Healthcare Commission

Salford Primary Care Trust

April 2004

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The Healthcare Commission

The Healthcare Commission exists to promote improvement in the quality of NHS and independent healthcare across England and Wales. It is a new organisation, which started work on 1st April 2004. The Healthcare Commission's full name is the Commission for Healthcare Audit and Inspection.

The Healthcare Commission was created under the Health and Social Care (Community Heath and Standards) Act 2003. In addition to a range of new functions, the Commission takes over some responsibilities from other organisations. It:

- replaces the work of the Commission for Health Improvement (CHI), which closed on 31st March 2004;
- takes over the private and voluntary healthcare functions of the National Care Standards Commission, which also ceased to exist on 31st March 2004;
- picks up the elements of the Audit Commission's work that relate to efficiency, effectiveness and economy of healthcare.

In taking over the functions of the Commission for Health Improvement (CHI), the Healthcare Commission now has responsibility for the programme of clinical governance reviews initiated by CHI.

This report relates to a clinical governance review, most of which was carried out by CHI prior to 1st April 2004. In order to provide readers with some consistency, we use the term CHI rather than the Healthcare Commission throughout.

It is important to note that the Healthcare Commission has full responsibility for this report and the activities which flow from it, such as ensuring that an action plan is published by the PCT, which the Commission will make available through its website.

Contents

Introduction

Salford Primary Care Trust (the PCT) was established in 2001. It serves a population of 216,000 people and covers an area of 37 square miles. The city of Salford lies to the west of Manchester and comprises of a number of towns and semi-rural areas. Ninety-six percent of the population is white, which is higher than the national ethnicity figures. There are approximately 1,300 asylum seekers, the majority of whom live in central Salford. Salford local authority is in the deprived tenth of the local authorities and, using one index, it is the fourth most deprived area in the northwest of England and, nationally, is the 28th most deprived of 354 local authorities. Four wards within Salford (Broughton, Little Hulton, Blackfriars, Ordsall) rank nationally within the top 2% of deprived wards. The 2001 Census figures demonstrate that 55% of the population is employed and 9.5% are classed as permanently sick or disabled.

The PCT is one of 14 PCTs within the Greater Manchester area and has the same boundaries as Salford City Council. There are approximately 2,300 people working within the PCT, including 1,300 directly employed staff, 115 GPs in 61 practices, 65 dentists, 80 opticians and optometrists. In addition there are 16 GPs employed directly by the PCT. Of the 61 general practices, 36 provide general medical services and 25 provide personal medical services.

There are 13 health centres, and the PCT provides a range of community services to its population including therapy services, district nursing, school nursing, children's nursing, health visiting, community dentistry and public health. It also provides adult and child learning difficulties services jointly with social services.

The PCT commissions acute services predominately from Salford Royal Hospitals NHS Trust and some specialist acute services from hospitals in Manchester. Mental health services are commissioned by the PCT from neighbouring Bolton, Salford and Trafford Mental Health NHS Trust.

As part of the PCT's agenda for improving health and reducing health inequalities in Salford, a Healthy City Forum has been established with other agencies. There are also joint arrangements with social services for the provision and commissioning of locally based wellbeing centres.

The PCT is a teaching PCT and is a national pilot PCT site for research management and governance.

For the 2002/2003 financial year, the PCT met all three of its financial statutory targets and operated within its financial resource allocation of £240 million.

This report by the Commission for Health Improvement (CHI) gives an independent assessment of clinical governance in the PCT.

PCTs have taken over from health authorities as the NHS organisations responsible for leading and developing local health services. Their core roles are to manage and develop primary and community health services, commission hospital and specialist services and to improve the health of their local populations by addressing inequalities in health. They are diverse and complex organisations, varying greatly in the ranges of services they provide and commission.

PCTs have recently assumed statutory responsibilities for NHS dentistry, optometry and pharmacy. This means that PCTs may not have had the opportunity to align clinical governance systems across these service areas by the time of CHI's assessment. CHI does expect to see evidence that PCTs are engaging with these professions to develop clinical governance, and this expectation is reflected in the findings of the review.

The review is part of a rolling programme of reviews of clinical governance in NHS organisations in England and Wales.

Clinical governance is the system of steps and procedures adopted by the NHS to ensure that patients receive the highest possible quality of care, ensuring high standards, safety and improvement in patient services.

What is the purpose of the review?

CHI's clinical governance reviews set out to answer three questions:

1 What is it like to be a patient here?

2 How good are the PCT's systems for safeguarding and improving the quality of care?

3 What is the capacity in the organisation for improving the patient's experience?

What is covered by a CHI review?

