

  "There are delays to accessing assessments, mainly OT. It takes four to six months, nothing less than four months. Since April, the Care Act has come in. If people are unable to do at least one task and this impacts on wellbeing they are entitled to assessment and some aids and adaption. But there is still lack of awareness of the national criteria and the wellbeing principle behind that." (Third sector organisation)

- Social workers and representatives of adult social care providers also reflected on difficulties in this area of mental health need. This included the capability of social care to provide for people in the community who do not meet the criteria for mental health care but have complex needs and require support, beyond 'conventional social care', e.g., help with for people with ADHD or personality disorder or alcohol problems.

  "This requires more knowledge and for staff to take a different approach. They have to talk to people on a day to day basis, and not just look at physical needs, but have insight into mental health and the mental capacity act,

DOLS, etc. that have historically not impacted on domiciliary care. But we struggle with staff and skills."

We were told that in care homes, when someone has a physical problem, they seem to be seen quicker than they used to. However, obtaining support for people experiencing especially lower level mental health difficulties was felt to be difficult for adult social care providers.

"Mental health services are always a problem. It can take weeks with people in a distressed state for an extended period of time. GPs are variable and tend to fall down on mental health. It's hard to get them to take on responsibility for even low level stuff. It takes time to get consultants and CPNs."

- It was also identified that there was a gap in services for the high percentage of the asylum seekers from war torn areas moving into Salford experiencing post-traumatic stress disorder (PTSD). These people have to go to London for services as GMW do not have expertise in PTSD.
- Service user representatives and third sector organisations said that local people tended not to be clear what would happen to them when they made contact with mental health services and were anxious about this, which could hold people back from accessing services.

The most recent mental health and wellbeing needs assessment, in 2010,[71] found a broad range of community-based projects and services provided within Salford which impact on mental wellbeing, projects targeting specific wellbeing issues, such as related to employment and debt, and targeting the most vulnerable populations. There were also 'excellent examples of partnership working between the public sector and third sector organisations'. However, the needs assessment also found gaps and areas for Salford to strengthen.

The assessment found:

- 'Mental wellbeing services not clearly joined up with the specialist services –gaps in service provision between the two areas
- imbalance in the focus of tertiary vs. preventative services resulting in lack of community based services;
- ineffective networking of services, with services on the ground unsure what others projects are doing, resulting in disjointed projects and unnecessary duplication of delivery
- care pathways not clearly defined leading to lack of agreement across services re where issues should be raised and where staff should signpost clients
- threshold levels for assessment re mental wellbeing / mental health unclear.'

It also identified several specific areas where there seemed to be gaps in provision, including 'limited choices of therapy interventions offered to people in Salford' and lack of 'intensive support services to build confidence in those that are struggling at the lower end of spectrum'.

71 Peck, C & Tocque, K (2010) Salford Mental Wellbeing Assessment, April.

The 2010 assessment recommended more comprehensive evaluations, including of community-based initiatives, and assessing the extent of need where gaps in provision had been identified. For example, the needs assessment estimated that except for the two most deprived wards (Broughton and Langworthy), people living in the more affluent wards appear to be obtaining more treatment within the community than people living in the more deprived wards. However, there was insufficient data to understand whether the needs of these individuals were being met by the broader range of community services. The Locality Plan's section on mental health highlights the financial constraints within which mental health services are likely to be operating. It is important for Salford to understand to what extent community assets initiatives are addressing need and to identify where need and impact for investment is greatest.

6.6 EXPERIENCE OF PERSON CENTRED COORDINATED CARE

We spoke with people with a diagnosis of schizophrenia about their support from mental health and other services in order to understand the experience of person centred coordinated care for people with complex mental health problems. Most people we spoke to were generally positive about their experiences and felt their needs were being met, with no suggestions for improvement. Having a care coordinator they could develop a relationship with was important to people, and overall this was a strength of the support provided. We saw many examples of care coordinators facilitating links with other services to support people's recovery and help them to meet their personal goals.

CARE CO-ORDINATORS AND SUPPORT TO RECOVER

The majority of people reported they had a good relationship with their care co-ordinator and their care plan was updated regularly. Most people told us they understood their treatment and have been involved in making decisions about their care.

"Everything's clear about what was happening. I have one contact (care coordinator), I have known her for a year and a half so have a good relationship with her" (MH Patient)

People told us about activities they undertook to support their recovery. These included: education around how the brain works and understanding your mental health condition (such courses were available through the 'Recovery Academy'), family therapy, support to develop coping strategies around personality traits, advice on staying well and learning problem solving skills. The Early Intervention Team (EIT) also supported people with recovery.

Other community groups were mentioned which were helping people with their recovery. One person was using the Community Engagement Recovery Team (CERT) community support service to help expand his interests. One person was doing voluntary work at a support centre to help prepare her for her return to work. One care-coordinator told us there were clear pathways in place for referral to voluntary agencies, such as Making Space and Creative Support.

