

Trafford

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:

- Delivery Lead: Ann Ford, CQC
- Lead reviewer: Rebecca Gale, CQC

The team included:

- Three CQC reviewers
- One CQC analysts

- One Pharmacy Inspector
- Two CQC Inspectors
- One CQC Expert by Experience
- Four specialist advisors (two current Directors of Adult Social Services, one Clinical Commissioning Board member and a former National Director).

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 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 requested 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:

- Senior leaders and managers from Trafford Council (the local authority), NHS Trafford Clinical Commissioning Group (the CCG), Manchester Health and Care Commissioning (MHCC), Manchester University NHS Foundation Trust (MFT – previously Central Manchester NHS Foundation Trust and University Hospital South Manchester NHS Foundation Trust), Salford Royal NHS Foundation Trust (SRFT) and Pennine Care NHS Foundation Trust (PCFT)
- Health and social care professionals including social workers, GPs, discharge teams, therapists, nurses and commissioners
- Healthwatch Trafford and voluntary and community sector (VCS) representatives
- Representatives of health and social care providers
- People using services, their families and carers at the Carers Centre, Fiona Gardens and a dementia day centre run by Age UK. We also spoke with people in A&E, the discharge lounge and visits to intermediate care facilities

We reviewed 20 care and treatment records and visited 11 services in the local area including acute hospitals, intermediate care facilities, care homes, domiciliary care providers, GP practices, extra care housing, the Urgent Care Centre, out-of-hours GP and the Trafford Co-ordination Centre.

The Trafford context

Demographics

- 16% of the population is aged 65 and over.
- 86% of the population is categorised as White.
- Trafford is in the 20-40% least deprived local authorities in England.

Adult Social Care

- 42 active residential care homes:
 - 23 rated Good
 - 13 rated Requires improvement
 - 2 rated Inadequate
 - 4 currently unrated
- 21 active nursing care homes:
 - 9 rated Good
 - 10 rated Requires improvement
 - 2 currently unrated
- 36 active domiciliary care agencies:
 - 16 rated Good
 - 13 rated Requires improvement
 - 7 currently unrated

GP Practices

- 32 active locations
- 2 rated Outstanding
- 28 rated Good
- 1 rated Requires improvement
- 1 currently unrated

Acute and community Healthcare

Hospital admissions (elective and non-elective) of people of all ages living in Trafford LA were almost entirely at the following NHS acute hospital trusts:

Central Manchester University Hospitals NHS Foundation Trust (RW3)

- Received 46% of admissions of people living in Trafford LA
- Admissions from Trafford made up 18% of the trust's total admission activity
- Rated Good overall.

The second main trust is University Hospital of South Manchester NHS Foundation Trust (RM2)

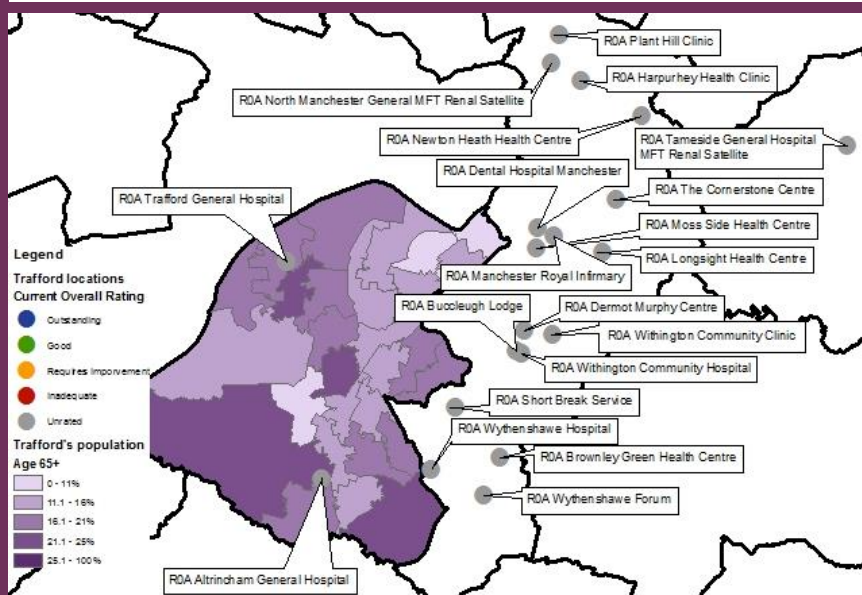
- Received 45% of admissions of people living in Trafford LA
- Admissions from Trafford made up 29% of the trust's total admission activity
- Rated Requirement improvement overall.

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

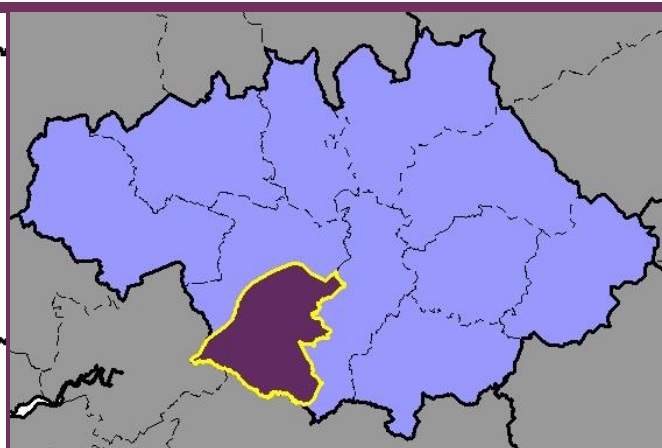
Community services are provided by:

- Pennine Care NHS Foundation Trust (RT2) - currently rated Requires improvement overall

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



Map 1: Population of Trafford shaded by proportion aged 65+ and location of services provided by the main acute trust for Trafford (ROA). Due to the recent merger, locations under this new trust are listed as Unrated. Community locations provided by RT2 aren't mapped as they cover a larger geographic area.



Map 2: Location of Trafford LA within Greater Manchester STP. Trafford CCG is also highlighted.



Summary of findings

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

- There was system-wide commitment to serve the people of Trafford well. Trafford was on a journey of transformation and integration to achieve the strategic vision. The CCG and local authority were due to become fully integrated as commissioners by 1 April 2018 and there were governance structures in place to facilitate this transformation.
- The New Health Deal (NHD) for Trafford in 2012 was a programme of transformation of out- of-hospital services to ensure future viability. This incorporated the redesign of Trafford General Hospital (TGH) from an A&E site to a nurse-led urgent care centre and minor injuries unit, as well a site for day case surgery, some specialist elective procedures and an older person medical assessment unit.
- The context of Greater Manchester (GM) and the devolution of power provides a unique opportunity to transform the health and social care landscape. The Greater Manchester Health and Social Care Partnership is the vehicle for transformation across the GM-wide health and care system. The GM *'Taking Charge Implementation and Delivery Plan,'* set out a compelling and powerful vision for the future of health and social care services. This vision clearly set out what it would deliver for the people of Greater Manchester, and its localities including Trafford. Secondary care was also in transformation with recent hospital mergers and the vision for a single hospital service provided the opportunity for change.
- There was a clear line of communication and accountability from the Greater Manchester Health and Social Care Plan to Trafford. The Trafford Locality Plan and associated Transformation Bid (the Trafford case for transformation and associated transformation funding) were aligned to the priorities and strategic objectives of the wider conurbation, but were specific to the Trafford area, informed by the Trafford Joint Strategic Needs Assessment (JSNA).
- The Transformation Bid from Trafford set out the vision for a new model of integrated community care, mental health services, primary care and social care services to underpin the establishment of a Local Care Organisation (LCO), which would come into shadow form in April 2018. Trafford was earlier on in its journey compared to some other areas in Greater Manchester and system leaders should take the opportunity to see how contractual arrangements are being developed with other LCOs in GM.

Is there a clear framework for interagency collaboration?

- Historical relationships had been challenging across the system and there had been a significant amount of change among system leaders. Relationships were now improving and system leaders described the transformation agenda as the opportunity and accelerator for addressing systemic challenges and cultural issues. There was a shared understanding of the challenges, and a willingness to work together to achieve solutions.
- Manchester Health and Care Commissioning (MHCC) was the agreed GM lead commissioner for acute care, but Trafford system leaders felt their voice was heard in the wider system, despite their relatively smaller 'purchasing power'. To maintain influence, Trafford should continue to ensure that their relationships with secondary care providers remain collaborative and effective. This is critical for improvements to be realised across the system.
- A section 75 agreement had been in place between the local authority and Pennine Care NHS Foundation Trust since 1 April 2016 to provide all-age health and social care community services. Joint commissioning arrangements existed between the CCG and local authority with regards to the voluntary sector, Ascot House (intermediate care facility) and children's community services and they had developed joint working principles ahead of the planned merger when they would form a single commissioning function.
- There was evidence of some risk sharing between partners. For example, the CCG and the local authority had proceeded at risk to implement some of the proposals outlined in the Transformation Bid. However, commissioning was collaborative rather than joint and the system needs to push forward with the transformation agenda through joint commissioning.

How are interagency processes delivered?

- The challenge for this system was to transform services while also delivering improvements to ensure people were cared for in the right place, at the right time, by the right person. While there had been some significant improvements in performance over the past year, it was from a low base and the system's ability to cope with periods of surge in demand was uncertain.
- Governance structures were aligned to the Greater Manchester model and supported partnership working. A high level of scrutiny and challenge was provided by the Greater Manchester assurance process, but the role of Trafford's Health and Wellbeing Board and Scrutiny Board (the health overview scrutiny committee) needs to be strengthened.
- There was interagency collaboration at a high level, but frontline delivery of services was

still siloed. There was a complex service landscape and much of the High Impact Change agenda needed to be implemented, including seven day services and the use of trusted assessors. Strict admission criteria meant Ascot House was not working at capacity and some work was required to engage staff, provide clarity about the purpose of the service and encourage appropriate referrals.

- There were mechanisms in place to consult with wider system partners, including providers and voluntary sector organisations. However, the extent to which they felt like partners varied and there were missed opportunities to include and maximise providers' contributions.