CHI's review assesses seven areas of clinical governance. The areas are:

1 patients' involvement

2 risk management

3 clinical audit

4 staffing and staff management

5 education and training

6 clinical effectiveness

7 use of information

CHI's review also describes two further areas:

1 the patients' experiences

2 the PCT's strategic capacity for developing and implementing clinical governance

An explanation of CHI's assessments
On the basis of the evidence collected, CHI's reviewers assess each component of clinical governance against a four-point scale:

i Little or no progress at strategic and planning levels or at operational level.

ii a) Worthwhile progress and development at strategic and planning level but not at operational level, OR

b) Worthwhile progress and development at operational level but not at strategic and planning level, OR

c) Worthwhile progress and development at strategic and planning and at operational level, but not across the whole organisation.

iii Good strategic grasp and substantial implementation. Alignment of activity and development across the strategic and planning levels and operational level of the PCT.

iv Excellence – coordinated activity and development across the organisation and with partner organisations in the local health community that is demonstrably leading to improvement. Clarity about the next stage of clinical governance development.

What are CHI's conclusions about Salford Primary Care Trust?

What was the overall impression of the PCT?

Salford PCT is an outward-looking organisation prepared to try new and innovative ways of working to deliver better services to improve the health of the people of Salford and reduce inequalities. The effective joint working arrangements with a number of different partners is impressive, and effort is being made to involve the public in the activities of the PCT.

The organisation is open and is prepared to learn, be challenged, change and develop. The staff are very enthusiastic, motivated and willing to share their ideas.

What are CHI's conclusions based on its review of the PCT?

There are significant developments across the PCT, with considerable investment of resources both in terms of finance and personnel. Planning and implementation is consuming a lot of time and energy.

Although there is considerable progress to modernise and improve the quality of current services, the development, management and monitoring of operational activity within the PCT and engagement with GPs, dentists and optometrists and opticians is not so robust. Change to locality management may improve the capacity to coordinate and manage effectively, but structures and accountability arrangements, systems and processes need to clarified and strengthened.

There are excellent examples of notable practice and good progress to improve and focus primary care on outcomes for the local population. To develop the primary care service further, enthusiasm and the drive to improve quality of care needs to cascade through the organisation and involve everyone responsible for delivering a service.

What areas of notable practice were identified?

There are two wellbeing centres where health staff work alongside a number of other agencies to provide a range of services to the local population.

The joint working arrangements with the local education authority to provide an integrated health clinic at Springwood special needs primary school are exemplary.

What, if anything, did CHI find that the rest of the NHS can learn from?

Intermediate care arrangements for patients discharged from the acute hospital are jointly arranged as a partnership agreement with social services.

What are the key areas of action that the PCT needs to address to improve its clinical governance systems?

CHI expects the PCT to review all aspects of this report. Here we highlight areas where action is particularly important or urgent.

- A patient, service user, carer and public involvement strategy needs to be developed and implemented across the PCT.
- A comprehensive action plan needs to be developed to implement the clinical audit strategy, ensuring it links with all the activity relating to clinical governance and is disseminated across the PCT.
- An assessment of the security arrangements for the working environment of all staff needs to be undertaken, with an action plan to improve the health and safety of staff.
- The PCT needs to consult, identify and implement effective systems and processes to ensure that education, training and development is an integral component of the contract for all staff that undertake work for the PCT.
- The information management and IT strategy requires updating to reflect current plans and thinking to give direction for the effective use of clinical information and to support clinical effectiveness and audit.
- Along with implementing the new health governance structure and locality management arrangements, robust reporting and accountability systems and processes need to be in place.
- The PCT needs to further promote and assist GPs, dentists, pharmacists, opticians and optometrists with the clinical governance agenda.

What is it like to be a patient in Salford Primary Care Trust?

In this section we report what we observed and what patients said about their experiences, through surveys or directly to CHI. We also look at what the PCT's figures can tell patients about waiting times and outcomes of treatment.

Many things can impact on a patient's experience of their local NHS service. These may include the outcome of their treatment, how long they waited to be seen or to have a procedure, the cleanliness of the practice or clinic and whether they and their relatives or carers were treated with respect.

Are patients treated with dignity and respect?

Several people express their satisfaction with the polite and courteous manner in which primary healthcare staff deliver services. In many general practices and health centres, CHI observed staff speaking with patients in a pleasant and helpful manner.

A few patients state they receive helpful explanations about their illness from the GPs and nurses, but other patients feel that explanations could be improved, particularly on the range of services available and continuing care arrangements. In the 2003 National Patient Survey, the PCT is ranked nationally within the worst performing 20% of trusts in terms of answering questions clearly at the GP surgery and for GPs and health professionals explaining the reasons for any treatment or action.

