

Manchester

Local system review report Health and Wellbeing Board

Date of review:
16 – 20 October 2017

Background and scope of the local system review

This review has been carried out following a request from the Secretaries of State for Health and for Communities and Local Government to undertake a programme of 20 targeted reviews of local authority areas. The purpose of this review is to understand how people move through the health and social care system with a focus on the interfaces between services.

This review has been carried out under Section 48 of the Health and Social Care Act 2008. This gives the Care Quality Commission (CQC) the ability to explore issues that are wider than the regulations that underpin our regular inspection activity. By exploring local area commissioning arrangements and how organisations are working together to develop person-centred, coordinated care for people who use services, their families and carers, we are able to understand people's experience of care across the local area, and how improvements can be made.

This report is one of 20 local area reports produced as part of the local system reviews programme and will be followed by a national report for government that brings together key findings from across the 20 local system reviews.

The review team

Our review team was led by:

- Senior Responsible Officer: Alison Holbourn, CQC
- Lead reviewer: Deanna Westwood, CQC

The team also included:

- 2 CQC reviewers,
- 2 CQC inspectors
- 1 CQC analyst
- 1 CQC Expert by Experience; and
- 4 specialist advisors (two current directors of adult social services, one former director of adult social services, and one nurse clinical governance lead).

How we carried out the review

The local system review considered system performance along a number of 'pressure points' on a typical pathway of care with a focus on **older people aged over 65**.

We also focussed on the interface between social care, general medical practice, acute and community health services, and on delayed transfers of care from acute hospital settings.

Using specially developed key lines of enquiry, we reviewed how the local system is functioning within and across three key areas:

1. Maintaining the wellbeing of a person in their usual place of residence
2. Crisis management
3. Step down, return to usual place of residence and/or admission to a new place of residence

Across these three areas, detailed in the report, we have asked the questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive?

We have then looked across the system to ask:

- Is it well led?

Prior to visiting the local area we developed a local data profile containing analysis of a range of information available from national data collections as well as CQC's own data. We asked the local area to provide an overview of their health and social care system in a bespoke System Overview Information Request (SOIR) and asked a range of other local stakeholder organisations for information.

We also developed two online feedback tools; a relational audit to gather views on how relationships across the system were working, and an information flow tool to gather feedback on the flow of information when older people are discharged from secondary care services into adult social care.

During our visit to the local area we sought feedback from a range of people involved in shaping and leading the system, those responsible for directly delivering care as well as people who use services, their families and carers. The people we spoke with included:

- Political leaders, senior leaders and managers of Manchester City Council (the local authority) and Manchester Health and Care Commissioning (MHCC) – a partnership between NHS Manchester Clinical Commissioning Group and Manchester City Council

- The newly constituted Manchester University NHS Foundation Trust (MUFT), including the former University Hospital of South Manchester Foundation Trust, Central Manchester University Hospitals Foundation Trust
- Pennine Acute Hospitals NHS Trust
- Senior Leaders from the Greater Manchester Health and Social Care Partnership
- Health and social care professionals, including social workers, GPs, discharge coordinators, and nurses
- Healthwatch Manchester and voluntary and community sector (VCS) representatives
- Local residents at an extra care housing service and at two residential care services, and people at a black and minority ethnic health forum, and at the Manchester Royal Infirmary and the North Manchester General Hospital
- Independent care providers and carers' representatives

We reviewed 28 care and treatment records and visited ten services in the local area including acute hospitals, intermediate care facilities, walk-in centres, care homes and a GP practice.

The Manchester Context

Demographics

- 9% of the population is aged 65 and over.
- 67% of the population identifies as white.
- Manchester is in the most deprived 20% of local authority areas in England.

Adult social care

- 50 active residential care homes:
 - 2 rated outstanding
 - 26 rated good
 - 14 rated requires improvement
 - 2 rated inadequate
 - 6 currently unrated
- 35 active nursing care homes:
 - 13 rated good
 - 16 rated requires improvement
 - 2 rated inadequate
 - 4 currently unrated
- 65 active domiciliary care agencies:
 - 1 rated outstanding
 - 30 rated good
 - 14 rated requires improvement
 - 1 rated inadequate
 - 19 currently unrated

GP practices

- 97 active locations
 - 3 rated outstanding
 - 75 rated good
 - 2 rated requires improvement
 - 4 rated inadequate
 - 13 currently unrated

Acute and community healthcare

Hospital admissions (elective and non-elective) of people living in Manchester are found at the following trusts:

- Central Manchester University Hospitals NHS Foundation Trust
 - Received 49% of admissions of people living in Manchester
 - Admissions from Manchester made up 40% of the trust's total admission activity
 - Rated good overall
- University Hospital of South Manchester NHS Foundation Trust
 - Received 25% of admissions of admissions of people living in Manchester
 - Admissions from Manchester made up 33% of the trust's total admission activity
 - Rated requires improvement overall

These two trusts have recently merged to create Manchester University NHS Foundation Trust.

- Pennine Acute Hospitals NHS Trust
 - Receives 20% of admissions of admissions of people living in Manchester
 - Admissions from Manchester make up 14% of the trust's total admission activity
 - Rated inadequate overall

Mental health services are provided by Greater Manchester Mental Health NHS Foundation Trust – rated good overall

All location ratings as at 29/09/2017. Admissions percentages from 2015/16 Hospital Episode Statistics.

Legend

Manchester_context Events

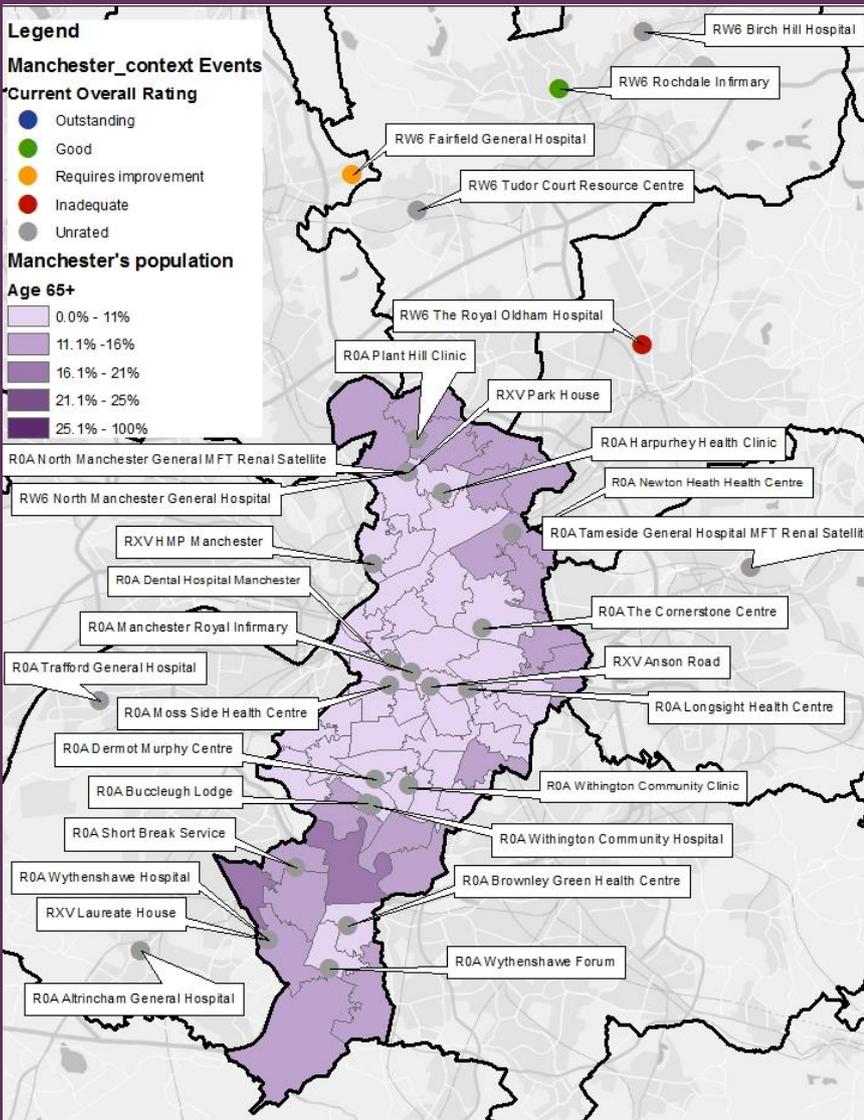
Current Overall Rating

- Outstanding
- Good
- Requires improvement
- Inadequate
- Unrated

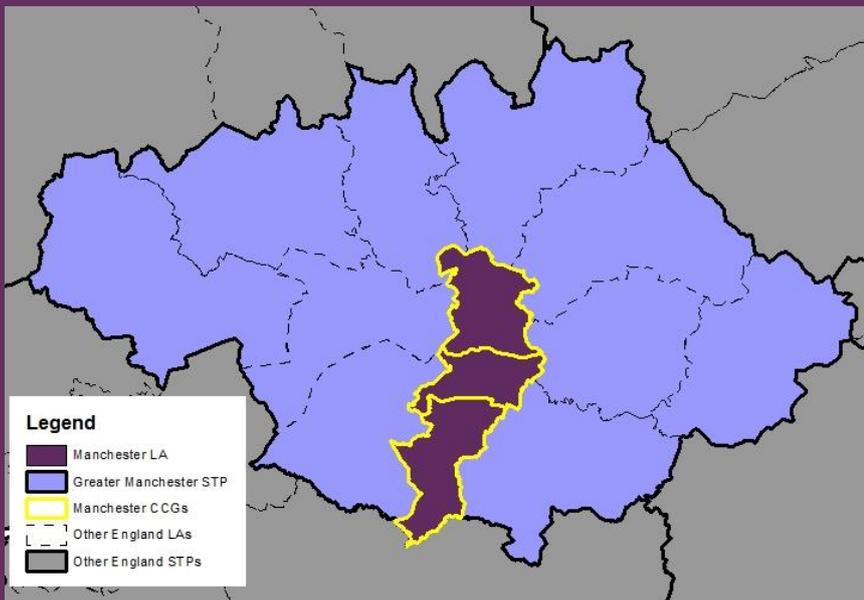
Manchester's population

Age 65+

- 0.0% - 11%
- 11.1% - 16%
- 16.1% - 21%
- 21.1% - 25%
- 25.1% - 100%



Population of Manchester shaded by proportion aged 65+ and location and current rating of acute and community NHS healthcare organisations serving Manchester.



Location of Manchester local authority area within Greater Manchester STP.

The former North, Central and South Manchester CCGs are also highlighted.

Summary of findings

Is there a clear shared and agreed purpose, vision and strategy for health and social care?

- The system has significant problems to be addressed in the immediate future. System leaders recognised this and that the full transformation they envisaged is a long-term programme of change that will take time. System leaders were clear that the real current challenges in health outcomes for Manchester will be addressed through the radical transformation programme envisaged. Significant progress had been made in the establishment of joint commissioning, creating conditions for change, however system leaders recognised that the maturity of the delivery would develop over time.
- System leaders in Manchester have a clear and compelling vision of future services. There was a sense of a true partnership between health and social care services based on a significant period of building relationships across health and social care and voluntary, community and social enterprise (VCSE) agencies. In April 2017 the formation of Manchester Health and Care Commissioning (MHCC) established formal arrangements for integrated commissioning across health and social care.
- The sustainability and transformation partnership (STP) process in Greater Manchester is unique in its system position with devolution. The Taking Charge Implementation and Delivery Plan sets out an ambitious programme for the integration of health and social care, and is reflected in locality-based transformation plans. There was a clear line of sight between the wider Greater Manchester (GM) vision set out in the Taking Charge Implementation and Delivery Plan and the Manchester vision.
- It was clear that the Manchester vision and strategy was about Manchester people and their needs. There was strong insight about the problems facing Manchester communities and a clear commitment to addressing these both through the GM vision and the Manchester vision.
- There was a clearly set out plan for the management of transformation funding supported by clear stages of implementation.
- Manchester's defined strategic vision has a clear value proposition with a clearly articulated approach to delivery. The new care model ambition and preventative approach delivered through neighbourhood plans, has potential to significantly improve health outcomes for people in Manchester. There was good buy-in to the Manchester vision from political leaders through to frontline staff. The creation of a local care organisation (LCO) would enable multi-professional teams to work in neighbourhoods encompassing staff from primary care, social care, mental health and community care with links to secondary care. This was in shadow form at the time of the review and, subject to the outcome of a

procurement process for a ten year contract, expected to go live in April 2018.

Is there a clear framework for interagency collaboration?