What are the experiences of front line staff?

- System leaders and senior managerial staff were visible, engaged and had an overview of system performance. However, staff were not always clear who held the overall responsibility performance at a system level. Escalation channels were organisation-based and although issues were being escalated, there was mixed feedback from staff on whether this led to change.
- The degree to which frontline staff could articulate the system's vision varied and was often in the context of their own role rather than the wider system. There was a perception that staff were working to competing priorities, often dictated by sector-specific budgets and targets. There was a lack of trust across the health and social care interfaces, which was a legacy of historical cultural issues within the system.
- Front-line staff were committed to providing high quality, person-centred care. We saw some good examples of multi-disciplinary working. However, the system was multi-faceted and not yet working operationally in an integrated way across the health and social care interface. The capacity of individual teams was not always sufficient to keep up with demand.
- Staff reported there were multiple and confusing points to navigate the system and they did not always know who they could contact or which services they could refer into. There was limited evidence to date to demonstrate the effectiveness of the Trafford Co-ordination Centre (TCC). The TCC aimed to provide a single patient register of those identified most 'at risk' to remotely co-ordinate their care and keep them well in the community by anticipating any interventions required.

What are the experiences of people receiving services?

- The experience of people receiving health and social care in Trafford was varied.

- If a person received a reablement service they achieved positive outcomes and were more likely to remain independent and at home. There were effective arrangements in place to provide equipment to people swiftly and community-based therapy services were responsive to referrals.
- However, there were also missed opportunities to support people to stay in their usual place of residence and prevent admissions to hospital. Primary care provision and GP access varied across the borough and information and support was not always easily accessible. In the first quarter of 2016, A&E attendances and emergency admissions from care homes were higher than average. A recent data refresh showed that emergency admissions from care homes had moved to being lower than comparator areas and the England average. However, the actual numbers of admissions from care homes were as high as they were the previous year and an increase in national averages overall had reduced the gap. People were being admitted with conditions that potentially could be cared for in the community, such as urinary tract infections.
- If a person went into crisis, data showed they were likely to be admitted to hospital and experience longer lengths of stay due to a shortage of homecare packages and affordable, high-quality residential and domiciliary care.
- The implementation of the personalisation agenda was underdeveloped. Very few people were in receipt of direct payments or personal health budgets and while there were innovation sites using the 'three conversations' model, commissioning and contractual arrangements were traditional with a time and task focus.
- Providers and people who used services were extremely negative about the continuing healthcare (CHC) process in Trafford in terms of the assessment process and timely provision. There had been an injection of resource into the CHC team and data showed there had been some significant improvements to performance in recent months. Work was required to improve relationships and the negative perceptions.

Are services in Trafford 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?

As part of this review we looked at the strategic approach to delivery of care across the interface of health and social care. This included strategic alignment across the system, joint working, multi-

agency and multidisciplinary working and the involvement of people who use services, their families and carers.

There was a shared clear vision and credible strategy for Trafford, which was aligned to the overarching vision for Greater Manchester. This was well articulated by leaders and there was a real commitment across system partners to deliver together; integration was the vehicle to achieve this. Historically there had been some challenging relationships, but these were improving. Staff at all levels were committed to achieving better outcomes, centred around the person and although there was a will to work more collaboratively they were frustrated by the number of barriers in the way. There were some missed opportunities to involve wider system partners in joint delivery plans, specifically around winter pressures which could have been addressed with a more cohesive, system-wide approach.

There were pockets of integrated working arrangements already in place. The strategic vision for Trafford included establishing a Local Care Organisation to provide the foundations of integrated provision, consistent with the GM-wide vision. These needed to be built upon and expanded at pace with a shift of focus to delivery.

Strategy, vision and partnership working

- System leaders acknowledged that historically some relationships had been challenging, which had resulted in silo working, a culture of blame and a lack of shared responsibility in relation to performance. There had been some recent changes to senior personnel and organisational structures in the system. Relationships within Trafford and between statutory bodies were improving and integration was the vehicle to making the strategic vision a reality. However, we found varying progress in implementation of effective partnership working across different levels of the system. Leaders that we spoke to recognised there was work to be done to integrate delivery, through system transformation.
- The Greater Manchester Sustainability and Transformation Plan, '*Taking Charge Implementation and Delivery Plan*' set out a compelling and powerful vision for the future of health and social care provision and new models of care. Developed in partnership with 37 NHS organisations and local authorities, it clearly outlined what it hoped to deliver for the people of Greater Manchester. The GM STP was rated category 2 – advanced in the July STP progress dashboard.
- A key deliverable of the Greater Manchester Plan was the development of a single hospital service which saw the merger of Central Manchester NHS Foundation Trust and University Hospital South Manchester NHS Foundation Trust to form Manchester University NHS Foundation Trust on 1 October 2017. There was universal support for this change from the

senior staff, voluntary sector organisations and providers we spoke with in the hope it would improve performance and consistency in people's experiences.

- There was a clear line of sight between the Greater Manchester STP, set out in the '*Taking Charge Implementation and Delivery Plan*', and Trafford's vision and strategy, set out in the Trafford Locality Plan and Transformation Bid, which was well understood and articulated by system leaders. These outlined the approach to providing integrated, co-commissioned services with a place-based and community-asset focus to deliver on the vision of "A sustainable health and social care system which aims to help older people be healthy, independent and enjoy living in Trafford". The strategic vision for Trafford focused on prevention and early intervention, outlining proposals for new models of community care, underpinned by the Local Care Organisation which would be coming into shadow form in April 2018.
- A section 75 Partnership Agreement had been in place between the local authority and PCFT since 1 April 2016 to provide community services via integrated health and social care teams within each of Trafford's four localities. Feedback from front line staff and senior leaders about this service delivery model was positive. Leaders described how the partnership agreement had led to effective working relationships with high levels of trust and thought it was something to be replicated across the system.
- Partners had agreed and signed of a joint plan for the Better Care Fund (BCF) within the deadline and the Improved Better Care Fund (iBCF) submission for Trafford was aligned with the Transformation Bid. System partners were working together to begin to implement the changes in the High Impact Change Model, one of the national conditions for the BCF. The rate of delayed transfers of care had started to improve, but much more needed to be done. Commissioners told us they were modelling future commissioning arrangements around the High Impact Change Model, but the extent to which this had been achieved was limited. For example, trusted assessors were being piloted in pockets, but not used widely. Some discharge to assess beds had been established, but seven day services were not operating across the system.
- There was awareness among system leaders of the shared challenge to reduce the causes of delayed transfer of care (DTC). Data showed the whole system had made improvements to the length of stay and number of DTC, but the latter remained considerably higher than average. At the time of our review there were 11 empty beds at Ascot House (an intermediate care facility), but on 16 October 2017 there were 39 people at Trafford General Hospital waiting to be discharged. Ascot House had dedicated GP input for approximately five hours a day, yet the service was supposed to be for medically

optimised people. We were advised that a review of the admission criteria was underway, but this should be concluded as a matter of urgency to ensure that services across the system are being used effectively and that people are being cared for in the most appropriate facility for their needs.

- A review was carried out by the Emergency Care Improvement Programme in 2017. This is a clinically led programme provided by NHS Improvement to provide practical advice and support to improve patient care and flow. As a result, a Head of Patient Flow had recently been appointed at Wythenshawe Hospital. A Community Flow Manager was due to begin work in November 2017. Although there was a clear ambition, there lacked a robust, system-wide response to the contributing factors to DTOC, such as managing capacity issues in the Homecare market. People from across the system told us issues were not being tackled with sufficient urgency to prevent a potential crisis.
- Trafford's plan for winter was presented and signed off at the Greater Manchester Urgent Care Board during the week of our review. The Trafford plan was aligned to Manchester's and had been developed jointly due to shared resilience plans around acute care. However, there was some confusion evident at strategic and operational level relating to the status of the plan. Some groups reported they had only recently been asked for their input, some had been asked to submit their organisation-level plans and others reported they had not been involved at all. Some system partners felt the plan was late, had not been adequately stress tested and was not a systematic approach.
- The system reported that they worked collaboratively with providers, housing partners and voluntary sector organisations. They had commissioned Healthwatch Trafford to undertake a system-wide review of intermediate care and were in discussions with extra care housing providers regarding winter capacity. While there were structures in place to facilitate engagement, there was not a single, coherent approach to working with other partners. Providers and VCS organisations felt the system was well-meaning, but some felt their input was a 'tick-box exercise' and there was a top-down approach to issues such as winter planning and managing delayed transfers of care. Commissioners told us they recognised the potential of VCS organisations in preventative work and the need to learn from previous years and engage with them earlier on, in a more flexible way. However, the plan for winter had already been signed off by the Urgent Care Board, while a meeting with the voluntary sector to discuss winter resilience was planned, but had not yet taken place.

Involvement of people who use services, their families and carers in the development of strategy and services

- The Trafford Partnership, chaired by the leader of Trafford Council, brought together organisations across the public, private, voluntary, faith and community sector and local residents and was the system's Local Strategic Partnership to deliver on the 'One Trafford' vision which aims to make Trafford a place where residents achieve their aspirations and communities thrive. There was a clear line of communication and accountability to Greater Manchester through Trafford's governance structures and Health and Wellbeing Board.
- The response to the System Overview Information Request (SOIR) described the approach to public engagement to ensure commissioning and service planning was based on the needs of Trafford residents. The local authority's approach was underpinned by a strategy, '*Building Strong Communities*' and the Trafford Partnership. Engagement approaches varied from targeted events to help shape the Care at Home vision and commissioning priorities, Locality Partnership Events to empower communities through funding and support; to engagement of the VCS via an umbrella organisation. Thrive Trafford had been commissioned by the local authority to establish a voluntary/ community/social enterprise (VCSE) strategic forum to bring together VCS providers, commissioners and other public service representatives to discuss issues including health and social care integration and isolation of older people. Positive outputs from these events have included a social isolation project delivered by the fire service and health walks from GP practices.
- System leaders were committed to involving service users, carers and their families in the strategic approach and a series of public and partner engagement events had been held in relation to the Transformation Bid. However, it was acknowledged that more targeted engagement was needed going forward to ensure service design proposals were co-produced. While there were mechanisms in place to obtain feedback from people, these were often focused at service or provider level rather than capturing their experience of the entire pathway.
- We received mixed feedback from some VCSE providers on how valued they felt as system partners in the planning and delivery of services, including planning for winter pressures. They felt underutilised by the system and that they had a lot to offer in relation to keeping people well at home. The VCSE organisations reported there used to be regular meetings with the local authority, but these had become fragmented. Concerns were also raised about the tender process and a lack of transparency around funding decisions following several short-notice contract terminations two years ago. Following our review, the system told us these contracts had not been part of the delayed transfer of care agenda and were a historic procurement issue. The local authority led joint commissioning arrangements with the CCG, including the Carer's Centre and children's community services.