Some people described how they had received help to meet their personal and physical health goals including reducing social isolation, accessing work or education, enjoying hobbies, losing weight and accessing alcohol and substance misuse services:

"She said she had made the decisions about her care and her care coordinator had supported her with work and university. For example, she worked part time and she and the care coordinator had met with her employers to discuss how they would support her to rest and not do too much overtime, and would put a limit on working hours if necessary. The CC supported her with getting back to university, and gave support with benefits so she could make travelling easier and support her studies. The university and work had copies of her crisis plan including what triggers to look out for to indicate she was becoming unwell." (Interviewer)

Many spoke to us about being supported to live independently and being given social support to help with housing, benefits, debt and budgeting.

"[My Care coordinator] gives me lots of good advice on housing and benefits. She helped me get this flat. Any help I need she will always go out of her way to do it." (MH Patient)

Most have effective medicines management in place and described having regular medicines reviews and support to moderate any side effects of medication, including weight gain.

However, a few people we spoke to in the case studies told us about patients being on a waiting list for treatment or that the particular support they needed was unavailable:

"She does not have psychology input and is on the waiting list. I saw a letter of referral but no appointment was ascertained. She had been on a waiting list since September 2015." (Interviewer)

"He has difficulty getting out and about and would benefit with input from a support worker to help him with this. These have not been available." (Care coordinator)

INVOLVEMENT OF CARERS

A few people told us about how carers and people close to them were involved in their care and spoke positively about how services worked with them. One person did not want to involve family and his wishes were respected by the services he used. Some people told us about how carers were offered support.

"[The patient's] mother has support from an organisation which supports carers, his care coordinator made the referral." (Interviewer)

One person told us about a lack of support for carers:

"[The patient] has three children and her older child takes care of her and relies on the younger son. There is an emphasis on children to support her; however there is no carer support input despite all children being relatively young at 17-22 years old." (Interviewer)

CRISIS

Most of the people we spoke with mentioned that they knew who to contact in a crisis or out of hours. Some explicitly mentioned having a crisis plan in place and most people appeared to be assessed and supported quickly when there was a need. Some people spoke positively about being supported by the home-based treatment team to cope at home during difficult times or to support early discharge from hospital. People told us about positive experiences with the A&E MH Liaison Team, because the team had information about their mental health history. (This is supported by other positive evidence on crisis support - see section 8.3.)

"[Patient at A&E] saw the liaison psychiatry team who knew all about her mental health history and said, 'It's brilliant when staff know your history as I didn't need to repeat any questions, and they knew I didn't like being admitted as an inpatient'." (MH patient)

MOVING BETWEEN SERVICES

Most people experienced smooth transitions between services. This included between hospital and community services.

"Transition between inpatients, CRHT and CMHT appears seamless." (Interviewer)

A few people told us about more difficult transitions between services. Some professionals had little or no information about the patient prior to handover which made the transition more difficult.

"[The patient's] social worker informed me she was given the patient by allocation manager and had no knowledge of the patient prior to the discharge." (Interviewer)

A few people told us that they saw many different people about their care – they often said they found this difficult.

"If it was the same two people who came round [each day from the Home Based Treatment Team] it would have been a lot better." (MH Patient)

"[She] has been supported by staff [from the] Community Mental Health Team and has had three different Care Coordinators over the last 12 months. [She] finds this difficult as she struggles to engage with people outside of her small family circle." (Interviewer)

One person had a difficult transition from CAMHS to adult services. His care coordinator told us that there was an *"Abrupt 'cut-off' point from CAMHS to Adults Services'* and that the '*Acute Adult Ward was not appropriate for a young adult*'."

ENGAGEMENT WITH PATIENTS

Most of the care coordinators we spoke with told us about their patients being disengaged with their care at some point during their treatment. Sometimes this meant not attending appointments, not taking medication, not engaging with treatments or masking symptoms.

Despite this, all of the patients we spoke with were currently engaged to some degree and some told us about how they were supported to engage with services. For example, one

person did not like to let people into her house and so was supported to have meetings with her care coordinator in a local coffee shop; one person preferred to attend appointments at a clinic rather than have home visits; and one had appointments scheduled around childcare.

Some people were not always getting the support they needed to engage with services. One person found it difficult to attend appointments due to paranoia when using public transport. This individual was not receiving support for his condition in this respect. One person, whose first language was not English, said she struggled to explain her need to services because interpreters were not available.

There was one instance where the interviewer observed:

"The care co-ordinator was unable to tell me a lot about the person other than he was difficult to manage. She explained he rarely turned up for appointments and rarely turned up on time for his depot injection. Records showed he went 15 days without medication." (Interviewer)

GENERAL PRACTICE

Although there were a couple of reports of GPs having minimal involvement with patients, most people appeared to experience that there were good links with GPs. A few people told us about poor experiences with their GPs:

"I talk to the GP and they seem to want to get you out as quickly as possible. They don't listen and rush you out of the door. I never got to explain how I was feeling." (MH Patient)

6.7 SUPPORT IN PRIMARY CARE

The people with a diagnosis of schizophrenia we spoke to were being supported through the mental health trust. However, it has been estimated that up to half of people who have a serious mental illness are seen only in a primary care setting. According to NICE clinical guidelines, patients on the severe mental illness register should have a documented primary care consultation that outlines a plan for care, including in the event of a relapse of mental ill-health.