- System leaders in Manchester had created the conditions for integration in the system through the development of a powerful guiding coalition with good alignment and integration of health and social care.
- A wider group of agencies could be included in the planning of the next phase, such as Healthwatch and provider groups
- Although work was progressing to establish how financial risks would be shared and the payment structure for GPs, there was not yet full clarity about this. Processes around the management of finances were still focussed on individual organisational drivers and the system was exploring options to move away from this.
- The vision for interagency collaboration is based on delivering an integrated local care organisation (LCO); with 12 neighbourhoods, which will be served by multi-disciplinary teams encompassing primary care, mental health, community nursing and social care professionals from four providers working collaboratively.

How are interagency processes delivered?

- At the time of our review, provision of joint health and social care working was inconsistent, with different delivery and outcomes across the north, south and central parts of the city. Providers in the residential and nursing home sectors found the system was fragmented and difficult to work with.
- In the north of the city there was a strong community-based delivery model with features such as a neighbourhood group and community connectors to manage people's non-medical needs and to combat social isolation and loneliness.
- The Community Assessment and Support Service (CASS), also in the north, was a very positive example of support to avoid admission to hospital and while we were on site we were advised that this was due to be rolled out across Manchester by January 2018.
- The primary care service (nursing home service) in the south of Manchester was achieving good outcomes and there was also a dedicated GP service in the centre of Manchester for care homes.
- System leaders need to consider the balance between the transformation of services and maintaining focus on day to day pressures and risks.

- We found that there was not enough use of the VCSE sector in the prevention agenda. There were some good initiatives in place such as Manchester Care and Repair, enabling people to remain independent in safer homes. However, the VCSE sector had been subject to funding cuts and there was not a consistent offer across the city. Systems needed to be in place with health and social care teams and primary care providers to ensure that people are proactively signposted to these preventative services.
- The provision of care packages to support people in their own homes was outdated and time and task focused. This was recognised by system leaders and, although there were plans to adopt a strength-based approach to homecare commissioning, these were not yet developed.
- System leaders need to be clear about performance in the different components of the trusts at a granular level in order to identify current issues that can be readily addressed through guidance and training. Some of these, such as ward level interagency management of delayed discharges, are not dependent on the implementation of the transformation programme. We saw examples of issues that impacted on delayed transfers of care that could be simply resolved and the need for staff to escalate these for them to be addressed risked fostering a culture of learned helplessness.

What are the experiences of front line staff?

- Staff were engaged and enthusiastic about the long-term strategic vision for Manchester and saw integrated working as a way to improve services for people and enhance their own working arrangements.
- Where services were co-located or integrated, staff reported that relationships between professionals such as occupational therapists and physiotherapists were good. This improved communication and information sharing.
- There were workforce pressures in a number of areas, and social workers were carrying high and complex caseloads. This meant that there was a waiting list for assessments and a risk that people who were not having their needs assessed could go into crisis.
- Domiciliary care agency providers told us that owing to pressures around primary care and a lack of preventative services, combined with the additional pressures on social workers, their workers were being asked to provide more support to people within the same time allocation. They described their services as “running on goodwill” as care workers ran over the paid timeframes and into their own time.
- Although system leaders had plans in place for the integration of data sharing systems, the number of different systems impacted on the ability of professionals to undertake their

roles. For example, on one hospital ward, a separate system for discharge meant that ward staff could not support people with discharge arrangements if the discharge manager was not present.

What are the experiences of people receiving services?

- People's experiences of receiving services differed across the city. In the north of the city there were good arrangements to support people in the community to prevent hospital admission. However, once people were admitted to hospital their discharge was more likely to be delayed. In the centre of the city there were fewer joined-up services to prevent hospital admission however when people were admitted their return to their previous or new place of residence was less likely to be delayed. Overall, there were high rates of attendance at A&E by people over 65 in Manchester, which showed that people were more likely to find themselves in crisis.
- People who attended A&E often had to wait for more than four hours, particularly in the north of the city, and there were high numbers of people who had to wait for more than an hour in ambulances. This could be distressing for people who were unwell and waiting to be seen.
- People who lived in care homes in Manchester were at a greater risk of becoming unwell from avoidable illnesses such as pneumonia and urinary tract infections than people in similar areas.
- There was little support for older people with low-level mental health issues which placed them at risk of escalating into crisis and depending on emergency services. In addition, although we saw good examples of psychiatric liaison in the Manchester Royal Infirmary, processes around triage for people with mental health issues were not always clear.
- Care for people at the end of their lives was inconsistent; there was a more robust service in the north of the city with a multi-disciplinary team to support people in their own homes. This was not available to people in the centre or south of the city and there was no hospice in Manchester to support older people at the end of their lives.

Are services in Manchester well led?

Is there a shared clear vision and credible strategy which is understood across health and social care interface to deliver high quality care and support?

Strategy, vision and partnership working

System leaders and political leaders across health and social care services in the city of Manchester, within Greater Manchester, have created a clear and credible strategy and vision that is built on partnership working. We found that this was clearly communicated and understood at all levels of health and social care commissioning organisations, secondary care providers, voluntary sector organisations and social care providers. Frontline staff we spoke with throughout the review were enthusiastic about the delivery of the vision and believed that it was a force for positive change.

However, we did find that there was some anxiety among primary care providers about how commissioning changes would impact them, and the focus on transformation has the potential to divert system leaders from opportunities to respond to current operational issues and pressures.

- In February 2015 system leaders in Manchester were among 37 NHS organisations and local authorities that signed the Greater Manchester devolution agreement with government which would enable them to take control of health and social care spending and decision making in the region. This became effective on 1 April 2016 and set out a vision across GM, which is reflected in the Manchester locality.
- Leaders across Manchester and Greater Manchester have a strong understanding of the challenges posed by poor population health, and poor health and care outcomes. Leaders reported in their response to the system overview information request (SOIR) that devolution provided the platform to address these challenges, through strong system leadership and governance provided by the Greater Manchester Combined Authority and the Greater Manchester Health and Social Care Partnership, working with localities including Manchester.
- The City of Manchester Health and Wellbeing Board (the HWB) is accountable for the delivery of Manchester's vision and plan which forms part of the delivery of GM transformation plan. The Transformation Accountability Board is accountable to the HWB.
- In Manchester, health and social care commissioners formed Manchester Health and Care Commissioning (MHCC), a partnership to drive the transformation of services across the city with the delivery of integrated health and social care through joint commissioning. The MHCC agreement is based on the principles that there should be a single commissioning voice in the city, underpinned by shared governance and a single financial budget for the

local authority and CCG to improve the population's health and wellbeing. This began in April 2017.

- The MHCC board is made up of members of the CCG governing body and the Director of Strategic Commissioning is also the Director of Adult Social Services (DASS) which ensures a genuine partnership approach to the commissioning of health and social care across the city. Two elected members of Manchester City Council also sat on the board which ensured that there was political leadership and representation of people who live in Manchester. Although the board was relatively new at the time of our review, board members had a clear strategic vision and insight into the areas that required development.
- Plans are agreed through the HWB and MHCC. Strategic plans such as the Joint Strategic Needs Assessment (JSNA), the Manchester Locality Plan and Our Manchester – The Manchester Strategy, had clearly aligned priorities that support the delivery of the Manchester Transformation Plan. A Population Health Plan produced for 2017-2021 through GM devolution had begun to inform the delivery of services. The Manchester Ageing Strategy was a key driver for Manchester as an age-friendly city. The Manchester plans are consistent with and aligned with the Greater Manchester devolution agenda - Taking Charge Implementation and Delivery Plan. Manchester as a locality is a member of the Greater Manchester Health and Social Care Partnership Board and its locality plan reflects the GM vision, while being responsive to the specific needs of Manchester. Manchester has secured transformation funding and has a detailed cost proposal in place for the deployment of the additional services captured in the Greater Manchester Investment Agreement.
- As part of the transformation agenda, structures around the delivery of health and social care will incorporate a single commissioner organisation (MHCC), a single hospital service and a local care organisation (LCO). In October 2017, the University Hospital of South Manchester Foundation Trust and the Central Manchester University Hospitals Foundation Trust combined to form the Manchester University NHS Foundation Trust, with the North Manchester General Hospital, currently part of the Pennine Acute Hospital Trust, due to join the single structure in the future. Timescales for this were not clear at the time of the review.
- The LCO had a board appointed which was in shadow form and due to become operational in April 2018 following procurement. This would be a collaborative partnership providing mental health services, community services, GPs and social services in Manchester. The single hospital service will hold the contract for the LCO. A Manchester Agreement was in development which described the approach the system would take to identifying, managing and delivering the performance, benefits and evaluation aspects of the transformational system change.

- System leaders were developing the contractual framework for the LCO and this was not yet in place at the time of our review. There were still three GP federations in place reflecting the footprints of previous CCGs in north, south and central Manchester; however a new overarching federation had been formed and each federation had a transformation manager in post.
- Discussions were underway to determine future partnership arrangements within the LCO. These were not yet as developed as the work around the single commissioning structure. GPs expressed some anxiety about the LCO being accountable to the acute trust; however federation leaders were realistic about the strategic requirement for the trust to hold the contract and were working on putting in place measures to identify any perceived risks. Within the LCO, 12 neighbourhood boards were being developed so that priorities and plans could be developed around local community identities.
- Prior to April 2017, health services were commissioned by North, South and Central CCGs; they combined in April 2017 to form one Manchester CCG. However, historically there were different ways of working across the city. Frontline staff told us that although they understood and supported the plans for transformation in Manchester, in practice they were still operating as three separate localities at the time of the review.
- There were clear timescales and measures for the delivery of the transformation plans. System leaders were clear that for these to become embedded they needed to be delivered in a measured and structured way. However, we found that the focus on transformation was resource intensive. Although performance across health and social care was closely monitored, the dependence on the transformation programme to resolve issues around delivery meant that sometimes system leaders missed opportunities to respond to shortfalls in delivery that could be addressed more quickly outside the transformation programme.

Involvement of service users, families and carers in the development of strategy

- People who lived in Manchester were routinely involved in the development of the transformation strategy. System leaders told us in their response to the SOIR that engagement with older people takes place through the Age Friendly Manchester programme. The Age Friendly Manchester Board is made up solely of older people and supported by the Council's Lead Member for Older People. When new initiatives are planned, commissioners and senior managers consult with the Age Friendly Manchester Board to shape proposals. We saw evidence that the views of local people were taken into account in the design of services. For example, a Healthwatch review into the impact of changes to dialysis services has resulted in the implementation of mobile dialysis units.
- People who use services, their families and carers were engaged to feed their views onto the following boards and committees that aligned to work streams delivering the strategy and vision:

- Our Manchester Disability Plan Board (formerly the All-Age Disability Strategy)
 - Housing for an Age Friendly Manchester Board
 - MHCC Mental Health Liaison Group
 - MHCC Quality and Performance Committee
 - MHCC Provider Selection Programme Board
 - GMMH Service User and Carer Forum
 - GMMH Transformation Work-Stream
- System leaders anticipated that the development of 'neighbourhoods' would further enable engagement with the local community, although some neighbourhood areas were ahead of other areas.
 - The shadow LCO board held 12 neighbourhood-based events in June 2017 with engagement from primary care, adult social care, community based nursing staff and representatives from the voluntary sector and members of the public to determine what local people wanted from the LCO. Afterwards, through a large participatory exercise, they worked with the people who had contributed to pull the feedback together, enabling people to write their own vision and goals. The LCO board told us they were absolutely committed to co-production, working with people who would be using services to test new systems.
 - The HWB worked to engage with LGBT people and black and minority ethnic (BME) communities. Engaging with BME communities presented a challenge in Manchester where there are 190 different languages spoken. The board had undertaken targeted work around engaging with hard to reach communities such as the Roma community and had undertaken specific work linking with Macmillan and a charity to engage the Chinese community.
 - Healthwatch were members of the HWB which ensured that the views of local people could be represented at this level.

Promoting a culture of inter-agency and multi-disciplinary working

- At the time of our review the previous commissioning arrangements based around the north, south and centre of the city meant that integrated services were at different stages of development. Where services were integrated and co-located, frontline staff were clear about the benefits to the people they supported. Leaders cultivated areas of good interagency working and were building on these successes to support the delivery of the transformation plan.
- Where health and social care providers operated separately across the city, staff expressed frustrations at having to deal with different systems which impacted on their own ability to support people. In one area, four weekly review meetings were held with domiciliary care providers which enabled them to discuss any issues regarding a person's needs with

contracts officers and social workers and facilitated timely reviews and reassessments. In other parts of the city, providers struggled to engage with services. Some of these arrangements could be delivered more widely as 'quick wins' and did not need to depend on the roll out of the transformation programme.