- It was recognised by the partnerships team at the local authority that there was a need to bring together health and social care contracts. We were told some 2017/18 VCSE winter resilience scheme monies were being used to work with VCSE organisations to develop innovative ideas.

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

- The Trafford Locality Plan, Transformation Bid and existing section 75 agreement between the local authority and community care provider PCFT, provided the foundations for inter-agency and multi-disciplinary working. The local authority and the CCG will be fully integrated commissioners by April 2018 and there were joint working principles already in place. We found some positive examples of staff working in an integrated way to commission and deliver services.
- All staff we spoke with during the week of our review expressed a will to work more collaboratively and although we saw some examples of staff working in an integrated way, these were often dependent on individual relationships and not always facilitated by the system. Frontline staff were frustrated by the barriers to inter-agency working. These included technological barriers, a lack of clarity about services available, duplication of efforts and a lack of trust or competing priorities between organisations. Frontline staff were highly focused on delivering high-quality care, focused on the needs of the person.
- Our analysis of 2015/16 Hospital Episodes Statistics (HES) data showed prior to the creation of Manchester University NHS Foundation Trust, 45.7% of admissions of people of all ages from Trafford went to Central Manchester NHS Foundation Trust (CMFT), 45.1% went to University Hospital of South Manchester (UHSM) and 6.9% went to Salford Royal NHS Foundation Trust. Additional information supplied by the system indicated that UHSM received a greater proportion of admissions of Trafford's older population. Admissions from Trafford made up 18% of CMFT's admission activity and 29% of UHSM's, so the system's purchasing power was less than others particularly as they did not commission services directly.

Learning and improvement across the system

- There were a variety of forums where quality and performance were monitored and discussed, but more evaluation and sharing of lessons learned across the system was needed. At the time of our review there were multiple pilots and concept testing programmes underway prior to system-wide roll-outs. Learning from these pilots was

shared with system leaders to demonstrate the impact they were having, but it was not systematically being cascaded to reach wider system partners or frontline staff at this stage. The system needs to work at pace to collate and implement the learning to drive improvement.

- Across the system, newsletters were used to share learning and feedback with staff. However these were for organisational news and there was not a system-wide mechanism for cascading messages to incorporate all partners. For example, staff reported they did not always receive feedback on incidents raised or whether there were common themes identified through safeguarding investigations.
- Social care providers reported there had historically been forums where they could feedback to the local authority, but all that existed currently were contract monitoring meetings. Following our review, the local authority told us there were fora available to providers, namely service improvements partnerships. Work was required to ensure these were well-known among commissioned services. There were plans in place to develop a Greater Manchester provider forum, but this had not been established at the time of our review.
- There were missed opportunities to ensure there was system-wide learning and improvement. The system could benefit from making sure there are opportunities to come together and discuss challenges, evaluate the effectiveness of initiatives and generate shared solutions.

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

We looked at the governance arrangements within the system, focusing on collaborative governance, information governance and effective risk sharing.

Providers and commissioners across the health and social care interface had governance systems and processes in place to assess, monitor and mitigate risks. There were three levels of governance to support the planning and delivery of integrated care, reporting upwards from the local system to Greater Manchester Health and Social Care Partnership Governance structures within the Trafford system and with Manchester Health Care Commissioning were aligned with those of Greater Manchester and provided a mechanism to ensure consistency in performance monitoring.

System leaders felt the level of assurance required at both Greater Manchester and national levels was burdensome at times, but this was outweighed by the benefits of a shared

endeavour. Data and intelligence monitoring was shared across the system and reviewed daily at a senior level, but there needed to be more evaluation to drive improvements at pace. The Chairs of the Health and Wellbeing Board and of the Scrutiny Board acknowledged that the challenge functions of these bodies were not being used effectively. While risks were being escalated at every level, it was not always clear who held overall accountability for them.

Overarching governance arrangements

- There were three levels of governance to support the planning and delivery of integrated care:
 - the local level – locally commissioned services and BCF governed through local commissioning accountabilities, HWBB and CCG, and through local providers;
 - the wider system level (e.g. urgent care delivery board joint with Manchester, and Manchester Health and Social Care Commissioning as lead commissioner for acute care; and
 - the Greater Manchester level through the Health and Social Care Partnership Board (HSCPB) and Joint Commissioning Board.

- Governance structures within Trafford mirrored those across Greater Manchester with local representation on the GM Health and Social Care Partnership Boards and there was a clear line of communication and accountability between the two, with vertical and horizontal reporting structures. Trafford's Integration Board, Joint Commissioning Board and Urgent Care Board worked alongside each other and reported to the local authority's executive boards as well as through to GM assurance structures. Although the level of assurance submitted to the GM HSCPB felt burdensome at times, this was outweighed by the benefits. System leaders felt the collaboration and supportive network facilitated by GM provided a unique, innovative accelerator for change. Trafford system partners need to continue to ensure their voice in the partnership; that the priorities set by GM remain relevant to the Trafford local area and that support is drawn from other areas where local challenges are identified.

- The Trafford Urgent Care Board provided the practical arrangements to deliver the vision for integrated health and social care pathways relevant to urgent care across Manchester and Trafford and set out strategic aims via a jointly developed and agreed project plan, providing oversight for implementation progress. This was attended by key system partners.

- There was a transparent approach to sharing of management information across the health and social care interface. There were some agreed performance metrics set by GM in relation to flow and performance dashboards were in place. However, there were no integrated metrics between health and social care and monitoring was based on traditional performance indicators. We were told that work was underway to develop system-wide universal outcome measures. SRFT had developed a set of agreed, integrated metrics and Trafford could look to wider partners to see if these could be replicated within their system.
- Local authority leaders were visible and engaged. They were aware of the challenges faced by the system and were sighted on performance, but some were relatively new in post. Leaders reported positive working relationships despite political tensions in the past and there was a shared vision for the future.
- Although there was a significant amount of monitoring and measuring, there needs to be more evaluation. The Scrutiny Board's challenge function was underutilised; the Chair told us they were given verbal assurances by system leaders that performance was improving and pilots were producing positive outcomes, but there was a lack of data to evidence it. The Health and Wellbeing Board Chair had taken up the post two months prior to our review. There was an acknowledgement the Health and Wellbeing Board would benefit from a strengthening of its oversight and challenge function in relation to the transformation agenda. Work was already underway at the time of our review to facilitate this.

Risk sharing across partners

- There was a shared view of risks across the system. These were managed in different forums depending on commissioning arrangements. For example, primary care performance was monitored by the CCG Governing Body and social care risks and quality performance were overseen by Joint Quality Monitoring meetings. There was little evidence of shared risk management outside of these arrangements.
- The Trafford system was early on in its journey to integration of health and social care. At all levels it was acknowledged there was some isolated working, but there was a will by system leaders to respond to risks collaboratively. Prior to the Transformation Bid being approved, the CCG and local authority had proceeded 'at risk' to implement some elements of the proposed schemes to prevent delay. For example, increasing capacity of reablement services in the community.
- Staff at all levels had clarity about their roles and responsibilities, but this varied in relation

to inter-agency working. Staff were able to describe the governance structures in place to identify, record and escalate risks appropriately within their organisations. While system leaders were clear about their accountabilities, staff at other levels were not always aware of who was ultimately responsible for performance and risks at a system level. For example, in relation to DTOC or winter pressures.

Information governance arrangements across the system

- The Trafford Locality Plan outlined the importance of adopting a universal approach to sharing information across health and social care to meet its strategic objectives and there were a number of information sharing agreements in place across the health and social care interface.
- The Trafford Co-ordination Centre (TCC), described by the system as “air traffic control”, aimed to provide a single patient register of those identified most ‘at risk’ to remotely co-ordinate their care. The TCC had signed up all Trafford partners to an information sharing protocol to enable personal information to be moved through different agencies. However, at the time of our review not all partners could access the TCC clinical portal containing the shared patient data. This, coupled with the confusion around the role of the TCC and mixed feedback around its effectiveness, meant the benefits of a reciprocal information sharing arrangement were not being fully realised.
- Staff throughout the system reported that information sharing across the health and social care interface needed to improve and this was described as a key barrier to integrated working and improving outcomes for people. GPs and PCFT used the same electronic records system and the University Hospital of South Manchester site had permission to access GP records on a view-only basis, but this was not being put into practice by staff. We heard from GPs that a lack of access to primary care records by people working in the acute sector lead to people undergoing unnecessary diagnostic investigations, assessments and admissions. Eight of the of 15 Registered Managers of social care providers who responded to our survey in relation to information flows reported they received discharge summaries at least 75% of the time, but these were mostly in paper format and rarely electronic. Three respondents reported they rarely received discharge summaries.

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.

There was a system-wide understanding of workforce capacity and future needs. Workforce strategies were aligned to that of Greater Manchester, however there was not one whole-system workforce strategy for Trafford; there were separate arrangements at commissioner level. While these were aligned in terms of strategic vision, the system needs to ensure that operational priorities are addressed through a fully integrated workforce strategy. There had been some efforts to address domiciliary care capacity issues, but with limited success to date.