- The Quality Outcome Framework (QOF) measures the percentage of people with a serious mental illness who have an agreed care plan documented in their primary record in the last 12 months. In Salford, 77.5% of patients had an agreed care plan documented compared to 83.1% in England in 2012/13. Salford is lower than the national average, which may mean that there are issues in primary care with support and monitoring to prevent escalation and crisis.
- CQC's Mental Health Crisis Review[72] found that one of the most important preventative tools in mental health crisis care is providing people who have a known mental health

72 www.cqc.org.uk/content/right-here-right-now-mental-health-crisis-care-review

condition with a care plan that includes guidance on what to do in a crisis.[73]

6.8 CRISIS CARE

FINDINGS ON SALFORD FROM CQC'S MENTAL HEALTH CRISIS CARE REVIEW

CQC's mental health crisis care review[74] in 2015 looked at the experiences and outcomes of people experiencing a mental health crisis in Salford, in particular those people who presented at accident and emergency departments and those people in crisis who were known to services and were receiving ongoing support from specialist mental health services. The findings of this report support the positive experiences of crisis care we found in our case studies with people who had a diagnosis of schizophrenia. This review found 'a strong culture of partnership working supported by effective multi agency working between all providers and agencies', including the local mental health trust, the acute hospital trust, local council, police, ambulance and local voluntary agencies including carers groups worked well together.

The report highlighted many areas of good practice:

- Joint training initiatives between acute trust staff, mental health trust staff and police had led to an understanding of respective roles in supporting people who experience mental health crisis.
- There were triage and assessment processes within accident and emergency and a 24/7 mental health liaison team within accident and emergency.
- There were pathways for managing to people who go missing from or who are frequent attenders at accident and emergency, based on risk and the person's needs.
- There was evidence of comprehensive care plans with chronological records related to each patient's care following admission to hospital, committed staff with good knowledge of patients they cared for and supported and involvement and consideration of the needs of carers.
- People supported by secondary mental health services in Salford had access to a range of specialist mental health services 24 hours a day, seven days a week, to support people to remain in their homes and avoid admission to hospital as far as possible. There is a 24/7 helpline for all service users of GMW. When service users are discharged from GMW, they can contact the helpline for up to three months as part of their crisis discharge plan. A Home Based Treatment Mental Health Team is staffed to provide acute

73 Health and Social Care Information Centre (HSCIC) - Quality and Outcomes Framework (QOF), 2012/13, CQC Mental Health Crisis Review First Phase Data, www.cqc.org.uk/content/thematic-review-mental-health-crisis-care-initial-data-review

74 Care Quality Commission (2015) Right here, right now. Mental health crisis care review, www.cqc.org.uk/content/right-here-right-now-mental-health-crisis-care-review ; Mental Health Crisis Care: Salford Summary Report, date of local area inspection: 20, 21 and 22 January 2015, Date of publication: June 2015; www.cqc.org.uk/content/mental-health-crisis-care-local-area-inspection-reports

care at home 24/7 for users of GMW services and those referred into the team out of normal office hours, usually by A&E liaison. People who used the home based treatment service in Salford receive visits up to four times a day and this helps them to remain at home (see also case studies below).

- Crisis beds have been made available in the community, within Hollybank supported accommodation, which is provided by Salford City Council. People are referred to these beds via the GMW Home Based Treatment Team, who manage this service.

INDICATORS OF USE OF HOME BASED TREATMENT IN CRISIS

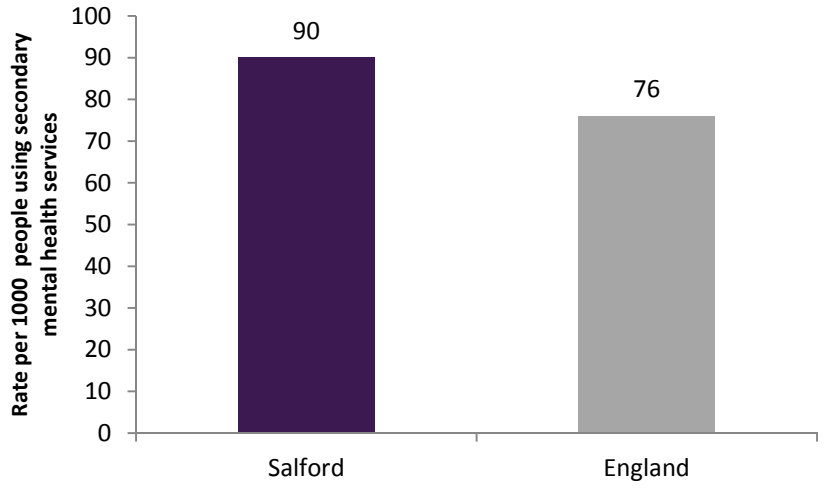
Home Based Treatment Teams assess patients who are being considered for hospital admission, and where possible provide intensive home treatment to prevent such admission. Where a hospital admission does happen they can also play a role in facilitating an early discharge from hospital.[75] In Salford, the ratio of home treatment episodes by crisis resolution home treatment teams to people using secondary mental health services is similar in Salford to the England average. The proportion of emergency admissions to specialist mental health providers that are gate-kept by crisis resolution home treatment teams is statistically higher than average in Salford. This, along with the other evidence suggests, Salford is making use of this form of intensive community support. However, data shows the percentage of hospital admissions as a percentage of crisis team referrals is higher than the national ratio (Salford 34.5%; national 18.3%), suggesting there may be over-reliance on hospital admission for people in crisis.[76] In addition, the estimated annual mental health bed occupancy levels are 92.1% in Salford, higher than the expected standard of 85% and the national average of 88.1%.[77] This may delay rapid access for people in urgent need.