- Manchester's transformation plans and changes in leadership and governance would ensure the integration of health and social care through multi-disciplinary and co-located teams based in neighbourhoods working together to deliver seamless pathways of care to local people.
- System leaders reported that the HWB is an effective strategic body that leads the system. The health scrutiny committee supports the full integration of services and will continue to scrutinise both health and social care which ensures that future interagency working would be supported by strong political leadership.
- Leaders were engaging with staff across organisations to prepare them for integrated working. For example, there had been regular face to face communication with staff from Manchester City Council over the last six months, including a staff conference. The Chief Accountable Officer for MHCC offered staff from across organisations opportunities to meet for informal conversations to discuss issues around transformation.
- Leaders told us that with new integrated teams they would reach a point where assessments would be 'trusted assessments' and strengths-based. Inter-agency work would enable people to connect to integrated support through an 'early help' service and wellbeing officers with strong community connections. This would be managed by infrastructure and services in the neighbourhood teams.

Learning and improvement across the system

- The quality of adult social care service provision in terms of CQC ratings was lower in Manchester than in most of its comparator areas with a high percentage of locations rated as inadequate or requires improvement. Although we saw that there was a culture of learning and improvement among system leaders, they had not focused on this area of provision. Work was being undertaken within the Greater Manchester framework but there was a need to urgently address the reasons for failure in local adult social care services. Some domiciliary care services had exited the market and there was no evidence of analysis and learning from this to prevent future failures.
- More generally, there was a focus on learning and improvement. During our review we found that system leaders were reflective and there was a culture of seeking and acting on feedback at all levels. Performance was measured through a continual review of shared health and social care data.

- System leaders told us in their response to the SOIR that work led through the Urgent Care Board was addressing deficits in systems and processes that impact upon the acute settings and delayed transfers of care. For example, with regard to winter resilience planning, for 2017/18 they agreed to move from local independently developed plans towards a citywide framework for system resilience planning across health and social care partners. This new arrangement was developed out of a system-wide debrief following the previous winter. The plan was presented to the HWB so that there was a clear line of sight through the system. Before it was signed off by the HWB, the health scrutiny committee had to opportunity to review and discuss it.
- Work was being undertaken at other levels of the system to facilitate learning and improvement. For example, the shadow LCO board reported that the GP federations had begun discussions about GP practices that were poorly rated and how they might improve them. We saw a paper which analysed the issues so that they could consider where to target improvement work.
- Arrangements were in place for frontline staff to learn and improve through the investigation of complaints. For example, at one service we visited, staff were able to describe how learning from complaints would be shared across the organisation and at education sessions. Leaders told us that staff involved in complaints would have the opportunity to produce a reflective statement and incorporate learning as part of their personal development.

What impact is governance of the health and social care interface having on quality of care across the system?

Overarching governance arrangements

- Governance arrangements were clearly articulated from the GM Health and Social Care Partnership down to locality levels. In the city of Manchester, the MHCC board was a single board holding to account the executive of MHCC. Sitting within the governance structure, the Director of Strategic Commissioning is also the Director of Adult Social Services (DASS). Leaders had ensured that the functions of adult social care would have a direct line from DASS to Chief Executive of the local authority with monthly reports on the statutory responsibilities of the DASS. There would also be a director of adult social care within the LCO for all safeguarding and statutory responsibilities with a reporting line to the DASS. These arrangements would ensure that the individual partner organisations could meet their statutory responsibilities while working within an integrated commissioning structure.
- System leaders told us in their response to the SOIR that a performance dashboard is presented to the Manchester Urgent Care Transformation and Delivery Board each month. We observed a meeting of this board as part of the review. Locality delivery groups focus at

an operational level on associated action plans. Comprehensive dashboards are presented within each group and data is circulated across all partners on a daily basis. Key performance indicators (KPIs) associated with investment are also reported against each month at these groups. We saw that the dashboards were based around continuously refreshed information. However, there was a focus on performance indicators that could be measured through national returns such as the Adult Social Care Outcomes Framework (ASCOF) and there was a missed opportunity to incorporate more operational key performance indicators at the board that would impact on the delivery of key targets, such as the quality of social care provision and the provision of care packages in the community.

- Frontline staff expressed frustration that the system leaders' focus was on indicators such as delayed transfers of care (DTC) and felt that more operational monitoring, such as on the availability and delivery of home care packages and the timeliness of assessments and reviews, would support the management of DTC. The LCO will be required to provide data around key performance indicators to MHCC, some of which are around promoting independence and should encompass these issues.
- On an operational level, parts of the system such as the Community Assessment and Support Service in the north of Manchester had a fully integrated performance report, which could demonstrate the success of the integration of intermediate care and reablement in avoiding admissions from the community to acute care.
- A Greater Manchester Health and Social Care Estates board was in place to draw together delivery of priorities around health and care estates management across the whole of GM based on national drivers. Agreed sets of memoranda had been put in place across health and social care to enable them to deliver joint priorities. Within the city the strategic estates group drew together property partners, interested third parties and health and social care to agree priorities and update on the progress of each work stream. This work was critical to ensure that estate management aligned priorities around the integration of health and social care teams and neighbourhood teams.
- Health scrutiny committee members felt able to fully challenge local authority officers and partner organisations on current performance and practice while also considering the proposals for transformation currently in development. They reported that they were assured that increased investment in additional support for reablement and complex care reablement was being released, including; additional resources to support carers, extra care housing and neighbourhood apartments to support more timely discharge from hospital. They demonstrated an understanding of and engagement with the local transformation strategy and its alignment with the GM programme of adult social care reform.

Information governance arrangements across the system

- System leaders recognised that the successful delivery of integrated working would be dependent on robust information governance arrangements and information sharing. Manchester's strategic plan for facilitating information sharing was the city of Manchester's Locality Plan - Integration of Health and Social Care: Information Technology Strategy. The strategy outlines the current technology programme in place and sets out a future roadmap, including options for how technology services are delivered to the LCO. MHCC has established data sharing contracts and data sharing agreements with health and social care providers to facilitate the sharing and linkage of datasets to support direct care, and population health and commissioning intelligence.
- In the Better Care Fund (BCF) returns for Q4 2016/17 the HWB confirmed they were working towards better data sharing between health and social care, based on NHS number; were pursuing interoperable application programming interfaces (APIs); had appropriate information governance controls in place; and had ensured that people have clarity about how data about them is used, who may have access and how they can exercise their legal rights.
- The development of technology to support the strategy was still in early stages and there were many different systems in operation across the city. There were concerns about managing data recorded in historical and hereditary systems, and some systems – although integrated – were still using paper. We saw an example of this in one of the acute hospitals where the ward staff were unable to access discharge managers' information, impacting on their ability to support the discharge process.
- An IT solution, the Manchester Shared Record, was being developed to ensure that health and social care practitioners had the required information to make informed care decisions. At the time of our review the system had gone live with around 7500 people who had been identified by risk stratification. The full roll out was planned for December 2017. It still requires practitioners to input into their systems of record i.e. MiCare (social care) and EMIS (for community health). To facilitate this, data sharing agreements and contracts had been signed by GP practices, the acute hospitals and mental health trust and the local authority. The GP record, acute hospitals record, mental health and social care record and any care plans inputted in the Manchester Care Record will be available on the system.
- Frontline services were continuing to seek solutions for information sharing in the meantime. For example, all 90 GPs in the city were using the same system and sharing information. Some GPs were involved in the pilot around the shared record and testing how they will be data sharing for some of the new models of care.
- In the former Central Manchester Foundation Trust, leaders identified that different systems were acting as a barrier to managing risk and performance so they developed a database

that recorded where patients were on their journey. This has helped as a short-term measure; however they felt that the introduction of the new system would effect a better level of information recording and security.

- Frontline staff told us that operationally there was a sense that systems were starting to align. Staff felt that the success of the integrated working would depend on a single electronic system.

Risk sharing

- System leaders told us that within the MHCC framework there was in development a risk sharing arrangement which sat across health and social care. This arrangement enabled pooled funds to be targeted at areas that would be robustly managing the emerging risks to the delivery of services while also managing their statutory functions and budgets. Leaders were candid and transparent about progress against targets and risks in the system which enabled joined-up approaches to determining solutions.
- Oversight of risks and delivery for urgent care sat within the city's Urgent Care Board whose membership included leaders across the system plus a neighbouring authority, Trafford. Leaders told us that this was a strong team whose remit was to monitor KPIs which identified pressures in the system particularly around DTOC and patient flow. We saw that performance metrics were regularly refreshed and updated. Information was monitored at city level and trust level so that activity could be targeted at areas of risk. System leaders reported on their progress against each of the eight high impact changes using the high impact change model self-assessment tool. They were able to identify early progress against each of the changes in the model that had been developed to reduce DTOC and improve people's care pathways.
- System leaders were responsive to identified risks. For example, a peer review of the safeguarding board identified gaps and as a result procedures were improved. They set up a multi-agency safeguarding hub (MASH). The MASH board met monthly and received performance data. Operations managers monitored performance on a weekly basis and could flag any concerns. There was an audit system and a quality assurance team in place. However we found that frontline staff and social care providers did not always receive information or assurance that reported safeguarding concerns had been addressed. While we did not find any evidence to show they were not being addressed, a system that updated people who contacted the MASH would reduce the likelihood of duplicate referrals and give assurance to people who used it.

To what extent is the system working together to develop its health and social care workforce to meet the needs of its population?

We looked at how the system is working together to develop its health and social care workforce, including the strategic direction and efficient use of the workforce resource.

System leaders had identified the challenges that a significant system transformation would bring to the workforce. A workforce strategy was in development to support this. There were challenges in maintaining a stable qualified GP workforce and social workers had high caseloads. These risks were identified by system leaders who were working with the Greater Manchester Partnership to address recruitment issues to reduce competition between areas and support a stable workforce.

Workforce planning and development

- System leaders told us in their response to the SOIR that a system-wide health and social care workforce strategy was in development and was regularly reviewed. They stated that workforce leads from across the system had come together to understand the range of workforce activity, to secure appropriate capacity, and to develop the strategy. This was governed through a monthly Locality Workforce Transformation Group, which comprised HR Directors from across the system. There were identified themes in place which would underpin the delivery of health and social care transformation plans. Some of the themes included: culture and behaviour change, new career pathways built around apprenticeships, a higher skill mix for care workers, and improving recruitment and retention.
- There were challenges identified in Manchester's primary care workforce. Health Education England reported that the national shortages of GPs was not as problematic in Manchester as it was in other parts of the country, however the north of the city was more challenging as it was an area of deprivation. Manchester was a very popular training rotation area with many trainees going through Manchester. There were difficulties retaining newly qualified GPs. GPs also reflected this and told us that when GPs completed their training there was a perception that they moved to other parts of GM such as Salford or Bury.
- Capacity challenges were identified within the social care workforce. At the time of our review it was reported that some teams were managing high caseloads of complex clients, which impacted on the timeliness of support. We were told that in some teams there were small waiting lists. Additional social workers had been recruited. Furthermore, through the LCO there were plans to expand the social worker workforce to enable more social workers to sit within each of the 12 neighbourhood teams.
- There had recently been a number of staff recruited who were undergoing an induction. To mitigate risks, senior managers undertook audits and dip-sampling so that they could

identify gaps in training and any emerging risks. Our analysis of adult social care staffing estimates from Skills for Care showed that while vacancy rates had reduced between 2013/14 and 2015/16 to be below both national and comparator levels, turnover of staff had increased over this time period. There was work ongoing with GM to resolve workforce issues and concerns had been raised about the retention of social workers, although system leaders identified that some of the recent turnover of staff could be attributed to the impact of significant transformation on some staff who were not ready for changes to their roles at the later stages of their careers.

- Commissioners told us that they saw workforce challenges as the main risk to health and social care providers being able to deliver their commissioning plans to timescale. They described GM-wide challenges to recruiting care staff, including competition from other industries, competition between boroughs, and between providers in Manchester. They told us that their approach was to work closely with providers, and encourage them to collectively address workforce issues to reduce competition. Through the Greater Manchester Health and Social Care Partnership workforce programme, they were able to work closely with their neighbouring boroughs to address challenges. In the longer-term they valued the opportunities through new care models to create an integrated workforce with career pathways that would enable people to move flexibly across the health and social care system.
- Commissioners were looking at how they could support social care providers to attract and sustain a workforce that would meet the needs of the population, including reducing the provider cost base. In addition to gaps in recruitment, there was also a need to address the skills and development of staff currently employed in the sector. An analysis of CQC reports of providers that were rated as inadequate as at October 2017 demonstrated that these providers had shortfalls around training and checking the competency of their workforce. Within GM there were plans for the delivery of a teaching care home which would recognise the skills of the care sector and enable the development of skilled and qualified staff. However, this work was at very early stages; a draft proposal had been completed and was due to be submitted in December or early January.

Is commissioning of care across the health and social care interface, demonstrating a whole system approach based on the needs of the local population? How do leaders ensure effective partnership and joint working across the system to plan and deliver services?

We looked at the strategic approach to commissioning and how commissioners are providing a diverse and sustainable market in commissioning of health and social care services.