System level workforce planning

- There was not a system-level strategy for Trafford; Manchester, as lead commissioners, had developed a strategy for acute sector staff and Trafford CCG fed into the Greater Manchester workstream for acute workforce. The local authority and PCFT had developed a strategy for community health and social care, aligned to Greater Manchester, and had identified local workforce priorities:
 - Growing our own
 - Developing and promoting our brand
 - Developing our talent and a system wide approach to leadership
- The individual workforce plans were aligned with the strategic vision to move to multi-professional, place-based and asset-focused models of care. However, as the Trafford Local Care Organisation comes into shadow form, system leaders should ensure priorities are complimentary to each other and succession planning is considered.
- There was a Greater Manchester workforce strategy overseen by the Health and Social Care Partnership Board, which outlined the workforce challenges and proposed GM wide solutions in the context of new models of care.

Developing a skilled and sustainable workforce

- System leaders were working to develop and future-proof the workforce through partnerships at local and regional levels as well as with local further and higher education institutions. Workforce development was focused on “growing our own”, using apprenticeship levies, developing career paths and re-skilling and re-purposing existing teams. Some teams were already working in an integrated way in the four locality areas and pilots were being rolled out to empower staff at the frontline to make decisions.
- We heard from all system partners that competition with the retail sector and high educational attainment were key factors in recruiting domiciliary care staff. Analysis of Skills for Care workforce estimates for 2016/17 showed that the staff turnover rate in

Trafford was 35%, which was higher than the England average. However, 61% of new appointments were made to people who were already working in the social care sector in Trafford, which supported the view of providers who told us they were recruiting staff from the same pool as each other. Therefore, while employers were having to recruit to posts, the sector was retaining skills and experience. The local authority had tried several methods to increase workforce capacity, including recruitment days and a 'grow our own' salaried, homecare workforce in the Partington area. The outputs from these initiatives had been minimal to date, so whilst the social care vacancy rate in Trafford was in line with the England average, it had increased since 2013. While all system leaders recognised domiciliary care capacity was a significant issue, there was not a system-wide response to addressing this issue.

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.

Future commissioning strategies were aligned to the wider Greater Manchester STP 'Taking Charge Implementation and Delivery Plan' and Trafford's locality plan, based on a needs assessment which took account of variation within the borough. Funding for transformation had just been approved and although some initiatives had been set up using iBCF monies and some partners taking shared risks, these had had limited success. Commissioners did not take a proactive approach and remained traditional and reactive to pressure points in the system, notably delayed transfers of care. Trafford faced significant market challenges which were widely accepted by system partners. However, responsibility for resolving them was not collective. There was scope for longer-term gains to the wider system if investment was made now to get a grip on the market.

Strategic approach to commissioning

- The Trafford Locality Plan and Transformation Bid, involving the local authority, the CCG and acute care providers, set out the strategic approach to providing care within the four localities. This model was already being used by integrated community health and social care teams and some of the iBCF monies had been used to begin to implement some of the proposals. A needs assessment had been carried out for each of the localities to inform future commissioning plans and ensure local variation was considered.
- There were joint commissioning arrangements between the CCG and local authority with

regards to the voluntary sector, Ascot House (intermediate care facility) and children's community services. The two organisations were in the process of integrating to form a single commissioning function and a Joint Commissioning Board was already in place. Commissioning arrangements were collaborative rather than integrated at the time of the review, but a commissioning outcomes framework was being developed as part of the wider Greater Manchester devolution and staff were positive about future working arrangements. A strategic commissioning decision had led to putting a section 75 agreement in place between the local authority and Pennine Care NHS Foundation Trust (PCFT) since April 2016 in relation to community health and social care services.

Commissioning support services to improve the interface between health and social care

- Future commissioning plans were focused on prevention, and on pathways and the person rather than services, which was positive. At the time of our review these were still to be implemented; commissioning was still separate and based on meeting national objectives and targets rather than taking a coherent system-wide approach.
- Data from March 2017 on provision of extended access to GPs outside of core contractual hours showed that only 3.2% of the 31 GP practices in Trafford surveyed offered full provision of extended access over the weekends and on weekday mornings or evenings compared to the England average of 22.5% and the average across Trafford's comparators of 23.8%. Weekend appointments were provided by the GP Federation on Saturdays and the out-of-hours provider on Sundays. However, if a person needed a face-to-face appointment out-of-hours when the walk-in centre and Urgent Care Centre were closed, they had to go to a site in Salford. Data available at the time of our review showed hospital admissions from care homes were higher than average. A recent data refresh showed that although there had been a reduction in the number of admissions, improvements were not sustained and care home providers reported that GP provision was variable. CCG staff advised plans were in place to enhance the level of support to care homes with a multi-disciplinary team model and up-skilling of nursing staff, but these had not been implemented at the time of our review.
- Although there were 'front door' services commissioned to avoid hospital admissions, including the Older Persons Assessment and Liaison (OPAL) team, Community Enhanced Care (CEC) team, out-of-hours GP services and local pharmacies treating minor ailments; emergency admissions for over 65s in the first quarter of 2017 were higher at 75 per 1,000, compared to similar areas and the national average which were 69 and 64 per 1,000 respectively.
- The number of intermediate care beds had increased from five to 36 at Ascot House and the local authority had also commissioned nine discharge to assess beds at the same

facility. The response to the System Overview Information Request (SOIR) stated this increase in capacity had enabled the system to respond to seasonal fluctuations in activity and led to 30 delays in the summer of 2017 compared to 70 the year before. Published data showed there had been a reduction in DTOC across Trafford in recent months. While Ascot House could be used for 'step-up' care, 90% of referrals were for 'step down' care. In September 2017, the occupancy rate was 75% compared to a target of 85-90%. There was potential for this service to increase system-wide capacity and be utilised more effectively. An evaluation of the admission criteria had begun, but this needed to happen at pace and in collaboration with acute partners.

- Published data in relation to continuing healthcare (CHC) showed that Trafford CCG's performance in quarter one of 2017/18 was poor. High numbers of people were waiting longer than 28 days for their assessment and low numbers of people had been deemed eligible for Fast Track CHC (an indicator of end of life care performance). The response to the SOIR stated that the CCG had increased spending across CHC and Funded Nursing Care between 2013/14 and 2017/18 by approximately £5 million. There had been some changes to the CHC team and data provided by the system showed some positive improvements in performance; more people were receiving CHC funding, were being assessed quicker and not in an acute setting.
- Uptake of personal budgets was low at 5% and of 339 recipients of CHC, only 26 had a personal health budget or direct payment for all or part of their care. There were pilots ongoing with a focus around the 'three conversations' model, which aims to replace traditional assessments for services with three conversations or questions, identifying what financial and social assets a person has and how they can be best supported to use them. While there were pilots ongoing around 'three conversations' and building on assets in the community, there was no coherent plan to increase uptake of more personalised options for purchasing care and supporting the informal workforce. Current contracting arrangements were traditional and time and task focused.
- Voluntary sector organisations felt they were underutilised and there were concerns about the lack of provision for people with dementia. There were limited intermediate care facilities for people with dementia due to the admission criteria and while the local authority told us they commissioned dementia day care from Age UK on a spot-purchase basis, the provider told us they had not received any referrals since block funding was stopped by the local authority in July 2016. The cost of this service was prohibitive to many, often the most vulnerable groups. People we spoke with described some voluntary sector organisations as their "life line", but finding out about the services available to support them was difficult.

Market shaping

- Trafford faced significant challenges in relation to the social care market, both in terms of quality and affordable capacity. Forty-nine percent of care home beds and 35% of domiciliary care packages were purchased by people funding their own care, which created a buoyant market where providers were not reliant on local authority income to exist. In addition, as of September 2017, 53% of nursing homes in Trafford were rated as requires improvement, a figure much higher than the comparator (30%) and national averages (27%). The percentage of domiciliary care providers rated requires improvement was 45% compared to 13% in comparator areas and 16% nationally. This meant that people were at risk of receiving unsafe care and it limited the capacity of the market as the local authority would suspend placing people in homes rated inadequate.
- The system had explored the use of innovative options to exert greater control over the domiciliary care market through the Partington pilot and purchasing packages of care off framework at a higher cost, although the number was small. The iBCF was used to finance some of these initiatives, but as this was one-off funding the system hoped the recently approved transformation fund would help to stabilise the market. New models of care were included in Trafford's Transformation Bid, but were not established at the time of our review.
- The local authority felt supported by wider Greater Manchester workstreams which recognised workforce was an issue for the wider conurbation. While system partners in Trafford all recognised the challenge the market posed, there was not a shared response. Homecare providers were not paid a retainer by the local authority to keep packages of care open if a person was admitted to hospital; there was an informal expectation they would do so for 72 hours. Frontline staff reported that this led to unnecessary delays while new packages of care were arranged and assessments carried out. It also impacted on continuity of care. In one case file reviewed a person experienced a 15-day delay because their previous long term agency had stopped their package of care and another provider had to be sourced. System partners should take a long term view and make short term investments for longer term gains. Traditional contractual arrangements with homecare providers with a time and task focus rather than flexible commissioning around the person, should be reviewed to create additional capacity and provide continuity of care for people.

Contract oversight

- Contract arrangements for health and social care provision were not joint, but were collaborative. As lead commissioner, Manchester Health and Care Commissioning had overall contract oversight for acute contracts. However, as an associate contract holder, Trafford system leaders told us they felt there was parity in the partnership and they had influencing power.

- Commissioners across health and social care had systems in place to monitor and respond to performance issues and there was evidence of partnership working to drive improvements. The CCG and the local authority worked together and had developed a virtual joint quality team to support providers which fed into joint quality meetings attended by key partners, including Healthwatch and CQC. Data showed this was having a positive effect as 46% of adult social care services were found to have improved following a CQC re-inspection compared to 33% in similar areas. However, 17% of all adult social care services had also declined on re-inspection, which was higher compared to 11% in similar areas. Commissioners had prioritised support to those services most in crisis and so this figure is perhaps not unexpected.

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.