75 Johnson, S. (2013). Crisis resolution and home treatment teams: an evolving model. Advances in psychiatric treatment, 19(2), 115-123.

76 MIND Mental Health Charity FOI request information, CQC Mental Health Crisis Review First Phase Data, www.cqc.org.uk/content/thematic-review-mental-health-crisis-care-initial-data-review

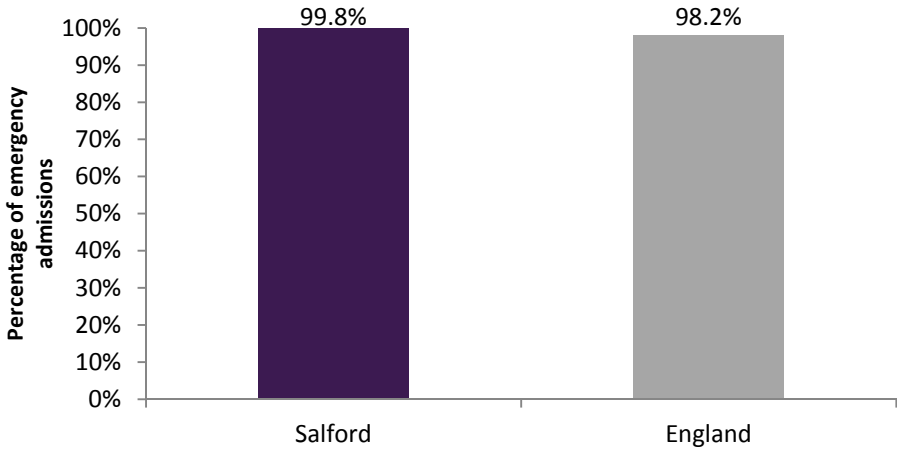
77 HSCIC KH03 returns, 2012/13, CQC Mental Health Crisis Review First Phase Data, www.cqc.org.uk/content/thematic-review-mental-health-crisis-care-initial-data-review

Figure 8: Rate of home treatment episodes, Salford and England, 2012-13



Source: CQC Mental Health Crisis Review First Phase Data

Figure 9: Percentage of emergency admissions to specialist mental health providers that are gate-kept by crisis resolution home treatment teams, Salford and England, 2012-13



Source: CQC Mental Health Crisis Review First Phase Data

6.9 ACCESS

The average time taken from referral to first contact with specialist mental health services is three days, which is much shorter than the national average of 13 days. This suggests Salford performs well on access to specialist mental health services. [78]

78 Mental Health Minimum Dataset 2012/13, CQC Mental Health Crisis Review First Phase Data, www.cqc.org.uk/content/thematic-review-mental-health-crisis-care-initial-data-review

7. The quality of health and social care providers

This section provides information on the quality of health and social care providers in Salford. This is based on inspection and ratings by Care Quality Commission. At the time of report production Salford has one acute hospital, 54 registered GPs and 77 registered adult social care providers. Not all of the services in Salford have been inspected and rated using CQC's current methodology.[79] The ratings information is correct to April 2016. All proportions of ratings given should be interpreted with caution as they do not yet provide a complete view of provider quality in the area.

7.1 SALFORD ROYAL NHS FOUNDATION TRUST (ACUTE AND COMMUNITY HEALTH SERVICES)

Salford Royal NHS Foundation Trust provides both acute and community services to people in Salford, and some acute services to people in Greater Manchester. The trust serves a national population for people requiring some specialist care for the treatment of disease or disorders of the brain, skin, renal system, spine and those with intestinal failure conditions. In our report published in March 2015, we rated the trust overall as outstanding. The Salford Royal Hospital was rated as outstanding and the community services as good. Salford Royal Foundation Trust received the following ratings overall and by core services:[80]