There was an integrated strategic approach to commissioning supported by detailed analysis of the population's health needs. Leaders understood that shaping the market, particularly around

the development of new care models, was integral to the success of the local care organisation. There were shortfalls in the quality of social care provision which required addressing in the short-term.

Strategic approach to commissioning

- At the time of our review there was not a consistent approach to clinical support to care homes across the city. Although commissioners expected this to be in place within 12 months, for people living in Manchester this was a significant shortfall and impacted on the health of people living in care homes. Our analysis showed high rates of A&E attendance and high rates of avoidable admissions, both of which are described in more detail later in this report.
- The strategic approach to commissioning was underpinned by analysis of the health outcomes and needs of the local population within the JSNA. System leaders told us that the changes to a single commissioning organisation and NHS acute trust were driven by data identified in an independent report to the HWB. Manchester faced particular challenges. The proportion of older people in Manchester aged over 65 was lower than the England average. Deprivation levels in Manchester were high with more than half the wards in Manchester in the top 20% most deprived wards in the country. The black and minority ethnic population was also much higher than the England average. As part of the planning for the transformation of health and social care services, system leaders had analysed data down to the level of the 12 proposed neighbourhood areas, looking at the breakdown of demographics and health outcomes so that commissioners and providers in those areas would be able to tailor their support to the area's specific needs.
- The shadow LCO board intended to take their plan for the delivery of services to the transformation board at the end of November 2017. The plan would describe the new models of care; there would be three 'front doors' for people to access health and social care services, reduced from 137 different processes currently in place across the city. They described online systems for buying services with personal budgets, online access to health and social care services and neighbourhood community connectors to reduce social isolation. However, voluntary sector providers told us that many people – particularly older people – struggle to engage with online services and leaders' plans will need to ensure that services are easily accessible to people who cannot manage technology and who rely on face to face contact.
- An integrated winter resilience plan, developed by the Urgent Care Board, had been presented to the HWB. Commissioners told us that they were working to building a resilient system to respond to people in crisis. The Community Assessment and Support Service (CASS), an integrated care model, in the north of the city had proven effective in reducing emergency admissions and system leaders planned to roll this out across the city from January 2018. This will encompass trusted assessors and discharge to assess, and be

supported by having pharmacy and diagnostics in the community to meet people's needs. Commissioners told us that as part of their winter planning they were mitigating against the risks of a fragile provider market by including incentives within contracts to support winter pressures. For example, they were offering financial incentives to providers to release beds that could be used for reablement and also block booking care hours.

Market shaping

- Capacity in the residential care and domiciliary care market in the city of Manchester was stretched. Our data analysis showed that the number of residential beds per population aged 65+ was lower in Manchester at 1009 than in similar areas which averaged 1306 and the England average of 1264. The number of residential beds had also decreased by 4% between April 2015 and April 2017. The number of nursing home beds for people aged 65+ was, at 1646, higher in Manchester than in similar areas which averaged at 1275 and the England average of 1126.
- Three of the 12 domiciliary care providers that the local authority commissioned had exited the market owing to financial constraints. Commissioners acknowledged the market pressures faced by homecare providers in terms of recruitment and retention and the impact of low wages. Domiciliary care providers reported that with the introduction of the living wage, the fees they received meant their businesses were unsustainable and that fees would require a significant uplift for the provision of their services to become financially viable. They also felt that the short-term contracts on offer were difficult to manage with little incentive to invest in resources such as equipment.
- System leaders recognised that the commissioning model to date had been time and tasked focused and there was a need to adopt a strength based approach to homecare provision and commissioning. A report was submitted to the health scrutiny committee in September 2017 describing how the city's plans for new models of homecare aligned with the GM strategy. The new model proposed was to be an intelligence-led and outcome-based approach; however this was in very early stages of development. In the meantime, commissioners were required to commission care outside of the framework to meet demand.
- The quality of nursing home, residential care and domiciliary care provision was poor. Although the city had more nursing home beds, only 45% of the nursing homes were rated as good by CQC, compared to 59% across similar areas and the England average of 68%. Our analysis showed that the number of DCA locations had reduced by 3% between April 2015 and April 2017 in Manchester although there were still more DCA locations per population aged 65+ in the area (65) compared to the average across similar areas (62) and the England average (46). However, a higher percentage of DCAs were rated requires improvement in Manchester (38%) compared to similar areas (21%) and the England average (15%).

- The GM Partnership had supported the formation of a GM level provider forum, although at the time of our review this was in its infancy and not fully signed up to by Manchester providers. Commissioners also recognised that new structures and ways of working would require new ways of engaging with providers in the future, particularly as a collective of boroughs with the GM area. Social care providers told us that they were feeling the impact of “fragmentation” and change and that commissioning arrangements needed to be more stable, as a lack of stability and issues around timeliness of contracts impacted on their ability to make long-term plans and investments. They were positive about the transformation programme, the work within GM and recent the appointment of the DASS. However, they felt that not all independent social care providers understood the long-term vision and that commissioners could do more to engage with them and to involve them in the development of the strategy.
- The local authority’s *Local Account and Market Position Statement* provided information for the marketplace on their strategic direction and commissioning intentions. Within MHCC, a market development post at a senior level was being developed. They reported that city-wide monitoring of patient flows was in place which track and monitor patient flow through the acute sector and including residential and nursing sectors. These would enable improved monitoring of bed capacity and will inform future commissioning requirements however this was not fully integrated at the time of our review.
- There was a residential and nursing care delivery group that sat within the GM Partnership and senior leaders from Manchester sat on the delivery group programme board. The focus of the delivery group was on quality improvement rather than expanding the market which, if successful, would improve the market in the city of Manchester as well as improving the health and quality of life of people living in these services. In the meantime, providers told us that they felt under significant pressure to accept placements. Some providers also received requests for placements from neighbouring authorities which meant that there was competition in the market that impacted on local people as local places were in short supply.
- System leaders told us that the locality plan is part of the GM strategy and they would work with GM leadership to engage the market and help them to co-design local services. In terms of engaging and developing the market, when the LCO becomes established, there would be a framework of contracts with providers who share their vision and the LCO will draw down packages of care from those providers.

Do commissioners have the right range of support services in place to enable them to improve interface between health and social care?

- At the time of the review, commissioners did not yet have the right range of support services in place to help them to improve the experience of people as they moved through health and social care. There were areas of good practice in parts of the system but

systems were not yet in place to support people in Manchester throughout their journey. For example, in the north of the city people were supported to avoid hospital admissions through joint working with health and social care services however the pathway for people became disjointed when people were admitted and required discharge.

- System leaders told us in their response to the SOIR that, “on a Greater Manchester level, the Greater Manchester Commissioning for Reform Strategy outlined the strategic approach to commissioning at different spatial levels- Greater Manchester, city wide, neighbourhood”. They were developing investment agreements to ensure that investments in new care models would lead to reduced demand for acute services, and payment mechanisms so that all parties would share in the financial benefit of reduced demand. This was encompassed in the new structures that were taking effect in the city with the single commissioner (MHCC), the single hospital service and the LCO.
- Commissioners also told us that they were adopting a more strategic approach to developing the VCSE sector market and commissioning contracts in a way that made it easier for VCSE organisations to bid for them. Previously the local authority’s funding to the sector was disjointed. They have since pooled voluntary sector funding, centralised commissioning, and were working with Manchester Community Central, a VCSE sector support organisation, to enable funding to reach smaller community organisations which would enable them to address issues such as social isolation.

Contract oversight

- An LCO outcome framework was in the early stages of development, with outcomes identified although measures were still under development at the time of our review. This would enable commissioners to gain assurance that providers were delivering against targets that were aligned to health and wellbeing priorities for the people of Manchester. There would be clear lines of accountability from providers to the LCO board, through to the single trust and to MHCC.
- System leaders told us in their response to the SOIR that MHCC has established strong governance arrangements to allow a joint approach to improving quality and performance across health and social care providers. This was overseen by the Director for Performance and Quality Improvement who reported directly to the MHCC Board.
- In the meantime, contract oversight appeared underdeveloped, particularly with regard to the social care market. Although there was a quality framework in place, providers reported that commissioners did not actively support providers to improve quality unless the service was in crisis. Support interventions for services in crisis were new in the city. CQC inspectors felt that contract officers did not readily engage to discuss emerging concerns and cited difficulties in being able to meet with commissioners; conversely commissioners believed that it was a lack of capacity in CQC that had impeded discussions about quality and risk.

- Some concerns around contract monitoring were reflected by system leaders. They told us that historically there had been two different approaches to quality monitoring in health and social care and they had done a lot of work to bring it together through the integrated team. They described a system of regular quality visits based on risk assessments of homes and a gold, silver or bronze rating which informed the frequency of the visits. There had been a pilot in one home with an integrated quality team looking at issues such as medicines management, tissue viability and infection control which had been successful and if rolled out would have a positive impact on the quality of care in services. Leaders acknowledged that there was further work to be done in proactively monitoring risks in residential and nursing homes.

How do system partners assure themselves that resources are being used to achieve sustainable high quality care and promoting people's independence?

We looked at resource governance and how systems assure themselves that resources are being used to achieve sustainable high quality care and promote people's independence.

- The health scrutiny committee detailed the plans they have scrutinised and endorsed relating to adult social care budgets, finance and social work team capacity. They also told us that, “the significant focus by Scrutiny on the system transformation programme is driven as a consequence of a deliberate approach to no longer secure financial savings/cuts through a silo based approach in isolation from wider system impacts”. Members reported that a joined-up health and social care system delivered through the transformation programme was fundamental to managing forecast gaps in funding. They identified that system leaders would need patience to see the programme through while delivering and managing current operation pressures.
- As part of the devolution agreement, there were pan-GM assurance processes around the BCF plans which gave the GM Partnership oversight of the BCF plans. The individual localities were able to agree their locality plans with the GM Partnership who supported the local delivery. System leaders described their relationship with the GM Partnership as “symbiotic”; Manchester benefitted from funding arrangements and support while their success would contribute to the success of Greater Manchester.
- System leaders reported that there were safeguards built into the governance systems to ensure that resources were managed effectively. For example, although the local authority and CCG had integrated commissioning arrangements under the MHCC board, safeguards ensured that MHCC could not overspend on the local authority budget. A treasurer was on the board as a guardian of the local authority statutory functions. Conversely, although partners could share resources to manage risks in the market, the CCG could continue to

meet its statutory responsibilities in respect of NHS funding. There were clear accountability frameworks from GM Partnership level through to the LCO to ensure that resources were optimised and organisational boundaries reduced.

- The shadow LCO board reported that their key priority was to establish a system that delivered safe and coordinated pathways of care. They reported that they had an external partner working with them around due diligence and would have a risk register to help them focus on this. They were realistic in understanding that they were taking on services that were very varied.

Do services work together to keep people well and maintain them in their usual place of residence?

Using specially developed key lines of enquiry, we reviewed how the local system is functioning within and across the key area: maintaining the wellbeing of a person in their usual place of residence

Are services in Manchester safe?

Safeguarding structures and processes were in place to avoid preventable harm to people as they moved through the health and social care system. Although there was an overarching strategic approach to managing safeguarding, there were different initiatives across the city, and this inconsistent approach meant that people were not always safely supported in their usual place of residence. The care home sector was a particular concern and more could be done to engage with and support providers to ensure that people using these services received safe care and treatment.

- Our data analysis showed that the rate of A&E attendances from care homes for people over 65 per 1000 population was much higher in Manchester than the England average (56.2 in Manchester; 36.1 England average). Updated analysis for 2016/17 showed that the rate of A&E attendance of people aged over 65 living in care homes in Manchester was still above national and comparator averages. In addition, the percentage of residential and nursing homes rated as inadequate was also higher in Manchester than in similar areas. In the south of the city, there was the Nursing Home Service, which provided support for care homes, including nursing support for medicines management which ensured that medicines were reviewed and only appropriate medicines ordered. Staff in the hospital in the north of the city told us that they saw a high rate of admissions from care homes and felt that a similar model to the Nursing Home Service would reduce admissions. The data also showed that none of the services which were based in the south of the city and may have benefited from the Nursing Home Services were rated as inadequate.
- Our analysis of survey data returned in March 2017 showed that 87.2% of GP practices in

Manchester provided full provision of extended access to GP appointments, which meant patients at those practices had access to pre-bookable appointments on Saturdays, Sundays, and on each weekday for at least 1.5 hours either through the practice or a group of which the practice is a member. This level of full provision is much higher than across comparator areas (22% of GP practices offering full provision) and the national average (22.5% of GP practices offering full provision).