There were governance structures in place which facilitated transparent and collaborative lines of reporting. There was a shared understanding of where resource gaps were, but the focus was on the transformation agenda and future projections. While there was high scrutiny of those financial pinch points within the system, current investments were not supporting people to remain at home and the personalisation agenda was underdeveloped.

- There was a shared understanding of where resource gaps were in the system, informed by activity data, quality monitoring reports and the Joint Strategic Needs Assessment for each the four localities. These gaps were articulated within Trafford's Transformation Bid which reflected the resource gaps in the context of the Greater Manchester Delivery and Implementation Plan and the move to a Local Care Organisation model.
- The planning and delivery of the BCF, including the delivery of the Section 75 agreement, was overseen by the Better Care Steering Group, which consisted of senior and middle commissioning managers from the local authority and the CCG. There were transparent reporting lines and evidence of positive working relationships between finance departments at the CCG and the local authority. However, system leaders told us it was difficult to pool budgets at the health and social care interface because of national conditions imposed on monies. System leaders felt that, as Trafford was not high on the deprivation index, they were not prioritised for funding in Greater Manchester despite having some of the most significant challenges in terms of performance.

- Governance structures were designed to provide assurance; commissioners monitored the outcomes for people through ongoing contract monitoring while finance teams assessed the value for money. Transformation Project leads attended the Transformation Board to present real-life case studies to demonstrate the impact pilots and interventions were having on individual people. However, many of the pilots and concept tests underway during our review had not yet been fully evaluated and any cost benefits were projected.
- There had been investment into the adult social care system, but system leaders acknowledged it was not as much as it should be while they were trying to transform it. There had been significant spend on tackling delayed transfers of care (SAMS and Ascot House), but no system-wide cost benefit analysis of the resource being spent on monitoring flow versus investment in managing the homecare market. The local authority had carried out a cost modelling exercise, which had assessed the current hourly framework rate for home care (£14.06) as value for money. Information provided after our review showed this rate was the third lowest out of the 10 local authority areas in Greater Manchester, which ranged from £13.50/ hour to £14.58/ hour. The local authority had paid a provider off the framework at a higher cost and they had subsequently been able to provide 24 packages of care. However, this had not addressed the wider issues and a feasibility study by the local authority estimated it would cost an additional £5.2 million per year to develop a local authority-owned homecare service. At the time of our review, there was no plan to proceed with this option.
- Our analysis showed that there were slightly fewer residential and nursing home beds per population aged 65+ in Trafford compared to comparator areas and the England average. However, data collected by the system and a recently published consumer report contradicted CQC's data and predicted an over-supply of 20% by 2020. Rates of admission to residential and nursing care homes to provide long term support for older people had declined in 2015/16 to 69 per 100,000 from 72 per 100,000 the previous year and were below the England average and that of similar areas. Avoiding permanent admissions is a good measure of delaying dependencies. However, with low uptakes of personal budgets, limited homecare capacity and high numbers of people waiting to be discharged from hospital, the system needs to assure itself that resources are being used most effectively to ensure good outcomes for people. Examples were provided of where high costs of care were agreed to meet the needs of the person, but it was reported that these were not sustainable in the longer term.

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 usual place of residence

Are services in Trafford Safe?

There was a system-wide commitment to keeping people safe in their usual place of residence and proactive prevention and intervention were key priorities in Trafford's strategic vision. However, the reality for people at the time of our review was that support was variable and disjointed at times; some people fell through the gaps and ended up in crisis. Although there was a shared view of who was most at risk, the Trafford Co-ordination Centre was not being used at full capacity and there was limited evidence it had reduced hospital attendances or admissions. There were shortfalls in support to care homes and we found evidence of people being admitted to hospital with conditions that could have been managed in the community.

- The system did not ensure people were consistently supported to stay safe and well at home and people's experiences varied significantly. Age UK held the overall responsibility for delivering the prevention and wellbeing contract for people aged 65 and over with the aim of reducing hospital admissions. They had jointly developed a falls pathway with system partners. Greater Manchester Fire Service conducted 'safe and well' visits and made minor adaptations following referrals from the community.
- However, when we spoke to a group of voluntary sector stakeholders and a group of carers, they felt the system was disjointed and there were gaps, particularly around support for people with dementia. There were no intermediate care facilities for people if they lacked capacity and there was a perception that people with dementia were unlikely to return home if they had a hospital admission. We were given examples of where people had been admitted to hospital with urinary tract infections (UTI) or pressure sores because of variable GP access and difficulties in obtaining specialised equipment. During our review of case files, we found an example where opportunities had been missed to respond to a person's social needs and they were later admitted to hospital following a fall in the community.
- Our analysis of HES data showed that in the first quarter of 2016/17, admissions from care homes in Trafford as a result of UTI were higher than similar areas at 189 per 100,000 aged 65+, compared to 171 per 100,000 aged 65+ across comparators, but in line with the England average of 190. During our review of case files we found an example of a person being admitted with a UTI and approximately two thirds of patients on the acute medical

unit (AMU) at Trafford General Hospital were referred by their GP. Staff felt that some of these people could have avoided admission to hospital if IV antibiotics could have been administered in the community, an opinion shared widely within the system. Care and nursing home providers were frustrated at the lack of response from commissioners to their suggestions. We were advised by system leaders that there was a programme of work in place to roll this out.

- System leaders told us partnership work was well established to safeguard adults at risk of harm. Safeguarding was monitored by system partners monthly, but with the merging of the CCG and the local authority commissioning functions there was an opportunity for these to become more integrated. The lead for safeguarding at the CCG had been in post for six months at the time of our review. They had begun to implement a series of safeguarding assurance and monitoring groups but these had not yet been fully embedded.
- Front line staff across health and social care providers and the voluntary sector were able to describe the process for reporting safeguarding concerns and other incidents. We were given examples of where action had been taken by commissioners to ensure areas of quality and safety concern were mitigated and monitored. While staff reported the system was responsive, they felt that there was limited feedback on any themes or lessons learned which could be cascaded widely across health and social care for future improvement.
- People who were frail, had complex needs or were at high risk of deterioration and/or hospital admission were identified at a system level using a risk stratification tool developed by the Trafford Co-ordination Centre, using primary and secondary care data. The information was shared with GPs and the Community Enhanced Care team (CEC) to provide a coordinated approach to managing their care. These people could be enrolled in the TCC, which aimed to reduce hospital admissions by providing telephone support and remote pathway tracking by managing referrals and preventing missed 'contacts' or appointments. It also provided a point of contact for carers or relatives if they felt the person's condition was beginning to deteriorate.
- Feedback from care home providers indicated there was a variable response from community healthcare services which was putting people at risk of avoidable harm. Some providers had their own contractual arrangement in place with GPs and were complimentary about the Alternative to Transfer initiative, a view which was supported by the Ambulance Service. However, others described a lack of support from some GPs and the out-of-hours provider, which led to some unnecessary admissions. HES data available at the time of our review showed in the first quarter of 2016 the percentage of older people that attended A&E from care homes in Trafford was higher at 11 per 1,000 people than in

similar areas and the national average at 9 per 1,000. A data refresh showed there had been some improvement in recent months. In the first quarter of 2017 the percentage of older people that attended A&E from care homes was lower than the national average at 955 per 100,000 people compared to 979, although it was still higher than the 866 per 100,000 in comparator areas. It was too soon to determine if these improvements were sustained. The numbers referred to A&E by a GP had fluctuated between 9% and 13% over a two year period up to the first quarter of 2017, but was consistently higher than the national average of 6%.

Are services in Trafford Effective?

The strategic vision for the future provided a compelling narrative and outlined how it could improve outcomes for the people of Trafford. Although pilots were showing promising outcomes and some proposals were entering the implementation phase, at the time of our review the landscape was fragmented and performance remained a challenge for the system. The system was not easy to navigate and hospital avoidance schemes were patchy.

- People's experiences were varied and they reported that the system was difficult to navigate and information about support was not easily accessible. There was not a single point of contact for people to access health and social care services. Those who thought they might need some social care support were triaged and either referred for an assessment or signposted to alternative services via the social services screening team. People, providers and voluntary sector organisations told us that information was not easily accessible or understood, particularly for people who funded their own care. Adult Social Care Outcomes Framework (ASCOF) data for 2015/16 showed only 69% people over 65 in Trafford found it easy to find information about support, the lowest of its comparator group.
- We received positive feedback from people who use services and staff about the One Stop Shop when low-level equipment (for example, raised toilet seats and grab rails) was needed and the 'safe and well' checks conducted by the fire service. However, we also heard about delays when waiting for more complex pieces of equipment, and individuals buying equipment themselves because of a lack of clarity about how the system worked. System leaders acknowledged there had historically been long waits for aids and adaptations. However, following a review and increase of resource, waits for major aids or adaptations had reduced from 18 months to nine months.
- While plans were in place for system-wide transformation, in the interim there was an inconsistent approach to assessments which was leading to duplication of work, referrals to services being refused and difficulties in planning care around the person. Care home and homecare providers reported the level of detail they received from commissioners to plan a package of care was poor. Case files we viewed supported this view; some assessments

contained repetitive standardised statements and very little about the person's needs or preferences.