79 For information on CQC methodology and to access inspection reports for individual providers see www.cqc.org.uk/

80 SRFT inspection report is available here, www.cqc.org.uk/provider/RM3/inspection-summary#overall

Table 19: CQC ratings, Salford Royal Foundation Trust

Name	Safe	Effective	Caring	Responsive	Well led	Overall
Urgent and emergency services	Outstanding	Good	Outstanding	Good	Outstanding	Outstanding
Medical care	Outstanding	Good	Good	Outstanding	Outstanding	Outstanding
Surgery	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Critical care	Good	Good	Good	Outstanding	Good	Good
Services for children and young people	Good	Good	Good	Good	Requires improvement	Good
End of life care	Good	Good	Outstanding	Outstanding	Outstanding	Outstanding
Outpatients and diagnostic imaging	Requires improvement	Not stated	Good	Requires improvement	Good	Requires improvement
Overall	Good	Good	Outstanding	Outstanding	Good	Outstanding

Table 20: CQC ratings by core service, Salford Royal Foundation Trust

Name	Safe	Effective	Caring	Responsive	Well led	Overall
Community health inpatient services	Good	Good	Good	Good	Good	Good
Community health services for adults	Good	Good	Outstanding	Good	Outstanding	Outstanding
Community health services for children, young people and families	Good	Good	Good	Requires improvement	Good	Good
Community health end of life care	Good	Outstanding	Good	Outstanding	Outstanding	Outstanding
Overall	Good	Good	Good	Good	Outstanding	Good

Source: CQC inspection ratings

HES data tells us that in 2013/14 patients attended Salford Royal NHS Foundation Trust as emergency inpatients from 42 different local authorities. The vast majority of these patients were Salford residents (73.37%) with the majority of other attendances residents from other local authorities within the North West of England. In 2013/14 patients attended Salford Royal NHS Foundation Trust as elective inpatients from 53 English local authorities and six Welsh local authorities, excluding those with counts less than five attendances and where local authority of residence was unknown. Less than half of these patients were Salford residents. In 2013/14 residents of Salford local authority attended 39 trusts and four private providers as elective inpatients (omitting trusts with less than five attendances). This demonstrates the way in which provision of care for the people of Salford extends beyond the area, while acute services in Salford are used by people across Greater Manchester and England.

7.2 GREATER MANCHESTER WEST NHS FOUNDATION TRUST (MENTAL HEALTH TRUST)

Greater Manchester West (Mental health Trust) provides district mental health services in Salford, as well as in Bolton and Trafford. The Trust also provides community services in Salford and Trafford, Cumbria, Wigan and Leigh and Central Lancashire. It provides inpatient alcohol and drug recovery services in Prestwich. The trust was inspected under the current CQC methodology in February 2016, with the report due for publication.

7.3 NORTH WEST AMBULANCE SERVICE NHS TRUST

North West Ambulance Service NHS Trust provides accident and emergency services to those in need of emergency medical treatment and transport in Salford. It provides services to a population of seven million people across a geographical area of approximately 5,400 square miles, including Greater Manchester, Cheshire and Merseyside, Cumbria and Lancashire.[81] 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 poor practice where the trust must improve. Notably, given the high emergency admissions in Salford, the service took a high number of patients to hospital when alternative services may have been more appropriate in meeting their needs. The trust was the worst performing nationally in this area. Less than 4% of calls to the trust were closed with telephone advice. [82]

7.4 GENERAL PRACTICES

Out of the 54 GP practices in Salford 31 have been rated. The ratings have been plotted on the map of the Salford area below. Two practices were rated as outstanding (green star), 26 as good (green box), three as requires improvement (orange box) and none as inadequate. Currently Salford has a higher