- A practice that we visited offered routine appointments seven days per week. For out-of-hours appointments, there was provision in hubs which were in close proximity to the GP practices. These services shared the same information systems which meant that they could access information about patients to support them in their care and treatment.
- Registered high risk patients were identified by the practice, and the GP, social worker, district nurse and active case manager undertook a monthly review of status, changes to condition and management plans. People who experienced recurrent issues such as urinary tract infections, or had two or more long-term conditions, would go on the high-risk register to ensure they were supported and reduce their likelihood of reaching a crisis.
- Concerns were raised about identifying and supporting people who had low level mental health needs and we were told that leaders were trying to address this. By supporting people with needs related to anxiety and early stages of dementia, there would be opportunities to prevent emergency admissions. The report to the July meeting of the HWB stated that although performance against the national BCF target for rate of early diagnosis of dementia had improved, at 62.33% it still fell short of the target of 67.04%.
- Frailty pathways were not yet in place to identify and support people who might be at risk at an early stage although there was some work underway in the acute hospital in the centre of the city. Early work to identify people who were frail or had complex needs was being undertaken in the emergent integrated neighbourhood teams. This was due to be rolled out as neighbourhood teams became functional across the city and the planned new care models became embedded. In the north of the city they had mapped processes having met with primary care, interim LCO team and community services with further work currently underway.
- At the time of our review there was not a cohesive approach to managing risk for people in communities although the new structures around MHCC and the LCO would enable a more consistent approach when it becomes embedded.
- System leaders told us in their response to the SOIR that the city has invested in assistive technology since 2013. This has included interventions such as fall detectors and automated medication dispensers which enable people to remain independent at home and maintain their safety.

- Other interventions were available in some parts of the city but not others. For example, there was a community falls service in place to support anyone over the age of 18 who was at risk of falling. This was led by nurses experienced in supporting older people. However, this service was only available to people who lived in central Manchester or who were registered with a central Manchester GP.
- The Manchester Safeguarding Adults Board (MSAB) was led by a joint health and social care partnership. The MSAB had consistent membership and offered a range of training to stakeholders. There were opportunities for frontline staff to explore learning from serious case reviews and a 'Professional Curiosity, Confidence, and Challenge' conference was scheduled for November 2017. The MSAB website had a learning and resource hub that was accessible to staff and the public. There was a quality assurance and performance improvement sub-group which had recently developed a set of performance indicators.
- The MSAB safeguarding report for 2016/17 showed a rise in the number of safeguarding concerns reported; however this was attributed largely to an increase in awareness of safeguarding issues. There was a central point of contact for all safeguarding referrals, however some providers and frontline staff said that they were not always made aware of action taken following the referral, and some providers felt that they needed to follow up telephone referrals in writing to assure themselves that information had not been lost. There was no evidence to suggest that referrals had been inappropriately managed, and system leaders began to investigate this concern during the week of our review. Some staff in care homes were anxious about making safeguarding referrals and system leaders had undertaken work with nursing home staff to better engage them in safeguarding processes. Each GP practice had links with a designated safeguarding nurse that carried out four visits per year to the practice and was available for training, education and advice.

Are services in Manchester effective?

There were some integrated services in the city that supported people to maintain their independence and the JSNA had set priorities to develop this further. There was good practice around assessment and intermediate care services in parts of the city, which were due to be rolled out across all neighbourhoods. Although there was some support for care homes in the north and south of the city, leaders needed to consider a strategic approach to developing the knowledge, skills and competency of care home staff, as this shortfall was resulting in high numbers of preventable admissions to hospitals.

- People in Manchester tended to be referred to VCSE sector providers once they were reaching crisis point. VCSE providers told us that in order to effectively support people to live at home, there needed to be more social prescribing from GPs. They confirmed Manchester's status as an "age-friendly" city and said that GPs were aware of services

available; it was the timeliness of referrals that could be improved. Health Education England confirmed that work was being planned to explore what GP services were doing in terms of understanding care pathways and ensuring that the workforce understood the needs of people with dementia and long-term conditions.

- There was also a mixed response with regard to information sharing and the seven-day integrated delivery of services across the city. Frontline staff reported that where services were already co-located, for example in Gorton where the intermediate care team was based, information was shared easily and social workers could discuss issues and get prompt advice and resolutions from GPs and district nurses. If people were already known to services, it would be likely that support provided would be more timely, as a social worker would be already allocated and information about their needs would be available. Staff told us about the “yellow folder” system which holds information about people receiving care at home with regard to their choices, preferences and family involvement. However, this level of information was not shared electronically. There was a shared care record for a small percentage of people using these services however it was not detailed and not shared among all professionals involved in the person’s care pathway.
- GPs were beginning to attend multi-disciplinary meetings to coordinate the care and support of people with long term conditions and complex needs. Frontline staff could describe how this process worked well in the south of the city where there was an integrated neighbourhood team in place. They described how social workers and district nurses being co-located enabled prompt conversations about a person’s needs and holistic assessments of their needs could take place.
- In the meantime, frontline staff and private providers felt that assessments were not always timely or consistent. They confirmed that new referrals would go through a central contact centre but there could be delays in these being allocated to social workers or the primary assessment team. The local authority told us that they continued to measure their progress on assessments against a 28-day target. Social workers carried high caseloads that could lead to delays in people being supported and people would have to be prioritised on the basis of need.
- Social care providers told us that services such as speech and language therapists (SALT), occupational therapists and incontinence assessments were stretched and there could be long waits. There was a risk that in the meantime people’s health could deteriorate and they might require medical intervention. However, when assessments were undertaken staff told us that they would try to enable the person to remain independent at home. People who were known to services would have a support plan in place and reassessments would look at whether people could be supported through the use of increased care packages.

- Data for Q1 2017/18 shows the rate of people receiving personal health budgets in Manchester was above the England average (7.34 per 50,000 compared to 5.82). The report to the July HWB meeting identified that 74% of people with a personal health budget were in receipt of continuing healthcare (CHC). Adult social care staff did not operate in a way that lent itself to the promotion of personal budgets to support people with social care needs. While there was a brokerage system in place to help support people to manage their personal budgets, people found the process of employing people complicated. We were told that consideration was being given to a pre-payment card system to enable people to shop around; however leaders were realistic in their understanding that the local health and care market would require development to support this.
- The take up of direct payments in the city was low. ASCOF data for 2016¹ showed that the proportion of people who use services who received direct payments was low at 10.10 compared to Greater Manchester as a whole (24.88) and the England average (27.47). However, there was much a higher proportion of carers who received direct payments at 93.10 compared to 78.14 for Greater Manchester and the England average of 72.77.
- System leaders described in their response to the SOIR that 12 integrated neighbourhood teams would play a key role in ensuring that people's needs would be assessed holistically to ensure that they experienced high quality care. They acknowledged that some of the teams were more established and effective than others and the neighbourhood team in Gorton Parks was becoming embedded at the time of our review. The CASS based in the north of the city had proven effective in supporting people in the community. There were plans to roll this out across the city and leader of the CASS team was working with the shadow board of the LCO to facilitate this.
- The Urgent Care Board met regularly and monitored a wide range of metrics around patient flow, however much of this analysis was around people who had presented at hospital and their subsequent flow through the system. There could be more focus at the Urgent Care Board on preventative services or analysing the factors that resulted in people seeking help at hospital rather than at home.
- The JSNA was aligned to the Our Manchester Strategy and identified objectives which would enable people to stay healthy and live independently for longer. The intended impact of these was to reduce social isolation, increase life expectancy and increase people living for longer free from disability. There was also a strategic priority aiming to deliver 'right care, right place, right time'. The proposed solution around integrated services with intermediate care and reablement care linked to neighbourhood teams aligned with the transformation work that was already underway.

¹ ASCOF data reported in the Adult social care locality pack q4 16 17.e

- Work was needed to promote training and competency of staff in care homes and nursing homes as our analysis showed there were high numbers of avoidable admissions from care homes. While our analysis showed the rates of emergency admissions to hospitals from care homes decreased during 2015/16 and updated analysis for 2016/17 showed they were below the comparator area average, by January to March 2017, the rate of avoidable admissions from care homes was higher. Manchester was significantly higher than the average with regard to the rate of admissions from urinary tract infections at 348 per 100,000 population aged 65+ in Manchester, compared to 187 in similar areas and 190 in England. The rate of admission from care homes for decubitus ulcers, pneumonia, pneumonitis, other respiratory tract infections and diagnoses related to accidents and injuries were all also higher in Manchester than they were across comparator areas or the national average. Analysis of the care home services rated as inadequate by CQC showed that there were failings in training, supervision, competency checks and understanding of the Mental Capacity Act (2005) in the majority of these services.
- If a person had a long-term condition this information would be held by GPs and they would have a named contact. Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) documentation was widely understood and transferred with the patient, including to independent healthcare providers. In the north of the city, GPs had access to shared data with reablement teams, which enabled timely support and freed up staffing resources. In the centre and south of the city, the lack of a shared information system meant that there was a reliance on staff attending multi-disciplinary team meetings to share information and support the decision-making process.

Are services in Manchester caring?

People in Manchester were supported to be involved in decisions about their care and frontline staff understood their emotional needs recognising the importance of family involvement and reducing social isolation. However, there were some challenges around enabling people whose first language was not English to be involved in decisions about their care.

- Generally, people we spoke with felt supported when they came into contact with services. People at an extra care housing scheme told us how they felt supported by staff and knew who they could speak with if they had concerns. Frontline staff recognised that loneliness and social isolation was an issue for older people living alone and advised that they would signpost people to services to support them with this. Staff told us that there was a sense, as they moved towards the transformation of the city through the locality plan, that people's needs were being considered more holistically taking into consideration people's social and housing needs.
- We saw that assessments of people's needs were coordinated effectively and there was evidence that professionals such as social workers, GPs, occupational therapists and physiotherapists were involved in planning people's care. Some voluntary sector providers

acted as a gateway to services and were an initial point of contact enabling people to access services which met their needs.

- Case files that we looked at showed that people were usually involved in decisions about their care. We saw that options were discussed with people and that consent was obtained where appropriate. However, this was more likely to happen when care was funded by the CCG or the local authority. People who were not eligible for funding received less support and there was a concern raised particularly around services in the north of the city that there was more of a focus on funding than care. Some social care providers suggested that they had been informed when reporting that a person's needs had changed, that residential care would be a more cost effective option than an increased homecare package.
- We saw that families were involved in discussions about care and support. Carers were identified as well as other key relationships. However, where language was a barrier there was a potential over-reliance by services on family relationships and some people told us that family members had turned down offers of support from services as they wanted to provide the care themselves. This did not necessarily reflect the wishes of the person at the heart of the discussion.
- One person we spoke with told us that when their funding was refused, this was done without compassion and that they had felt "abandoned" by social services. A lot of information about services and access to services was online and this could prove a barrier for older people who were trying to arrange their own care and support.
- System leaders were challenged in their ability to accommodate Manchester's diverse population in terms of involving people in their care. Some of the care plans we saw documented people's preferences in terms of support and relationships, but not of their religious and cultural needs. We spoke with people who use services and voluntary sector staff who told us that although there were NHS translation services, interpreters and accessible information were not always routinely available. People whose first language was not English very often had to rely on family members to explain information to them but this presented a risk that family members would make decisions on their behalf. There were interpreter services available to GP practices if appointments were made in advance, however letters sent to patients were written in English. GP surgeries had access to a 'language line' but people were not clear about how to use it and the initial contact needed to be in English. People we spoke with gave examples of having missed appointments because they did not understand the letter and did not have someone at home to help them with it. Some members of black and minority ethnic communities reported that they were uncomfortable with being "screened" by receptionists when contacting their GP surgery.

Are services in Manchester responsive?

Limited preventative services in place resulted in high numbers of older people in Manchester being admitted to hospital. People in care homes were particularly vulnerable with high numbers of avoidable admissions. Arrangements tended to be more robust for people who had already experienced a hospital admission and were being supported by the reablement teams. Intermediate care teams worked to support people to remain independent and there was a wide range of voluntary sector support available for people to choose from. Access to primary care was variable and more work was needed to develop links between GPs and residential services; where there were established links, these worked well.