- The Trafford Locality Plan and Transformation Bid outlined the shared vision for supporting people to stay in their usual place of residence, to remain healthy, safe and independent for as long as possible. Health and wellbeing priorities had been reviewed to reflect Trafford's local context and there had been a surge of activity around the public health agenda. Future service delivery was being planned around a locality model, where teams would use the Joint Strategic Needs Assessment (JSNA) to determine the care needs of the people in their local neighbourhood. However, some plans were not fully operational at the time of our review and the *Ageing Well* strategy, frailty strategy, dementia strategy and falls strategy were all in draft.
- The system had considered the wider determinants of health in future plans and had worked with partners in housing and leisure. For example, the falls rehabilitation programme had been expanded from an eight week to a 16-week course, through collaborative working between commissioners, PCFT and Trafford Leisure to incorporate prescribed exercise classes. There were four extra care housing facilities, some with primary care facilities co-located and commissioners were in discussion with Trafford Housing Trust about winter resilience.
- The strategic vision placed an emphasis on keeping people healthy and at home, but this was not being achieved in reality and the personalisation agenda was underdeveloped. Data showed the proportion of people who received personal budgets was low with only 5% of the local authority's total adult social care expenditure going on direct payments. There had been a downward trend in the number of people aged 65 and over whose long-term support needs had been met by admission to residential care, which was positive. However, a higher proportion of the local authority's adult social care expenditure was on nursing and residential care (60%), compared to services designed to maintain people in their usual place of residence (26% of expenditure was on homecare and 11% on reablement). Ascot House was designed to be used as a 'step-up' as well as a 'step-down' facility, but at the time of our review, 10-15% of referrals were from the community. Local authority commissioners had hoped to expand the Stabilise and Make Safe (SAMS) service to include 'step-up' provision but it was currently operating at capacity.
- Although frontline staff in acute and social care services had the skills to support the transition of people between health and social care services, their knowledge of the services available varied and there was a risk that people could fall through the gap. Information about the services available was not always consistent and staff reported they

did not know where and when they could refer people. For example, the CEC team was a 24/7 service, but the information available to staff at Wythenshawe Hospital stated it was available from 08:00 to midnight. Staff reported they felt confused by the different pathways, especially when different local authority areas had different systems or services in place. As a result, some people ended up being seen in the wrong place by the wrong person and at the wrong time.

- Voluntary sector organisations felt there were missed opportunities and that they could be better utilised by commissioners to support people to stay at home. One voluntary organisation told us they had been approached last winter about doing shopping and wellbeing visits in an effort to reduce admissions to hospital, but it had been too late to arrange. They have not been approached since and this was felt to be a short-sighted response by the system.
- There were some good examples of integrated working between health and social care staff delivering community services. However, staff across the system reported that the lack of digital interoperability impacted on their ability to share information effectively. Health and social care services used different IT systems and the lack of trusted assessors meant duplication of effort by services.
- There was an initiative being piloted in the northern locality, 'One Trafford Response'. Coordinated by Trafford Partnership, staff from different agencies including health, social care, police and housing were co-located in a central hub to see how working together to manage referrals and community issues in real-time could reduce the burden on other parts of the system. Initial findings were positive and there were plans to roll this out further.

Are services in Trafford Caring?

There was a commitment and desire from staff at all levels in the system to provide person-centred care and to empower people to make decisions and to remain in their usual place of residence. While we found examples of where people had been well supported and their preferences documented, they may have had to tell their story multiple times to multiple professionals. There was not a coordinated approach to assessments and information and support was not always easily accessible.

- The voluntary sector was extremely active in Trafford and provided a range of services designed to maintain and improve people's health, wellbeing and independence. These were targeted at specific groups, such as the BME community, people with Alzheimer's Disease and carers. Services offered included, support groups, yoga classes and advice lines. Voluntary sector organisations felt they could be better utilised by health and social

care partners to provide information and support to people and carers to prevent crisis episodes.

- During our review we visited an extra care housing facility where people were universally positive about their involvement in making decisions about their care and the information and support available to remain well.
- Some people felt there was a reliance on carers and relatives to navigate the system, particularly if a person was funding their own care. We were told that if a person had an advocate they could have a good experience and while there was an advocacy service in Trafford, this was not well known. Another person described how they had needed to reduce their working hours to care for their relative, and pay for equipment to keep them at home.
- Several carers reported that they had not been given information on how to access financial support until they had discovered the Carers Centre or had searched the internet themselves. According to a 2017 survey carried out by the Carers Centre, only 27% of 333 respondents had been signposted or offered information. ASCOF outcome data for 2015/16 showed the proportion of people over 65 in Trafford who find it easy to find information about support was the worst compared to comparator areas.
- ASCOF outcome data for 2016/17 showed the overall satisfaction score of adults in Trafford who use services with their social care and support (58) had improved from the previous year (52), but still remained below most of the comparator local authority areas where scores ranged from 55 to 68.
- Front-line staff were, without exception, committed to providing more personalised care. Assessments of need were not always coordinated effectively to ensure the person was at the centre of their care and support planning. We heard from people who use services and from staff that often multiple assessments would be carried out meaning the person would have to tell their story more than once. Our review of case files found examples of duplicated assessments where different conclusions were reached about the person's needs by different professionals. This was recognised by the system; for example, the local authority was piloting a neighbourhood-based scheme where referrals, assessments and interventions were managed by one local team to provide consistency and reduce duplication.

Are services in Trafford Responsive?

There were some good initiatives in place to respond to people's needs and prevent admission

to hospital, but the system was fragmented, over-complicated and not easy for people or staff to navigate. Therefore, people were not always seen in the right place, at the right time by the right person.

- People were not always seen in the right place, at the right time by the right person. People we spoke with described varied experiences. GP patient survey data showed there had been a decline in the number of people who felt supported to manage their long-term condition from 70.5% in 2011/12 to 65.1% in 2016/17, but this was in line with the national average of 64%. Case files showed some positive examples of where staff had carried out assessments and arranged packages of care to either support a person to remain at home or be referred to Ascot House for intermediate care. However, in two cases there had been missed opportunities to provide preventative interventions, which may have contributed to their hospital admission.
- The care coordination aspect of the TCC had been in operation for 12 months. At the time of our review, it was providing support to approximately 1,000 people, but had capacity for 3,000. We received mixed feedback from staff across the health and social care system about the purpose, efficacy and impact of the service. As it was a telephone-based service only, the perception from health professionals was that it did not reduce the burden on other professionals as they would be expected to carry out home visits if one was required. The Transformation Bid outlined plans to optimise performance but these had not been realised at the time of our review.
- The rate of emergency admissions in the first quarter of 2017 for over 65s was higher at 75 per 1,000, compared to similar areas and the national average which were 69 and 64 per 1,000 respectively. Performance against this indicator had worsened over a twelve-month period.
- Feedback on GP provision from people who use services, families and carers, staff and system partners was mixed. National survey data showed that satisfaction with GP opening hours was in line with national averages, but data from March 2017 showed that a low proportion of practices provided full extended hours provision. Analysis of HES data showed that in the first quarter of 2017 the percentage of older people that attended A&E as a result of being referred by their GP was 8% which was in line with similar areas and the national average of 8%. The percentage of those people who were then discharged from A&E without being admitted to hospital was lower in Trafford (12%) than similar areas (17%) and the England average (17%). Staff throughout the system felt a lack of support available in the community meant more people were being admitted to hospital.

- The response to the SOIR stated there was a Local Enhanced Service to encourage GPs to proactively manage their patients in residential care by producing individualised care plans to help reduce unnecessary admissions. Although A&E attendances from care homes had declined and were in line with England averages as were emergency admissions, care home providers reported a variable response from GPs and the out-of-hours provider, which meant that people were being sent to A&E unnecessarily. System leaders told us the aim was to provide an enhanced, multi-disciplinary level of support to care homes **in two of Trafford's localities** by Christmas 2017, but this timescale was ambitious with no contracts in place at the time of our review.

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 Trafford Safe?

Systems, processes and practices did not always keep people safe when they were in crisis. There had been some improvements in performance in recent months, but data showed that more older people in Trafford were attending A&E, being admitted to hospital and staying longer compared to similar areas. While there was a positive risk reporting culture, risk-averse decision making may have contributed to more people going into crisis than necessary.

- Systems, processes and practices across the health and social care interface did not always safeguard people from avoidable harm. More older people in Trafford were going into crisis, being admitted as an emergency and staying longer than necessary. Our analysis of HES data in the first quarter of 2017 showed the rate of A&E attendances for people aged 65+ was 13,601 per 100,000 compared to similar areas with a rate of 9,724 per 100,000 and the England average of 10,534 per 100,000. The emergency admission rate for people aged 65+ in Trafford was 7,470 per 100,000 compared to a rate in similar areas of 6,922 per 100,000 and the England average of 6,391 per 100,000. While there had been a slight upward trend over the past year, performance had consistently remained worse than average and indicated a gap in community service provision.
- Risks to people were not always assessed, mitigated and monitored to support them to stay safe. Our analysis of HES data showed that in the first quarter of 2017, 33% of people aged over 65 had a hospital stay lasting longer than seven days, which was in line with similar areas with an average 32%, but a slight increase from 32.7% the previous year. Significant capacity issues in the homecare market were contributing to this, however there

were no systems in place to risk stratify people according to need once they became medically fit for discharge; the priority was around their length of stay. Longer hospital stays put people at risk. We were given an example where a patient who had waited a significant time to be discharged and had suffered a fall in hospital, resulting in a sub arachnoid haemorrhage.

- There was a positive risk reporting culture and frontline staff were able to provide examples of where they had reported incidents and safeguarding concerns. However, some staff shared their frustration about when they had escalated incidents or operational issues which presented risks and there was no evidence of any action being taken in response.
- There was a system-level escalation procedure to manage risks to service delivery; the Operational Pressure Escalation Levels (OPEL) framework. There had been some inconsistencies about when to trigger a Level 3 response, but system partners were agreeing the criteria at the time of our review.
- System leaders had a shared view around the reasons for high levels of A&E attendances and hospital admissions and were hopeful this would be addressed as part of the system-wide transformation. There was a shared view among front-line staff that social care market capacity and primary care support was a key factor. However, both acute and community staff described each other as “risk averse” when it came to decision-making. This was supported by the findings of our relational audit where one of the lowest scores was on the statement: people take organisational risks where it had the potential to serve wider system goals without fear of criticism or failure.
- There was a shared view of risks to delivery of services to people in crisis across the Greater Manchester landscape. Safeguarding dashboards were shared monthly and there were daily status update reports to system leaders on flow and system capacity. Working groups had been set up to respond to particular pinch-points, such as delayed transfers of care.

Are services in Trafford Effective?

During a crisis front-line staff demonstrated an awareness of assessing a person holistically in order to meet their needs. Where multi-disciplinary teams were co-located this was working well and they were supported to move through the system more effectively. However, the multiple and confusing pathways meant staff did not always know who to refer to, particularly out of hours. Communication and sharing of information varied and trusted assessors had only been piloted in parts of the system.