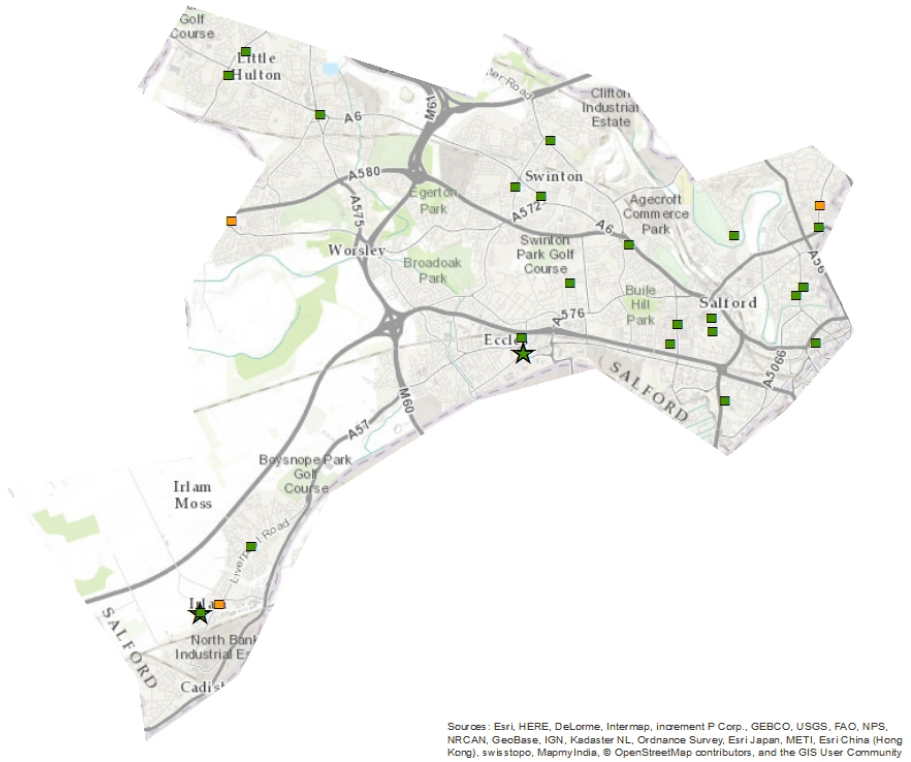
81 www.nwas.nhs.uk

82 The inspection report for GMW is available here, www.cqc.org.uk/provider/RX7/inspection-summary#overall

proportion of GPs rated as good (48%) or outstanding (4%) than the national average of 32% good and 2% outstanding. However, this is based on 57% of Salford GPs and 39% of England GPs having been rated and so this may alter when we have a more complete dataset.

Analysis of inspection reports found that outstanding practice related to the work of some practices to engage and meet the needs of those made vulnerable by their circumstances and deprived communities.

Figure 10: GP locations with their overall rating, Salford



Source: CQC Provider Data

7.5 ADULT SOCIAL CARE PROVIDERS

Out of 77 Adult Social Care Providers in Salford 46 have been rated. Of those rated to date, 19 (41%) have been rated as good, 24 (52%) as requires improvement and three (7%) as inadequate. No services have yet been rated as outstanding.

This compares nationally to 67% rated as good, 29% rated as requires improvement as 3% rated as inadequate. However, this is based on 60% of Salford adult social care providers and 51% of England adult social care providers having been rated and so this may alter when we have a more complete dataset.

Analysis of CQC inspection reports as of August 2015 indicated the following were common problems in Adult Social Care providers.[83]

- There was evidence of poor record keeping with examples such as failure to date and sign moving and handling charts. There was also evidence that patients were not being involved in their individual care planning and of failing to update care plans. Inaccuracies within care plans were an issue highlighted in two providers.
- Five care home providers had limited opportunity for patients to engage in meaningful social activities. Generally there were complaints that service users did not have access to the activities that they specifically enjoyed or commented that there were just not enough activities available.
- A number of care homes appeared not to manage risk effectively, including incomplete risk assessments and not managing falls risk assessments.
- A common issue highlighted in the inspection reports was not having sufficient staffing levels. Insufficient staffing was highlighted as a cause of risk or other problems within the service.
- A number of issues were raised involving medication risks; including poor record keeping, poor storage of medicines and no night staff to administer pain medication.

7.6 EVIDENCE OF PROVIDERS COORDINATING HEALTH AND SOCIAL CARE

Inspection reports showed evidence of partnership working and coordination between providers, giving some indication that the efforts to join-up services in Salford have impacted at provider level.

Some of the care homes demonstrated good examples of coordinated care and services working together, including examples of liaising with specialist external organisations to meet people's care needs and care homes partnering for training. Across all care homes access to external services such as GPs, dentists and appointments was noted on inspection.

There were examples of coordinated care from several general practices. Staff were knowledgeable about other health and social care services, including how to access them. Records from other providers were kept in practice records. References

83 Care Quality Commission, Qualitative analysis of CQC inspection reports, Salford, 15 October 2015. 21 Adult Social Care provider reports for providers rated inadequate, requires improvement and outstanding were included (those obtaining a rating of good were not analysed). Analysis looked only at the key questions 'safe, effective and response'.

were made to integrated neighbourhood team meetings and meetings with multi-disciplinary teams to discuss care for those with complex needs, including a variety of health and social care professionals.[84]

84 Care Quality Commission, Qualitative analysis of CQC inspection reports, Salford, 15 October 2015. 21 Reports for providers rated inadequate, requires improvement and outstanding were included (those obtaining a rating of good were not analysed).

Appendix

DESCRIPTION OF THE DATA INDICATORS

Indicator	Source organisation	Original source data	Benchmarking method
Proportion of adults with a learning disability in Employment	PHE's Adult Social Care Fingertips tool	ASC-CAR proforma	Statistical Process Control for proportions (binomial) with a significance level of 95%
Proportion of adults with a learning disability who are in settled accommodation	PHE's Adult Social Care Fingertips tool	ASC-CAR proforma	Statistical Process Control for proportions (binomial) with a significance level of 95%.
Proportion of people who use services and their carers, who reported that they had as much social contact as they would like	PHE's Adult Social Care Fingertips tool	Adult Social Care Survey Carers Survey	Statistical Process Control for proportions (binomial) with a significance level of 95%.
Mortality rate per 100,000 from causes considered preventable (Persons)	PHE's Public Health Outcomes Fingertips tool	ONS	Confidence intervals overlapping reference value with a significance level of 95%.
Under 75 mortality rate per 100,000 from cardiovascular diseases considered preventable (Persons)	PHE's Public Health Outcomes Fingertips tool	ONS	Confidence intervals overlapping reference value with a significance level of 95%.
Under 75 mortality rate per 100,000 from cancer considered preventable (Persons)	PHE's Public Health Outcomes Fingertips tool	ONS	Confidence intervals overlapping reference value with a significance level of 95%.
Under 75 mortality rate per 100,000 from liver disease	PHE's Public Health Outcomes Fingertips tool	ONS	Confidence intervals overlapping reference value with a