- Variable access to GPs was reflected in the Hospital Episode Statistics data for April 2015 to March 2016. The rate of A&E attendances that were referred by the GP for people 65+ in the general population was, at 7%, in line with similar areas and slightly below the England average of 8%. However, the percentage of A&E attendances that were referred by the GP for people 65+ from care homes was, at 8%, higher than similar areas (5%) and the England average (6%). For both population groups, the percentage of A&E attendances referred by a GP that were discharged without a follow up was higher in Manchester than in similar areas and the England average, which would indicate that some of those attendances could have been avoided had there been earlier GP intervention.
- Social care providers experienced variable access to GPs across the city. Residential social care providers advised that they struggled to register their residents with GPs and one service was working with at least ten different GPs. This was not as a result of patient choice but as a result of difficulties getting support. They told us that this had an impact on preventative support and could also be a factor in the high numbers of avoidable admissions from care homes. Another residential service had all their residents registered with the same GP. The GP would examine residents on request, including out of normal hours, and worked closely with the service to prevent people needing hospital admission.
- Social care providers told us that people across the city would have a different experience with regard to whether they were seen and supported in the right place and at the right time to suit their needs. In the north of the city, four care navigators were newly appointed with the plan to increase the number of these to twelve. They would support GPs in signposting people to services.
- In the south of the city, the Nursing Home Service reported that there had been success in reducing the number of outpatient appointments that nursing home residents would need to attend as they received regular reviews by a geriatrician. There was a rolling programme of resident reviews which were reported to have reduced emergency admissions.
- There was emerging preventative work in GP neighbourhood teams working together to enable people to get the right treatment without a secondary care intervention. For

example, a GP practice which was part of a neighbourhood team described how the GPs were setting up a group to peer review orthopaedic referrals and identifying which GPs offered services such as injections that would enable them to refer patients to each other rather than to hospital services.

- Overall, the preventative schemes in place were not yet having an impact on the reduction of attendances at A&E for older people. Our updated analysis shows that in every quarter from the start of 2014/15 through to the end of 2016/17 the rate of older people attending A&E in Manchester has been significantly higher than the national average. Between January and March 2017 there were 15,443 A&E attendances per 100,000 people aged 65+ compared to 11,912 across comparator areas and 10,534 across England.
- Domiciliary care providers reported variations in practice which impacted on the level of support for people using services and they told us that in some parts of the city they struggled to engage with services. Levenshulme was cited as an example of good practice where four weekly review meetings with local authority contracts officers and social workers enabled them to discuss any emerging issues with regards to people's needs. This would enable a timely consideration of changing needs and help to prevent people from unnecessary hospital admissions. This approach, if rolled out across the city, would help to reduce admissions.
- There were two intermediate care pathways to prevent hospital admissions; a homecare pathway or a bed-based pathway. If a person was receiving reablement services and became unwell, the home pathway team would work with the reablement team. A multi-disciplinary team assessment would follow up nursing, pharmacy and care support for three or four days and then look at referral to home pathway or increasing care package. Frontline staff confirmed that if increased packages of care were not available, people could be placed into respite or residential beds, particularly as there were challenges with regard to capacity in the homecare market. They stated that this would be a last resort however this needed to be monitored to ensure that 'step-up' bed-based care was not being overused.
- Social care reviews and assessments were not always timely and work was underway to reduce the number of outstanding reviews. Additional staff resources had been put in place to clear the backlog and the local authority was utilising different approaches to reviews, for example telephone reviews. While this might prove effective as a short-term measure to reduce the number of outstanding reviews, there was a risk of reduced personalisation. There were clear targets for the review team to meet by March 2018.
- The CASS had proved effective and the extension of this service across the city would impact positively on avoidable admissions. The CASS team monitored its performance and

was able to demonstrate that, since February 2017, 100% of referrals had been acknowledged within 30 minutes and since May 2017, 100% of initial, urgent and non-urgent referrals had been responded to. They also reported that in August 2017, 94.3% of people using the service saw their independence improve following a CASS intervention compared to 80.4% the previous year.

- VCSE providers told us that people’s choices of services depended very much on where they lived in the city and described this as a “postcode lottery”. However, there was a wide range of support for people to choose from which would enable them to remain independent for as long as possible. Homelessness was a concern in Manchester and there was an aging population of homeless people and the local authority was working with agencies to set up a homelessness hub of 36 units focused on moving people into supported accommodation. Voluntary sector organisations worked well together and liaised to support people to maintain their independence.
- In the south of the city a higher population of students and retired people meant that there was good support for people with services such as befriending services and there was work ongoing with Manchester Metropolitan University looking at ways to reduce social isolation. The care and repair service operated citywide and supported older people with property repairs and improvements. Although the service was designed to support anyone over the age of 60 living in Manchester, only people registered with a GP in the north of the city could self-refer to the service. People living in other parts of the city needed to be referred by a health or social care professional which could act as a barrier to people reluctant to engage with services.

Do services work together to manage people effectively at a time of crisis?

Using specially developed key lines of enquiry, we reviewed how the local system is functioning within and across the key area: crisis management

Are services in Manchester safe?

People in Manchester who were admitted to hospital in an emergency sometimes experienced delays in being transferred to hospital from the ambulance services and also experienced long waits at A&E which could put them at risk.

There were systems in place to ensure that, as far as possible, people who were in crisis were protected from avoidable harm. There was a flow of risk monitoring from individual hospitals to executive boards and these processes sat under the overarching Urgent Care Board. The MSAB managed referrals and there was training available to providers and frontline staff around learning from past reviews and enabling challenge. There was some work in place to identify older people

at risk owing to frailty however this still required further development as there were high numbers of admissions of older people to A&E.

- Although performance was better in central Manchester, people who attended hospitals in the south and the north of the city were likely to experience long waits in A&E. This meant that people might be waiting on trolleys to be seen which placed them at further risk. In addition there were periods when high numbers of people had to wait longer to be transferred from the ambulance to the hospital, which in addition to their needs not being met, could be distressing. Analysis of A&E waiting times during 2016/17 at the former Central Manchester University Hospitals NHS Foundation Trust showed that 92% of people were seen within 4 hours; although below the 95% target, this performance was better than the England average (89%). However performance at the former University Hospitals of South Manchester NHS Foundation Trust was worse with only 86% of people being seen within 4 hours. At the Pennine Acute Hospitals NHS Trust which incorporated the North Manchester General Hospital, only 82% of people were seen within four hours.
- There were systems in place to identify the risks and pressures in relation to secondary care. Leaders across health and social care attended the Urgent Care Board. System leaders analysed and monitored indicators around patient flow including DTOC, ambulance turnaround times and A&E waiting times. There was a citywide urgent care dashboard and an Operations Pressures Escalation Level (OPEL) framework which also identified risks and triggers for escalation, monitoring, in addition to the aforementioned indicators, risk factors such as conversion rates and medical outliers.
- The multi-agency safeguarding hub (MASH) has been running since April 2017 with experienced social workers and approved mental health professionals (AMPs). The hub undertook initial triage and screening. To ensure that the hub was safe and effective, regular were dip sampling and quality assurance audits were carried out. There were clear referral processes for safeguarding concerns raised in the hospitals. Referrals were made through the safeguarding teams and into the MASH. The referral allocation system ensured that, as far as possible, there was continuity of care from the same social worker who would address the concern.
- There were challenges to managing and identifying risk across three hospital sites as they came together to form the single Manchester University NHS Foundation Trust. The board of the new foundation trust told us that there would be arrangements in place to manage risk across the new combined trust. Risk and performance were managed at a high level through the Board Assurance Framework, while also being monitored locally through the sites' individual risk registers
- Work was being undertaken to identify individuals in hospitals who may be more vulnerable owing to their condition and, at the Manchester Royal Infirmary in central Manchester, the

acute frailty team was expanding to include a mixture of GPs and AMPs. The process of identifying frailty had recently been made more effective, moving from a blanket review of all people over 75, to the increasing use of a frailty screening tool administered by the acute team. Frontline staff in the north of the city told us they felt there would be a benefit to the wider development of a frailty tool and support for this group of people.

Are services in Manchester effective?

System leaders in predecessor organisations had designed different systems to support people through the care pathway when they became unwell. Where there were focused initiatives they were generally successful however this meant that other areas operated comparatively less effectively. In the north of the city people were less likely to be admitted to hospital on presenting at A&E, while in the centre of the city, although people were more likely to be admitted, arrangements to discharge them from hospital were more effective. Although system leaders had robust long term plans to standardise good practice across the city, there were solutions around training and awareness for frontline staff that could be put in place in the short-term.

- We reviewed case records of A&E admissions at the North Manchester General Hospital which identified that those admissions were appropriate. Patients had been seen and assessed within expected time frames, with good medical and social histories to inform discharge planning. We saw from case studies that people were involved in discussions about their care and that families were involved where appropriate. However, we observed that discharge planning did not begin at an early stage. We did not see evidence of admission and advice leaflets to help people to plan for their discharge. Patient choice was cited as a reason for delays by staff we staff with. However, analysis of DTOC data covering February to April 2017 shows that this accounted for only 1.1 daily delayed days per 100,000 people aged 18+, below both comparator and England averages for this reason for delay.
- In addition, there was not an embedded choice protocol to support staff. A social worker manager had been doing some work across the city to address this and had identified that people who funded their own care could fall through the gaps. For example, they identified a person who had not been referred to a home-finder service to plan for their discharge as they had not been flagged to social care services. Once they had identified this person, they were able to have conversations about their choices and support them to move out of hospital.
- Frontline staff told us that ward-based social workers had made a difference with ward based planning for discharge able to start soon after admission. However social workers were not based in all the acute hospitals on a seven day a week basis. In one acute trust, we found that social workers managing discharge had separate systems which could not be accessed by ward staff. This meant that ward staff were reliant on meetings and relationships with social workers to support their patients with their discharge arrangements. On one ward we found that this arrangement meant that ward staff did not

understand their responsibilities with regard to discharge arrangements and relied on social workers to manage this. Some frontline staff felt that some of the surgical wards did not engage with discharge planning in a timely way as they often dealt with less complex patients while stroke wards were more effective in engaging with discharge processes. This suggested that training and development around the integrated management of people with more complex needs needed reinforcing.

- Frontline staff from acute hospitals in the centre and north of the city told us that when people presented at A&E, the medical professional might think about transferring the person to an assessment unit, which was not considered to be an inpatient ward. The social workers would get alerts from the homecare agency or family that a person had been admitted to hospital, rather than from staff at the hospital. This presented risks that if the person was not supported by an agency or family there could be delays or missed opportunities to support the person more holistically. There were social workers based in the A&E in the centre of the city but they were only there during normal working hours so the support they offered could only be effective at limited times.
- A discharge to assess model was implemented recently in A&E in central Manchester to assess people before admission to support them to return home or place them on an intermediate care pathway. However frontline staff across the city reported that there was a significant pressure to meet four hour targets at A&E and they felt that some people may get admitted simply to move them out of A&E. In the north of the city care navigators, working in the hospital were able to support patients back into the community.
- Information was shared where systems allowed on the wards. In the acute hospital at Wythenshawe in the south of the city, frontline staff supported a mix of patients predominantly from Manchester and Trafford. They reported that the different local authorities' commissioning arrangements could cause confusion which in turn could be a risk to patients. At the Manchester Royal Infirmary, a hospital social worker held daily length of stay meetings which would enable them to identify new patients who needed support. Before the meeting, bed managers and ward managers would undertake ward rounds and which would feed in to the length of stay meetings. New patients could then be allocated a discharge manager or social worker. This system appeared to work effectively as the Urgent Care Board's DTOC trajectory analysis showed that the DTOC rate at the Manchester Royal Infirmary was, month-on-month significantly lower than at Wythenshawe in the south and at the North Manchester General Hospital. In October the rate was 3.1% at the Manchester Royal Infirmary compared to 9.4% at Wythenshawe and 10.1% at North Manchester General Hospital.
- At North Manchester General Hospital, discharge arrangements were less focused and staff did not always have the knowledge, support and skills to manage these effectively. A pilot project had begun earlier in the year using a "red and green" board system to monitor

delays but this had not been actively followed through or evaluated. There was a lack of awareness among some ward staff around patient information particularly around their length of stay which meant that they were less likely to be proactive in supporting people to return home as soon as possible. On one ward there was no single discharge plan that could be shared with all professionals, but individually-held assessments instead. The discharge team would undertake assessments which they held electronically and the system could not be viewed by ward staff. These wards were also supported by high numbers of bank and agency staff which would also contribute to a lack of continuity of care for patients and impede their smooth transition through services.

Are services in Manchester caring?

People were not always involved in decisions about their care and frontline staff would sometimes liaise with family members to the exclusion of the patient. There was an effective arrangement with the Manchester Advocacy Hub to ensure that people who lacked the capacity to make decisions about their own long-term care had their rights protected however frontline staff needed to be more proactive in engaging these services at an earlier stage to avoid delays.