- In two case files we viewed there was evidence of holistic assessments of peoples' needs and effective multi-disciplinary working. There was a Choice Policy available to help support people in making decisions, but this was not being universally implemented.
- Services designed to improve flow through the health and social care system were evidence based, but there were multiple, disjointed pathways which meant they were not always being used effectively. The CEC team was designed to provide short term emergency care and where it was providing care to people we were advised it was having good outcomes. According to the CEC's key performance indicator dashboard, 49 people were referred to the urgent arm of the service in September 2017, but there was no measure of whether this was in line with the number of referrals they would expect and there was no break-down of where referrals had come from so targeted engagement could be done with system partners.
- Acute hospital staff showed us the different algorithms they were meant to use depending on where a person lived, but these were not used consistently. They found the system confusing and difficult to navigate and described how strict admission criteria and complex referral processes to services such as Ascot House, made them disinclined to refer.
- Where and when a person was treated had the potential to impact on how well they moved through the system. Multi-disciplinary teams were based at Trafford General Hospital and Wythenshawe Hospital five days a week. At Wythenshawe Hospital there was a geriatrician-led, multi-disciplinary team (OPAL) which worked in A&E Monday to Friday and the Medical Assessment Unit seven days a week. The team identified those people who could avoid admission who may be put on the frailty pathway and supported at home with a package of support. This model of care was producing positive outcomes for people and the system should review any outcome data available to determine whether rolling out the same model to Trafford General Hospital or in to the community would have wider benefits, building on the Community Enhanced Care team to avoid duplication.
- Trusted assessors had been piloted in parts of the system, but there was not widespread implementation at the time of our review. Each service would carry out their own assessments, which could cause a delay to care being delivered. There was little evidence of system-wide learning from pilots or incidents being disseminated across the workforce. Where staff could describe where they had achieved positive outcomes for people this was very much at team or location level.
- One of the strategic objectives of the Trafford Locality Plan was to have a universal approach to sharing information across health and social care. At the time of our review

there was limited interoperability of record systems to allow staff to share accurate, real time information and staff told us often the only piece of information available at the point of crisis was a person's DNACPR record. The senior executive team of the newly formed, Manchester University NHS Foundation Trust outlined the plans to have one IT system and one assessment process, but acknowledged this was in the early stages of development.

Are services in Trafford Caring?

Frontline staff understood the importance of involving people who needed support and their families in decisions in about their care and there was an innovative approach to supporting people in their discharges from Trafford General Hospital. However, we received mixed feedback from people and their families during our review. Some did not always know who was coordinating their support or feel they had been given sufficient information to make decisions.

- Our review of case files showed assessments of care were centred around the needs of the person and people we spoke with at the hospital knew the plan for their care and felt involved in making decisions. However, when we spoke to a group of carers and relatives they were less positive. They felt decisions had been made without their input even where they had Lasting Power of Attorney. Staff reported more advanced care planning in the community would prevent the person from having to tell their story multiple times.
- We found some innovative practices to involve carers, families and advocates in future plans. At Trafford General Hospital there was a purpose-built flat based on Ward Two where discharges could be simulated to determine what support was required and how the family or carers felt they might cope.
- Providers, voluntary sector organisations and carers raised concerns about the support for people with dementia when they went into crisis and felt that the right people were not always involved. They reported that staff were not able to provide the support they needed and the hospital environment often heightened a person's anxiety. Hospital staff told us that relatives and carers were encouraged to visit at all hours, especially meal times, and to stay overnight. Some specialist support was also available and dementia was observed to be a high priority for staff at all levels.

Are services in Trafford responsive?

People living in Trafford did not always receive the services they needed at the right time and in the right place. People were more likely to be admitted to hospital and were also more likely to stay in hospital for too long because of a shortage of care packages and affordable beds in the community.

- In July 2017 North West Ambulance Service (NWAS) treated 32% of 999 calls without transferring them to hospital, which was slightly below the England average. We were told there were few incidents where ambulances were diverted elsewhere, which may indicate that the transfers were appropriate or it may be there were shortfalls in community provision.
- During our review we identified an operational policy which directed staff caring for people within the OPAL unit at Wythenshawe Hospital to call 999 if a person became acutely unwell. System leaders should review the policies and procedures relating to the OPAL unit to ensure additional burden is not placed on the wider system and that people who are still under the care of the acute trust are seen by the right person at the right time.
- Central Manchester University Hospitals NHS Foundation Trust (CMFT) and University Hospital of South Manchester NHS Foundation Trust (UHSM) merged and as of 1 October 2017 formed Greater Manchester University NHS Foundation Trust. Published data was still at the disaggregated level. Between 2014/15 and 2016/17 both CMFT and UHSM failed to meet the national four hour A&E target of 95%. Unverified data, collated by the system as part of their on-going monitoring of performance showed performance had declined across both hospital sites in the last quarter.
- Older people in Trafford were more likely to end up being admitted to hospital and staying longer. Between 2016 and 2017, bed occupancy at CMFT was consistently above the optimal target of 85%. Bed occupancy at UHSM was slightly lower, but only dipped below 85% in one quarter.

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 Trafford Safe?

There was not a coordinated response to discharges, which meant some people experienced unnecessary delays and, in some cases their risk factors increased as a result. Once people were ready for discharge, there were some systems in place to ensure their safety was not compromised, including provision of equipment and reviews of their needs. However, these need to be strengthened to ensure information is provided to all partners in their care and is sufficiently detailed and accurate. Emergency readmission rates for older people in Trafford had

increased over time.

- The number of older people in Trafford requiring emergency readmission once discharged was in line with the England average at the time of our review, but had been higher for five of the last six quarters. Our analysis showed that over all of the financial year 2016/17, Trafford's emergency readmission rates occurring within 30 days of discharge for people aged 65+ was 19.5% compared to the England average of 18.7%.
- The systems in place to return people to their usual place of residence or a new facility did not always protect them from avoidable harm. In two case files we found examples where people had experienced hospital stays of over a year and their health condition had deteriorated as a result. Groups of voluntary sector organisations and carers we spoke with also described hospital acquired delirium as a barrier to people returning home and we saw an example of this in one case file we reviewed.
- At Trafford General Hospital, Ward Two was a 25-bedded 'complex discharges' ward and staff gave examples of where people had experienced falls or detriment whilst waiting for packages of care to be arranged. Although these were reported as incidents, there was no evidence of these incident reports effecting changes. There was a sense of learned helplessness among staff and that these incidents were a symptom of the wider flow issue within the system.
- Eight of the of 15 Registered Managers of social care providers who responded to our survey reported they received discharge summaries at least 75% of the time, but these were mostly in paper format and rarely electronic. Three respondents reported they rarely received them. Eleven said they usually received summaries within 24 hours, but there was mixed feedback on the quality of the information and whether it was sufficient to plan a package of care. Six respondents said there was sometimes enough information, five said there was not; eight said there was rarely information in relation to any mobility issues. This was supported by a group of care home and homecare providers we spoke with who also reported referrals often failed to include whether a person had a cognitive impairment.
- Once a person was discharged there were some systems in place to ensure they were reviewed to prevent a readmission. There was a Directed Enhanced Service in place to encourage GPs to review and amend care plans for those identified at risk of admission and if a person was in receipt of reablement, they received weekly reviews following discharge to ensure the package of care was sufficient to keep them safe. The One Stop Shop prioritised discharge referrals and aimed to provide equipment the same day (93% of urgent referrals were completed within 48 hours). Community pharmacies were informed by

Trafford General Hospital if a vulnerable person was discharged with a monitored dosage system, but there was no formal scheme in place to facilitate discharge information being sent from secondary care to community pharmacies. There was a pilot ongoing in Salford, but no concrete plans were in place to roll this out in Trafford.

- Our analysis of HES data showed that in the first quarter of 2017 emergency readmission rates occurring within 30 days of discharge for people aged 65+ from care homes in Trafford was lower, at 14%, than similar areas and the England average (21% and 20% respectively). This was an improvement from 21% the previous year (compared to an England average of 20%), but the system needs to ensure this is sustained.

Are services in Trafford Effective?

Whilst there had been some improvement in performance, the number of delayed transfers of care remained high and people were not always enabled to return to their preferred place of residence with a timely integrated approach. Those that did receive reablement had good outcomes, but the number in receipt of these services was below the England average and market forces were having an impact on the system's capacity to keep up with demand. The recent appointment of a Community Flow Lead was intended to provide a system-wide view of capacity and co-ordination, but they were not in post at the time of our review.

- Readmission rates had declined over recent months, but so too had the number of people receiving a reablement service from 3% in 2013/14. Analysis of ASCOF data for 2015/16 showed that the percentage of older people who received a reablement service was slightly lower compared to similar areas at 2.6% for Trafford and 3.0% for comparator areas. Where people did receive reablement, it had good outcomes; 93% of people over 65 were at home 91 days after discharge from hospital to a reablement service. This had improved significantly from 69% in 2011/12. The Stabilise and Make Safe (SAMS) service, commissioned from two homecare providers, was the preferred route out of hospital. For bed-based reablement, people could be referred to Ascot House and Wythenshawe Hospital. Patients could also be sent to Opal House, based on site.
- There had been a sharp decline in DTOC between February 2017 and July 2017 from 46.3 days to 25.5 days per 100,000 population (aged 18 and over). While this shows a significant improvement, it was still high compared to the average of 13.6 days for both comparator areas and England averages. A Community Flow Lead had been appointed to have a system-level view of capacity and was due to start in November 2017. Daily meetings were held at each hospital site to discuss delayed transfers of care and next steps. However, the sense of urgency varied and there was an attitude that delayed transfers of care were an accepted symptom of the system.