Indicator	Source organisation	Original source data	Benchmarking method
considered preventable (Persons)			significance level of 95%.
Under 75 mortality rate per 100,000 from respiratory disease considered preventable (Persons)	PHE's Public Health Outcomes Fingertips tool	ONS	Confidence intervals overlapping reference value with a significance level of 95%.
Mortality per 100,000 from communicable diseases (Persons)	PHE's Public Health Outcomes Fingertips tool	ONS	Confidence intervals overlapping reference value with a significance level of 95%.
Excess Winter Deaths Index (Single year, all ages)	PHE's Public Health Outcomes Fingertips tool	ONS	Confidence intervals overlapping reference value with a significance level of 95%.
Excess Winter Deaths Index (3 years, all ages)	PHE's Public Health Outcomes Fingertips tool	ONS	Confidence intervals overlapping reference value with a significance level of 95%.
Infant mortality - Rate of deaths in infants aged under 1 year per 1,000 live births	PHE's Public Health Outcomes Fingertips tool	ONS	Confidence intervals overlapping reference value with a significance level of 95%.
Total delayed transfers of care per 100,00 aged 18+	PHE's Adult Social Care Fingertips tool	Department of Health Delayed Transfer of Care and ONS population estimates	Statistical Process Control for Directly Standardised Rates and crude rates (poisson) with a significance level of 95%.
Rate per 100,000 hospital admissions for alcohol specific conditions in Salford	PHE's Alcohol Profiles	HSCIC HES data and ONS population estimates	Confidence intervals overlapping reference value with a significance level of 95%.
Rate per 100,000 hospital admissions for alcohol specific conditions under 18 in Salford	PHE's Alcohol Profiles	HSCIC HES data and ONS population estimates	Confidence intervals overlapping reference value with a significance level of 95%.
Successful completion of drug treatment, opiate users (% of adults in treatment)	PHE's Public Health Outcomes Fingertips tool	National Drug Treatment Monitoring System	Confidence intervals overlapping reference value with a significance level of 95%.
Successful completion of drug treatment non opiate users (% of adults in treatment)	PHE's Public Health Outcomes Fingertips tool	National Drug Treatment Monitoring System	Confidence intervals overlapping reference value with a significance level of 95%.
Successful completion of alcohol treatment (% of adults in treatment)	PHE's Local Alcohol Profiles	National Drug Treatment Monitoring System	Confidence intervals overlapping reference value with a significance level of 95%.

Indicator	Source organisation	Original source data	Benchmarking method
Excess Winter Deaths Index (1 year, ages 85+) (Persons)	PHE's Public Health Outcomes Fingertips tool	ONS	Confidence intervals overlapping reference value with a significance level of 95%.
Excess Winter Deaths Index (3 years, ages 85+) (Persons)	PHE's Public Health Outcomes Fingertips tool	ONS	Confidence intervals overlapping reference value with a significance level of 95%.
Health related quality of life for older people (survey score)	PHE's Public Health Outcomes Fingertips tool	GP Patient Survey	Confidence intervals overlapping reference value with a significance level of 95%.
Rate per 100,000 hip fractures in people aged 65 and over (Persons) 65-79 (Persons) 80+ (Persons)	PHE's Public Health Outcomes Fingertips tool	HSCIC HES data and ONS population estimates	Confidence intervals overlapping reference value with a significance level of 95%.
Permanent admissions to residential and nursing care homes, per 100,000 population aged 65+	PHE's Adult Social Care Fingertips tool	HSCIC NASCIS - ASC-CAR and ONS population estimates	Statistical Process Control for Directly Standardised Rates and crude rates (poisson) with a significance level of 95%.
The percentage of the population that had avoidable emergency admissions for UTIs out of the total admissions ages 75+	CQC Integrated Care for Older People Review	HSCIC HES	Zscores to indicate the standard deviations from the mean with 95% significance
The percentage of patients diagnosed with dementia whose care has been reviewed in a face-to-face review in the preceding 12 months, all ages	CQC Integrated Care for Older People Review	HSCIC QOF publication October 2014	Zscores to indicate the standard deviations from the mean with 95% significance