- Patients were not always supported in a caring way or in a manner that respected their dignity. We saw in one ward that people who were medically fit for discharge were left in bed in hospital pyjamas. There were no attempts made to encourage people to dress and there was no stimulation for people. People who were living with dementia did not have plans to support their specific needs.
- One person who was living with dementia was described as “part of the furniture”. This person had been refused a placement by care home services owing to behaviours that related to their condition. Although the mental health rapid assessment team had reviewed the patient we did not see evidence that their discharge was being proactively managed and as their behaviour had “settled”, there had been a request for a reassessment. This example demonstrated a lack of understanding of the person’s condition. There was a risk that an assessment on a “good” day could result in the person being placed inappropriately and the placement breaking down which would be distressing for the patient and for other residents and staff at the service.
- Once people were admitted to hospital, they were not always involved in planning and decisions about their care. Three patients we spoke with on the wards were either not involved or only partly involved in plans about their discharge. We met with one person who had been waiting for some length of time to return home and their family member was involved in the discharge arrangements. The patient was not kept informed about discussions regarding their care. We did not see evidence of any diagnosis that would indicate this person lacked the capacity to make decisions about their care and this person was worried that they would not be returning home which was their preference. We saw that this was the case, but nobody had discussed it with the patient in order to enable them

to make an informed choice for themselves or to help them understand any potential risks and how they could be supported to manage these. In the meantime, this was causing unnecessary delays while people were making decisions about this person's care, which put the person at risk of becoming unwell and was causing them distress.

- Where patients lacked the capacity to make decisions for themselves, we saw that best interest assessments were undertaken. The Manchester Advocacy Hub was utilised to ensure independent advocacy where required as Independent Mental Capacity Advocates (IMCA) and with regard to Deprivation of Liberty Safeguards (DoLS). This would ensure that people who could not make choices and decisions for themselves would have their rights protected.
- Representatives of the hub told us that as frontline staff became more aware of the Care Act, independent advocacy, and how to access it, there was an increase in referrals. They felt their service enabled more people to be represented and have a voice in their care plans, assessments, and reviews. However, the success of the scheme was dependent on social workers recognising urgent need, identifying appropriate referrals which would require an IMCA and the relevant care home applying at the earliest time for DoLS. Some referrals could be requested at a late stage with best interest meetings planned for the same day. This could impact on the patient as they could not always be available at short notice and this could delay discharge. They also reported that Paid Relevant Persons Representatives referrals sometimes arrived late in the process which could cause further delays. We saw an example on a ward we visited which supported what we were told; a patient who had been medically fit for discharge for a week was waiting for a best interest meeting to be arranged by a social worker.

Are services in Manchester responsive?

People who lived in Manchester and found themselves in crisis were more likely than those in similar areas to be admitted to hospital and once they were in hospital, they were more likely to experience delays in coming out of hospital. Disjointed systems and pathways of care resulted in delays. System leaders recognised good practice in the north of the city where people were less likely to be admitted and there were plans in place to share this best practice with the south of the city. Although patient flow was monitored closely by commissioners, ward level analysis would identify specific pressures around staffing, training the implementation of policies.

- There were high numbers of emergency admissions to hospital. The Department of Health's analysis of March 2016 to February 2017 showed there were 34,556 emergency admissions per 100,000 population aged 65 and over in Manchester, significantly higher than the national average of 24,092 and also higher than the average of Manchester's comparator areas of 28,851. Quarterly analysis conducted by CQC shows that emergency admission rates were significantly higher than average in Manchester in every quarter spanning from the start of 2014/15 through to the end of 2016/17.

- Once people were in hospital, they were more likely to remain there for longer than they should. Analysis of DTOC in Manchester showed that the rate had increased from being below national and comparator averages in 2015, to exceeding both national and comparator averages throughout most of 2016, and then spiking again in February 2017, reaching a peak average of 22.6 daily delayed days per 100,000 population aged 18+ compared to an average of 17.9 across comparator areas and 15.4 across England. The rate of delayed transfers quickly dropped after this point in Manchester and by July 2017 was at 13.9 daily delayed days per 100,000, below the average of its comparators, but still just above the national average of 13.6.
- Services had been designed across the city to address the needs of people in crisis; however they were not consistent in the point at which they impacted on the person's pathway. For example, in the north of the city, there were robust arrangements at A&E to prevent admissions when people presented in crisis. The crisis team took referrals from both secondary and primary care providers and worked to support people who were in crisis in their own environment where possible. This reduced the numbers of people in crisis presenting at A&E. In addition, leaders at A&E worked to analyse the reasons for admissions so that services could be responsive to their needs. There was GP support based in the department until 10pm in the evenings who saw six to eight patients per hour and enabled people to avoid hospital admission.
- North West Ambulance Service (NWAS) had 'alternative to hospital' schemes where they looked at alternatives to admission such as the 'see, hear and treat' system. They reported that there had been a good uptake of this service across Greater Manchester. They reported that this was successful in supporting people in crisis to avoid hospital with only about 40% of calls resulting in transfers to hospital in the Greater Manchester area according to their own data. Overall, our monthly analysis of data for NWAS between August 2016 and July 2017 showed that 68% of calls resulted in a transfer to hospital; however the trust services a wider area than Greater Manchester, including Cheshire, Merseyside, Lancashire and Cumbria.
- System leaders had a robust framework of outcome measures which were shared with the Urgent Care Board. This analysed performance at A&E and conversion rates of A&E attendance to admission. Commissioners of health and social care and leaders in hospital executive teams were candid about the pressures in the patient pathway, particularly around DTOC. They reported in their response to the SOIR that they were particularly concerned about delays at Wythenshawe and in August a business case was approved to release investment monies to enable the range of multi-agency organisations involved in discharge planning to be brought together into a co-located Integrated Discharge Team. Additionally, a new post of Integrated Hospital Discharge Team Leader, to lead the delivery of the new integrated approach to an effective and safe hospital discharge team had recently been appointed to.

- System leaders told us that MHCC is working to coordinate how community services and primary care can support early discharge planning in a more effective way. There was a city-wide approach being developed, based on established practice in the north of the city where the Crisis Team and CASS was effective in preventing admissions to hospital.
- On the hospital wards there were different processes for working with patient flow. This was less streamlined in the north with variation in practices on the wards while in central Manchester there were daily length of stay meetings. In the south, the hospital had different wards for Manchester and Trafford patients who were experiencing delays. This meant that staff were working with different systems and were reliant on arrangements with separate commissioners rather than commissioners working jointly to resolve issues for all patients. However, this disparity should be addressed by the implementation of the Integrated Discharge Team. There had been some recent improvement in reducing the average length of stay for patients. The Department of Health's analysis of the 90th percentile length of stay for older people admitted as emergencies between March 2016 and February 2017 showed that 10% of older people in Manchester who were admitted to hospital stayed in hospital for 24 days or longer. This was longer than many of Manchester's 15 comparator areas, although six other comparator areas had longer lengths of stay. Our analysis of lengths of stay for people aged over 65 showed that the percentage of older people in Manchester staying in hospital for longer than 7 days increased during the 2015/16 year to be above national and comparator averages by the last quarter (35% of older people in Manchester who were admitted to hospital compared to 33% across comparator areas and 32% across England). Updated analysis for 2016/17 shows that lengths of stay over 7 days for older people in Manchester decreased a little to 33% by the last quarter of the year, below the comparator average of 34%.
- Overnight bed occupancy at Central Manchester University Hospital was above the England average, being at or above 90% for each quarter, however over the first quarter of 2017/18 bed occupancy at the hospital fell to 89%. Meanwhile, overnight bed occupancy at University Hospitals of South Manchester was at or below the England average during 2016/17 and was at 87% over Q1 2017/18. Although optimum occupancy rates for hospital beds may vary according to type of services offered, hospitals with average bed-occupancy levels above 85% risk facing regular bed shortages, periodic bed crises and increased numbers of healthcare acquired infections.
- The discharge to assess model in the centre of the city was new and was not yet effective in reducing admissions. In the south of the city the system was working to redirect people from A&E to ambulatory care units but frontline staff felt under pressure to manage high volumes of patients quickly, and because people presented from different local authority areas they didn't have time to consider different admission avoidance pathways. They felt that admission avoidance would be more effective if they were working with a single system.

- Data presented to the Urgent Care Board about conversation rates at A&E showed that admission avoidance initiatives were working in the north of the city. The conversion rates from A&E over the twelve months leading to 9 July 2017 fluctuated between 20% and 25% at North Manchester General Hospital. At Manchester Royal Infirmary, which supported central Manchester, the conversion rates were higher, between 25% and 30%. At Wythenshawe Hospital in the south, 30% of the patients who presented there were from Manchester. Their conversion rates were higher and although they had shown a slight improvement in the period leading up to our review, in some months over the preceding year they had exceeded 30%.
- In the hospital setting there was more support for people from black and minority ethnic communities to access information and frontline staff told us that this was also supported by an ethnically diverse staff group. Information was available in a range of different languages. If people needed to complain there were systems in place across the hospitals to enable this although again, these processes differed. For example, Wythenshawe and North Manchester General hospitals invited complaints by email, while Manchester Royal Infirmary offered an online form. Patient Advice and Liaison Services were available at each of the hospitals.

Do services work together to effectively return people to their usual place of residence, or a new place that meets their needs?

Using specially developed key lines of enquiry, we reviewed how the local system is functioning within and across the key area: step down, return to usual place of residence and/ or admission to a new place of residence

Are services in Manchester safe?

People who returned to their own homes were supported to do so safely, however people who were discharged to services were sometimes at risk of receiving unsafe care and treatment as social care providers did not always have the skills to meet people's needs. Providers reported being pressured to take admissions and commissioners needed to be more proactive in their contract monitoring around quality and safety.

- When people returned to their usual place of residence, there was a Transfer of Care policy with community pharmacists to support the safe transfer of medicines in and out of services between hospital and home. In the south of the city, the Nursing Home Team supported the review of medicines however social care providers told us that in other parts of the city, particularly where residents were supported by more than one GP, management of medicines could be particularly difficult as people would be on different medicines cycles. This meant that managing and ordering people's stocks of medicines could be difficult and a number of different ordering systems could increase the likelihood of errors.
- Nursing home, residential care and domiciliary care providers reported that they were often under immense pressure to take people from hospital owing to the need to reduce DTOC. However, this sometimes resulted in inappropriate admissions. An example was given of a patient being admitted to a care home with a Radiologically Inserted Gastrostomy tube but there were not staff at the care home with the skills to support this person. Nursing Home Team staff reported that these admissions occurred as a result of poor communication from hospitals.
- System leaders did not monitor performance issues in the independent social care sector as closely as they did in secondary and primary care services. There were missed opportunities through their commissioning arrangements to strengthen contract monitoring around quality. Although there was a quality framework with financial incentives for providers to provide better care, this was not robustly monitored and managed. Providers reported that there was little proactive support unless a service was in crisis. They reported that healthcare commissioners did not engage with provider forums despite the difficulties in the nursing home market. In the meantime, commissioners were missing opportunities to assure themselves that people they commissioned support for were receiving safe care and treatment. Analysis of the services in Manchester rated by CQC as inadequate overall as at October 2017 showed that all these services had been rated as inadequate within the 'safe' domain.

- For people who were able to return to their own homes, there were a number of schemes available to ensure that they were able to do so safely. The home from hospital and care and repair schemes which operated across the city ensured that when people returned to their homes they were safe and fit for purpose.

Are services in Manchester effective?

Reablement services were at different stages of integration across the city and people who lived in Manchester were more likely to be readmitted to hospital following discharge. Where reablement services were co-located with staff across health and social care, they proved more effective and there were plans to roll this way of working out across the city. When information was shared between systems it did not always take into account issues such as people's mental health needs which could negatively impact on the person's return from hospital. There was less support for people at the end of their lives in the south and centre of the city. There were some good initiatives such as the home IV service and extra care housing which enabled people to return from hospital and be supported in the place that suited them and their needs.

- At the time of our review, reablement services were at different stages of integration across the city. Where staff were already co-located, they felt this enabled them to support people promptly by making timely joint decisions about their care. Reablement teams in the south and central parts of the city were expecting to be co-located by the end of the year. Social care providers and frontline staff suggested that people who were supported by the reablement team were more likely to receive prompt support with better outcomes if they became unwell again.
- System leaders reported in their response to the SOIR that Manchester was developing a new model of care in accordance with the GM standards on discharge to assess. The focus of the model was to significantly expand the assessment capacity of the domiciliary reablement and intermediate care services with almost a doubling of intermediate care home pathway caseloads and 30% increase in reablement caseloads. This service was intended to support people to return to their usual place of residence and assessments would take place there rather than in a hospital or nursing home bed. This would enable people to receive reablement support and to make decisions about their future care in their own homes.
- The CASS was the wraparound service for reablement and the crisis team in the north of the city. This included the care navigators at A&E who supported people to link with services that would enable them to return home or to an intermediate care bed.
- The provision of extra care sheltered housing has enabled people to return to more independent lives in the community. The reablement team had funding for five units in a sheltered housing complex. This enabled people to leave hospital and live there

temporarily while they regained their confidence and independence before returning home or in some case, for adaptations and repairs to be made to their properties while they recovered.