- There were multidisciplinary teams co-located at the four hospitals serving Trafford residents to facilitate timely, holistic assessments to promote a person's independence on discharge. While we saw some good examples of where teams worked together, the system was disjointed and not easy to navigate. A lack of in reach by community staff, shared records, trusted assessors and competing priorities were cited as barriers by staff to providing an integrated response to a person in crisis. We were told about a person who presented to A&E on a Friday evening and due to a lack of seven day services could not be discharged back out into the community. Their package of care was stopped over the weekend and they ended up staying in hospital for a month while a new one was arranged.
- The acute medical unit (AMU) at Trafford General Hospital no longer had any formal occupational therapy input following the retirement of member of staff, funded by PCFT. System leaders told us this change was made in 2013 as part of the transformation of community services. Hospital staff felt it had negatively impacted on delayed discharges with the AMU. This example was illustrative of the feedback from some staff who felt changes were made in isolation without wider consultation. Where referrals had been refused to Ascot House, referring staff were not always clear why and felt the criteria was too strict. Staff at Ascot House recognised a need to work more closely with their secondary care colleagues to ensure there was a shared understanding of the purpose of this service.
- Some private providers told us they had to ring hospital wards to find out when an existing client may be ready for discharge; often they were only contacted when the person was medically fit. For new packages of care, they were alerted via an email from commissioning teams. They were required to submit an 'Expression of Interest' based on the information provided, which was often limited. If their tender was accepted, they would be expected to assess and start delivering a package of care within 24 hours. Providers were concerned about the level of information supplied by commissioners and relied on their own assessments, so there was a reluctance to consider the use of trusted assessors. Furthermore, the practicality of this system did not encourage person-centred care.

Are services in Trafford Caring?

The extent to which people, their families, carers or advocates were treated as active partners varied. Where efforts were made to put the person at the centre, the extent to which they could make choices was limited to what care was available in the community, particularly if they were not funding their own care. There was limited use of voluntary sector organisations by the system to support people to return to their usual place of residence.

- The SOIR stated people and their families were engaged at each assessment in each

setting and choices offered between solutions to meet needs, providers to deliver care and commissioned care or direct payments. Our review of case files showed a person-centred approach was applied inconsistently and to varying degree. In one example, there was consistent support of the community social worker upon hospital discharge and a package of care was increased rapidly to prevent a carer breakdown. However, we also saw some assessments where there was little evidence to demonstrate the person's input. People we spoke with awaiting discharge or assessment felt they had been kept up to date and knew what the next steps were. However, a group of carers were less positive and did not feel like they had been treated as partners in care.

- There was a choice policy in place, but this was not understood by all staff or universally applied. We heard from various sources that due to demand outweighing supply in affordable, high-quality community care, it was less about choice and more about what was available. This was contributing to delays as people and their families refused placements. There was a common perception among different groups we spoke with that if a person funded their own care, they would get a better experience.
- Voluntary sector organisations told us they were rarely directly involved in supporting people to return home. The response to the SOIR stated that a volunteer-led support to hospital discharge service had been commissioned to work in partnership with hospital discharge teams, but this had delivered limited outcomes and a new service was being co-designed. Voluntary sector organisations we spoke with told us they were not involved in any discharge planning or support and felt this was a missed opportunity. A Carer Liaison Worker was based at Trafford General Hospital twice a week with the aim of providing information, advocacy and advice around admissions and discharges.
- We received negative feedback in relation to the CHC process. Unverified data from the system's latest submission showed there had been some significant improvements in the last quarter. However, work was required to alter this negative perception through positive engagement with staff, providers and people who use services. As of September 2017 only 42% of local resolution meetings were happening within three months of notification of an appeal compared to a target of 100%.

Are services in Trafford Responsive?

Systems processes and services were in place to support the transition of people to their usual place of residence or alternative setting, but there was insufficient capacity to meet demand. The system had made significant improvements in relation to delayed transfers of care, but the significant shortage of homecare packages meant people were still waiting too long in inappropriate settings and not always receiving continuity of care or choice.

- Services were commissioned to help improve the flow through the health and social care system, but there was insufficient capacity to meet demand. A reliance on the homecare market with its workforce capacity issues, a lack of Elderly and Mentally Infirm (EMI) beds and affordable residential care, meant people were not always being seen in the right place, at the right time, by the right person.
- The SAMS service had seen a 68% increase in referrals between November 2015 and October 2017. Following a change in criteria in August 2017 to include more complex cases, the service quickly became full. System leaders told us they had hoped to use the SAMS for 'step-up' as well as 'step-down' provision, but the providers could not recruit to keep up with the demand. The service had recently been supplemented by the in-house Care at Home service to increase capacity. Between April 2016 and March 2017 out of 287 completed cases, 33% of people who had received the service were living independently and 12% were able to have their packages of care reduced. It was not clear how this compared with expectations and the system should review how performance is measured.
- Where there was a reliance on homecare staff to provide a service, there were bottle-necks in the system. This was demonstrated by data in relation to reasons for DTOC; between February and April 2017 'awaiting care package in the home' was reported as one of the main reasons for delay in Trafford, accounting for an average daily rate of 12.7 delayed days per 100,000 population, compared to an average of 2.6 days in similar areas and 3.1 days nationally. The system should consider its reliance on the homecare sector to provide its community rehabilitation service, considering the workforce challenges and inability to reduce capacity with winter approaching.
- Nine discharge to assess beds had been commissioned at Ascot House and Opal House and Ward Two were also using the same model. The response to the SOIR stated that there was flexibility to enable the SAMS service to provide additional capacity. However, as this service was already at capacity this seemed to be an unrealistic assertion.
- There had been significant improvements in performance of continuing healthcare (CHC) over the past quarter. NHS CHC data showed the conversion rate for people being referred and then assessed as eligible for CHC had stayed below the system's target of 23% (19.65% in September 2017), but the total number of people referred had increased from 63 in May 2017 to 173 in September 2017. More people were being identified by frontline staff. People were receiving timely assessments once in the most appropriate setting for their care; 83.3% of assessments were completed within 28 days compared to 10.8% in May 2017 and only 6% took place in an acute setting. One hundred percent of people referred for Fast Track CHC received it, meaning people at the end of their life were

supported to be moved to their preferred place of care.

- The High Impact Change model for managing transfers of care identifies seven day services as one of the changes that can support health and social care systems reduce delays. The Department of Health's analysis of activity between October 2015 and September 2016 showed that the proportion of older people discharged over the weekend in Trafford was slightly higher than similar areas at 20%. There was the potential for this number to increase through improved partnership working and further development of seven day working across the system.

Maturity of the system

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

- Although the system had a clearly and consistently articulated vision across health and care agencies, which was aligned to the Greater Manchester STP '*Taking Charge Implementation and Delivery Plan*', delivery and implementation was at an early stage. The CCG and the local authority commissioning functions were on track to become fully integrated and the Local Care Organisation would be coming into shadow form in April 2018. These foundations need to be built upon and expanded at pace to ensure the benefits are felt more widely across the system. Trafford's strategic vision for a Local Care Organisation is the vehicle to achieve this, and now that the Transformation Bid has been approved by the Greater Manchester Health and Social Care Partnership Board, the focus needs to shift to delivery
- Governance arrangements in Trafford facilitated transparent conversations, information sharing and some shared decision-making between statutory organisations. However, the challenge function of Trafford's Scrutiny Board and the Health and Wellbeing Board were underdeveloped and a lack of integrated outcome measures meant monitoring of performance was siloed and in accordance with traditional key performance indicators.
- Historically relationships within the system had been challenging, but these were improving. System leaders were united in a shared endeavour and there was a commitment to work together in a collaborative way. There were still some legacy cultural issues which were apparent among frontline staff, but these were recognised by system leaders and actions were planned to address them.
- Some funds from the iBCF had been used to stabilise and shape the adult social care market. However, market pressures remained a significant challenge for Trafford and the extent to which system leaders worked collaboratively to address them was limited and system partners recognised they had scope to improve.
- There was a shared understanding of where resource gaps were in the system. While the BCF had facilitated integrated working between health and social care, budgets remained separate. The use of personal budgets was low and commissioning was collaborative rather than integrated. The CCG and the local authority will form a joint commissioning function in April 2018.

- Trafford did not have a single workforce strategy, but were aligning to the strategy at GM level at GM level
- Information governance arrangements were at the early stages of integration. Health and social care used different records systems, but there was a shared use of NHS numbers.
- There was some evidence of multi-disciplinary team working for effective outcomes, but they were not system-wide. There were multiple pathways and a reliance on homecare to provide services meant people became stuck in the system and suffered poor experiences and outcomes as a result.

Areas for improvement

We suggest the following areas of focus for the system to secure improvement

- With winter approaching; the system should remain focused on the here and now to ensure improvements in performance are sustained while delivering transformational change. There should be a shift from monitoring and piloting to evaluating and implementing.
- The system should fully implement the High Impact Change Model.
- The challenge functions of the Health and Wellbeing Board and Scrutiny Board should be strengthened. Where there are shared risks these should be made explicit and managed through joint governance structures.
- There should be a proactive system-wide response to effectively managing the social care market and domiciliary care capacity.
- The OPAL multi-disciplinary team were producing positive outcomes in preventing admissions by providing an in-reach service. The system should endeavour to review outcome data and consider whether the model can be rolled out in other areas.
- Operational policies in place at Opal House should be reviewed to ensure they are not placing additional burdens on the wider system.

- Admission criteria to intermediate care services should be reviewed to ensure consistency and efficacy of service provision. Acute hospital staff should be engaged in the evaluation process.
- The system should ensure there is a Trafford-wide workforce approach, which identifies current needs as well as predicting future requirements in alignment with the GM workforce strategy.
- The system should continue to ensure that its voice is heard in partnerships with the wider conurbation to make sure priorities remain relevant to the Trafford area and that support is drawn from other areas where local challenges are identified.
- With the Local Care Organisation coming into shadow form, the system should learn from wider system partners to ensure that new contractual arrangements do not destabilise the system.
- There should be a joined-up, coordinated response to engaging with the voluntary sector and provider organisations as system partners.
- Work is required to share learning and experience between staff at the interface so there is shared trust and understanding and historical cultural barriers are broken down.