Indicator	Source organisation	Original source data	Benchmarking method
The percentage who receive self-directed support out of the total population of people receiving community based services, ages 65+	CQC Integrated Care for Older People Review	HSCIC ASCOF Publication December 2014	Zscores to indicate the standard deviations from the mean with 95% significance
The percentage receiving direct payments out of the total population of people receiving community based services, ages 65+	CQC Integrated Care for Older People Review	HSCIC ASCOF Publication December 2014	Zscores to indicate the standard deviations from the mean with 95% significance
The percentage of the population that had A&E attendances, ages 75+	CQC Integrated Care for Older People Review	HSCIC HES data	Zscores to indicate the standard deviations from the mean with 95% significance
The percentage of the population that had emergency admissions with an overnight stay, ages 75+	CQC Integrated Care for Older People Review	HSCIC HES data	Zscores to indicate the standard deviations from the mean with 95% significance
The percentage of all discharged patients that have emergency readmissions, ages 75+	CQC Integrated Care for Older People Review	HSCIC HES data	Zscores to indicate the standard deviations from the mean with 95% significance
The percentage of the population that had multiple emergency admissions per	CQC Integrated Care for Older People Review	HSCIC HES data	Zscores to indicate the standard deviations from the

Indicator	Source organisation	Original source data	Benchmarking method
year, ages 75+			mean with 95% significance
The percentage of all deaths which occur at usual place of residence out of the total number of deaths, ages 75+	CQC Integrated Care for Older People Review	Data requested from PHE and received in May 2015	Zscores to indicate the standard deviations from the mean with 95% significance
The percentage of patients admitted to hospital (emergency admissions) in last 100 days of life out of the total population, ages 75+	CQC Integrated Care for Older People Review	HSCIC HES data	Zscores to indicate the standard deviations from the mean with 95% significance
Excess under 75 mortality rate in adults with serious mental illness	PHE's Public Health Outcomes Fingertips tool	ONS	Not compared
Suicide rate per 100,000 (Persons)	PHE's Public Health Outcomes Fingertips tool	ONS	Confidence intervals overlapping reference value with a significance level of 95%.
Rate of recovery from IAPT treatment (% recovering from treatment)	PHE's Community Mental Health Profiles	HSCIC Improving Access to Psychological Therapies Dataset	Confidence intervals overlapping reference value with a significance level of 95%.
% of emergency admissions via A&E for a MH condition (for	CQC Mental Health Crisis Review	HSCIC HES and MHMDS	Zscores to indicate the standard deviations from the

Indicator	Source organisation	Original source data	Benchmarking method
patients with a history of previous MH contact) that returned to A&E within 30 days (for any reason)			mean with 95% significance,
% of emergency admissions via A&E for a MH condition (for patients with NO history of previous MH contact) that returned to A&E within 30 days (for any reason)	CQC Mental Health Crisis Review	HSCIC HES and MHMDS	Zscores to indicate the standard deviations from the mean with 95% significance,
Rate per 100,000 hospital admissions for unipolar depressive disorders per 100,000 aged 15 and over	PHE's Common mental health disorders profile	HSCIC HES data and ONS population estimates	Confidence intervals overlapping reference value with a significance level of 95%.
Rate per 100,000 emergency admissions for neuroses	PHE's Common mental health disorders profile	HSCIC HES data and ONS population estimates	Confidence intervals overlapping reference value with a significance level of 95%.
Rate per 100,000 hospital admissions for mental health conditions, 0-17 year olds in Salford	PHE's Children and Young People profiles	HSCIC HES and ONS population estimates	Confidence intervals overlapping reference value with a significance level of 95%.
Rate per 100,000 hospital admissions as a result of self-	PHE's Children and Young People profiles	HSCIC HES and ONS population estimates	Confidence intervals overlapping reference value

Indicator	Source organisation	Original source data	Benchmarking method
harm, 10-24 year olds in Salford			with a significance level of 95%.
Avoidable emergency admissions for UTIs, 75+ with a mental health condition	CQC Integrated Care for Older People Review	HSCIC HES and MHMDS data	Zscores to indicate the standard deviations from the mean with 95% significance
Number of A&E Attendances, 75+ with a mental health condition	CQC Integrated Care for Older People Review	HSCIC HES and MHMDS data	Zscores to indicate the standard deviations from the mean with 95% significance
Number of emergency admissions, 75+ with a mental health condition	CQC Integrated Care for Older People Review	HSCIC HES and MHMDS data	Zscores to indicate the standard deviations from the mean with 95% significance
Rate of emergency re-admissions, 75+ with a mental health condition	CQC Integrated Care for Older People Review	HSCIC HES and MHMDS data	Zscores to indicate the standard deviations from the mean with 95% significance
Number of A&E Attendances, 75+ for falls with a mental health condition	CQC Integrated Care for Older People Review	HSCIC HES and MHMDS data	Zscores to indicate the standard deviations from the mean with 95% significance
The percentage of patients admitted to hospital (emergency admissions) in last 100 days of life out of the total population, ages 75+, MH PATIENTS	CQC Integrated Care for Older People Review	HSCIC HES Data	Zscores to indicate the standard deviations from the mean with 95% significance

Figures and tables

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