- Social care staff told us that there was a mixed picture with regard to information shared about people returning to their usual place of residence. Frontline staff at the Wythenshawe community housing group told us about the procedure enacted when residents were discharged from hospital; hospital social workers would share information with staff at the extra care housing service to ensure that any adjustments to care needs were available. Occasionally social care providers felt that they were given the wrong information when people returned from hospital to live at their services. One social care provider reported three instances where issues around behaviour related to mental health needs had not been disclosed. In two instances, this had led to breakdowns in the placements which meant that the person would have had to experience the distress of either returning to hospital or another place of residence, and in the third case the person had been able to remain at the service because they had employed additional staff.
- Responses to our information flow tool supported this finding. There were mixed responses about the frequency with which discharge summaries were shared with social care providers (six of the 16 registered managers of ASC locations that responded said they received discharge summaries 75%-100% of the time, while seven said they received discharge summaries less than 25% of the time). Responses were also mixed in terms of the comprehensiveness of discharge summaries. In particular, six respondents said they rarely received comprehensive information on changes in the person's care needs, while eight respondents said they rarely received comprehensive information on mobility issues.
- In central Manchester the home IV service was commissioned to provide intravenous medicine to people in their own homes, enabling them to return home from hospital sooner. Staff we spoke with were able to describe an example of supporting a patient with a “red list” drug, which meant that they did not have to return to hospital regularly. At the time of the review this service only covered the centre of the city but leaders had recognised its benefits and there were plans for the service to be rolled out across the city. The COPD service in the south was also described as a successful community based service and staff reported that it would also benefit the population of the city if it was rolled out more widely so that people could be supported in their own homes without readmission to hospital. In the north of Manchester, step up and step down IV services are established and an Acute Respiratory Assessment Service is in place.
- There were some gaps in services for people who were at the end of their lives and who wished to be supported outside of hospital. At the time of our review there was no hospice in Manchester and people who needed hospice beds would need to access them in Bury,

Salford, Oldham or Cheadle. Palliative care was supported by the Macmillan service but again the extent of provision varied. In the north of the city there was a multidisciplinary team in place which included GPs, occupational therapists and physiotherapists as well as a consultant and assistant practitioners. In the centre of the city there were only four palliative care nurses employed. The multidisciplinary team had been developed as a pilot and we were told that there were plans to roll this out over the next three years.

- System leaders told us that they were in the very early stages of developing an asset based model across the social care workforce, and this time of change was a good opportunity to work differently. This would encourage an ethos of independence and enablement for people who returned to their own homes and enable them to stay healthier for longer. To support this, they planned to roll out a large organisational development programme over the six months following our review.
- Organisational development would be supported by a change in their recording system to Liquid Logic which would link into EMIS, enabling practitioners across health and social care to share information. This was described as an opportunity to design software around needs which would drive an asset based approach, rather than current software (MiCare) that drives a 'tick box' approach to recording plans.

Are services in Manchester caring?

There needed to be a more joined up approach to services at the periphery of people's care pathways, such as transport. People often found it difficult to navigate through different services and particular attention needed to be given to the people's cultural and religious needs to ensure that they received compassionate and dignified support.

- Representatives of people who use services told us that the system needed to be more joined up and easier to use. It was not easy for people to navigate around the system when they left hospital, as support around services such as patient transport and orthotics were not part of a clear pathway. They felt that rather than describing what a system should look like, the focus should be on patients who want to know and understand how their own needs would be met. They stated that most people did not know that they could self-refer to services. If people did not require reablement, intermediate care support or a domiciliary care package of care, they would struggle to manage the pathways between follow up care and accessing services to support them to stay well.
- People from BME communities reported similar issues and told us that when they returned home they would occasionally receive calls from agencies, possibly with regard to further support or follow up care, but when English was not their first language they would not understand who was calling, what the caller wanted or who to contact for further information.

- Leaders told us that the number of DoLS applications submitted had almost doubled in the previous two years, reflecting an increased awareness among providers. They had increased staff capacity to authorise DoLS and cleared their backlog. They had also seen improvements in the appropriateness of the submissions. They felt that the system had progressed significantly in last 18 months in terms of understanding the requirements around the Mental Capacity Act 2005 (MCA) and the best interests principle. The introduction of integrated discharge teams meant that they are planning for discharge earlier on in the process and working more closely with health partners to do this so that when people returned from hospital to their previous or to a new place of residence, their rights were protected. However, they acknowledged that further understanding was still needed around the MCA, and understanding that it is time and decision specific.
- Case studies showed that people's care plans did not document their religious or cultural needs. For some parts of the community, this could be important in determining how care was delivered. For example, for some people it would be important to them that they did not receive personal care from a member of the opposite sex. This could also impact on cultural traditions and routines as well as personal ones and there needed to be a stronger focus on this. One person from a BME community told us that the refusal of their housing provider to allow an alteration to a toilet resulted in them having to be carried by family members which they found embarrassing.

Are services in Manchester responsive?

Reablement services needed to be more targeted as there was reliance on these services to support people in their return home in the absence of more appropriate packages of care. This was reflected in the low percentage of people who remained at home 91 days after being discharged with a reablement package. Equipment, aids and adaptations were not available seven days a week which could delay people's return home. There were missed opportunities to engage with the voluntary sector to support people on their return to their usual place of residence.

- Although reablement teams and intermediate care teams supported the discharge of people from hospital into communities, our analysis showed that the percentage of people aged 65+ who were offered reablement services in Manchester had followed a slightly declining trend from a peak in 2012/13 of 5.3% to 3.8% in 2015/16. While Manchester remained above the national average during this time, by 2015/16 it had dipped below the average of similar areas (4.2%). However, more recent data for 2016/17 showed that offers of reablement had increased slightly to 3.9% in Manchester while comparator areas had decreased and were averaging 3.8%.
- However, the data indicated that reablement services were not always effective in maintaining older people's independence by supporting them to remain in their home or previous residence 91 days after leaving hospital. In each year from 2011/12 to 2015/16

the percentage of people aged 65+ who were still at home 91 days after discharge into reablement services was significantly lower in Manchester compared to the national average. It was also much lower than the average across comparator areas. While there was some improvement in more recent analysis of 2016/17 data, Manchester's performance was still below similar areas and the national average (70.6% compared to 79.9% and 82.5% respectively).²

- System leaders were candid about their performance benchmarking themselves against other authorities, and described the need to ensure that reablement was more targeted at people who would benefit from the service rather than being relied on as a service to move people out of hospital.
- Frontline staff and system leaders reported that there were not enough domiciliary care agencies and care homes, which impacted on the timeliness of people's discharge from hospital. There was a shortage of homecare provision which meant that reablement services were often providing support to people who could not benefit from it. When we visited wards across the city we saw a number of people who were unable to return home from hospital because they were awaiting packages of care. We saw from case studies that people were routinely offered reablement services although this did not always seem an appropriate option.
- The single main reason for delayed transfers reported between February and April 2017 was 'awaiting care package in own home' accounting for an average of 4.1 daily delays per 100,000 people aged 18+, above the comparator average of 3.2 and the national average of 3.1. Awaiting residential or nursing home placements was also a significant cause of delays, together accounting for an average of 5.8 daily delayed days per 100,000 aged 18+, higher than the comparator average of 3.9 daily delayed days, and the national average of 3.6. While there were more nursing home beds per population aged 65+ in Manchester compared to comparator areas and the national average, the number had reduced since April 2015 by 10%. There were fewer residential care home beds per population compared to comparators and the national average and these had also reduced since April 2015 by 4%.
- There was little evidence of an asset based approach to homecare commissioning across the case studies. One person who preferred to be independent was discharged with a reablement package which they cancelled themselves shortly after their return home. Another study showed an individual being given a reablement package although it was agreed that they would require a long-term care package. Sometimes people who did require reablement were unable to access it. One case study showed that people could not access the reablement service as they were unable to support the person on weekend mornings.

² NHS and Social Care Patient Flow Dashboard, slide 54

- The provision of equipment, aids and adaptations was also variable. If a person was returning home and needing equipment, the occupational therapists and physiotherapists on the ward could arrange this. They could also order the equipment and have it delivered directly to the person. However, the joint equipment store only operated from Monday to Friday which could result in people being unable to return home at weekends. The Macmillan service in the north of the city had access to equipment six days a week.
- In addition, frontline staff told us that if the equipment required was complex, a moving and handling assessment would be required and these could take up to three weeks during which time the person could not return home and was at increased risk of becoming more unwell. System leaders were monitoring this and reported that the percentage of equipment installations by Manchester Service for Independent Living that supported a hospital discharge increased from 2.3% in 2015/16 to 6.2% in 2016/17, but the percentage of installations which prevented a hospital admission decreased from 5.5% in 2015/16 to 3.4% in 2016/17. However, our analysis of data from February to April 2017 showed the rate of delays attributed to awaiting community equipment and adaptations was the same in Manchester as it was across similar areas and England as a whole
- There were missed opportunities to work with the VCSE sector to enable people to return home. In all of the case studies we reviewed voluntary sector providers were not involved in assessments or meetings about people's care. They told us that they received fewer requests for discharge support at weekends and that they were attempting to raise their profile and to be involved in the development of discharge packs so that people could benefit from their offer on their return home. Some told us that they were not given advance notice of discharges; often it was left until the day before or even on the day of discharge to inform services of some adaptations needed. They felt that discharge arrangements did not take into account transport, support services or adaptations which mirrored feedback from people who used services about the difficulties of navigating services.

Social care providers told us that once people returned to a service, or were admitted to a service it was difficult to get their needs assessed again. This meant if they could no longer meet the person's needs, there was an increased risk that the placement would break down and they would return to hospital. Our analysis showed the percentage of emergency readmissions of people aged 65+ within 30 days of discharge in Manchester was consistently above the national average between the start of 2014/15 and the end of 2016/17, although not greatly so. In the final quarter of 2016/17 the percentage readmitted in Manchester was 19.7%, the same as the average of its comparator areas, and just above the national average of 18.6%. Emergency readmissions of older people living in care homes was also consistently higher than the national average between 2014/15 and 2016/17 although it had decreased and by the last quarter of 2016/17 was at 20.6%, below the average of its comparators of 21.5% but still above the national average of 19.6%.

Maturity of the system

What is the maturity of the system to secure improvement for the people of Manchester?

- The system had a clearly articulated vision across health and social care agencies. However, this was in the early stages of maturity. It was aligned with the devolved Greater Manchester Partnership STP (Taking Charge Implementation and Delivery Plan), with a locality plan and an agenda for transformation with clear links all the way through. System leaders had made progress towards realising the vision with the formation of single commissioner, Manchester Health and Care Commissioning. Two NHS trusts had combined to form a single trust although there were not clear timescales for the third hospital to join the single trust arrangement. The board of the local care organisation (LCO) was operating in shadow form and due to become operational in April 2018.
- Governance processes were in place to ensure that there were clear lines of sight around decision making and the development of strategies which were integrated across the system. They were becoming embedded at high-level and operational issues were still being delivered locally in the different parts of the system. It was anticipated that governance and delivery would become unified with the development of the LCO. There is further work to be done on contractual arrangements and provider governance within the LCO model.
- System leaders were working within the GM partnership to agree and shape a sustainable and responsive structure of supply of health and care services.
- While system leaders were moving towards full integration, there were different systems across Manchester operating at different levels. As the system was moving towards fully integrated services, they were engaging with frontline health and social care staff to enable an underpinning ethos to support delivery and this was also being addressed as part of the developing workforce strategy.
- System leaders demonstrated strong relational working and collaboration in the interests of the population of Manchester.
- Digital interoperability was addressed by system leaders through the BCF. At the time of our review there was a wide array of information systems across the city however there was a robust strategy in place to move towards streamlined digital information sharing.
- An integrated health and social care commissioning arrangement facilitated the development of integrated working. There was further work to be done around the

development of personal budgets and direct payments. Arrangements with regard to the LCO capitated budgets required underpinning by clear contractual arrangements.

- The workforce was on target to become fully integrated when the LCO becomes operational in April 2018. There is work with the GM Partnership to address issues around workforce recruitment and retention.
- Plans to develop fully integrated systems had started to be realised through the implementation of the new system structures underpinned by the single health and social care commissioner. However there were significant variances in the provision of services. Where integrated services and preventative services were in place they were provided in different systems across the city. System leaders planned to ensure that the systems that worked well would be rolled out, however evaluating the different workstreams and implementing them was a task of some magnitude and will take time.

Areas for improvement

- There needs to be a greater focus on current operational delivery improvement while developing the transformation agenda.
- There needs to be more robust commissioning and quality contract monitoring to improve the quality of social care services in the city.
- The homecare model is outdated, being time and task focussed and needs to move to a strength-based approach.
- Work is needed with other system leaders within the Greater Manchester area with regard to the secondary care sector to enable streamlined, uniform processes that reduce the need for frontline staff having to work with a number of different systems.
- There needs to be more support for older people with low-level mental health issues.
- Seven-day working across health and social care, including primary care services needs to be more consistent.
- Priority needs to be given to ensuring a consistent offer of services across the city.