In the reception area of some practices and centres, and also from treatment rooms when doors are left open, patient confidentiality is an issue as it is possible to overhear conversations.

Can patients access the services they need?

In the 2002/2003 performance ratings, the PCT is in the top band for access to quality services and is significantly above average for 14 indicators, one of which is the length of the wait in the A&E department.

There is investment and plans to further improve patient access to a primary care professional. Many of the general practices have introduced a same-day appointment system to improve access to a GP. Some patients report that the system improves access but others report difficulties in contacting the surgery at the required time.

The out-of-hours GP service is provided by the PCT or by a private firm. Currently, the GPs decide how to deliver the service for their practice population. CHI received positive comments about the PCT's out-of-hours service.

Difficulties in accessing appropriate dental services are recognised by the PCT and action taken to improve the waiting times. The PCT has a modern mobile dental unit to provide treatment for NHS patients. Sometimes there is still a wait, particularly for people with learning difficulties and when an anaesthetist is required.

A few people report the benefits of the Angel Healthy Living Centre, where there is access to a range of health professionals and advice about a range of services. The Lower Kersal and Charlestown Well-Being Centre provides similar services and access to a range of professional staff. There is an integral health service in Springwood School, where children with special needs have easy access to a range of health professionals.

Despite changes to the referral system to Hope Hospital, some patients and clinicians remain concerned of the long wait to see a specialist. The referral triage system is not clearly explained and understood by some patients.

Working in partnership with Hope Hospital, the PCT operates a new minor community-based surgery unit in The Willows Care Centre, which reduces the waiting time for patients requiring minor surgery.

How good are the standards of cleanliness and facilities?

There is a mixture of new, refurbished and old buildings from which health services are provided. Some of the buildings are well maintained, and patient areas are generally clean.

CHI received positive comments about the location of the practices. There are designated facilities for wheelchair users in some premises. Most practices and health centres are well signposted externally but the standard varies internally.

Following a patient survey of patient access needs, health centres have combined induction loops and communicators for patients with hearing disabilities. As part of the PCT visit to general practices and community pharmacies, a form has been completed to measure compliance to standards relating to the fabric of the building and its facilities for patients.

Four new health and social care centres are planned and funded via the Manchester, Salford and Trafford Local Improvement Finance Trust (LIFT).

What do the figures show about outcomes at the PCT?

In CHI's July 2003 NHS performance ratings the PCT was awarded one star. The ratings contain nine key targets, of which the PCT achieved five, underachieved three and significantly underachieved one: access to a primary care professional. There has been an improvement in performance, particularly in accessing a primary care professional, inpatient waiting times and investment in public health initiatives.

The all ages mortality rate for the PCT is 120, which is significantly higher than the national rate of 100, particularly for the age group 15 to 74. Death rates from coronary heart and cardiovascular disease, lung cancer, bronchitis and emphysema are also higher compared with the national figure. Admission to hospitals for people with asthma, chronic lower respiratory disease and ischaemic heart disease is also high.

In the Salford Local Authority area there is a high teenage conception rate and infant mortality rate for babies under seven days old. Compared with the national figures, there is a high number of children under the age of 14 who have decayed teeth.

The PCT states that, for 2002/2003, the child immunisation uptake ranges from 83% for the measles, mumps and rubella (MMR) vaccination to 95% for diptheria, tetanus and polio (DTP) by the second birthday, which is higher than the national average.

In 2003, 66% of the local population aged over 65 were immunised against influenza, which is an increase of 4% from 2002. Cervical screening uptake for women between the ages of 25 and 64 is 81% and compares favourably with the national average. The current level for breast screening uptake, ages 53 to 64, is 71%. The PCT achieved its smoking cessation target, with almost 1,000 patients not smoking for four weeks.

What did CHI find out about how care is organised by the PCT?

As part of the PCT's aim to re-design the delivery of services to a diverse population and improve multidisciplinary teamworking, the organisation is split into four localities: north, south, west and central. The PCT envisages that these localities will result in a better service delivery, with more effective use of resources, devolved decision making and easier access to services for patients. There is a comprehensive directory of services, developed in March 2003, for each locality. The implementation of the change is in its infancy, and the PCT is establishing locality working groups and clinical forums.

Each locality has responsibility for different specialist services across the PCT. The public health agenda and health promotion is targeted to the specific local needs.

To minimise the delay for patients discharged from Hope Hospital to home or a suitable alternative environment, the PCT works jointly with social services to provide multidisciplinary assessments for referral to intermediate care, which can be provided in a residential setting or patients' own homes.

There is a rapid response team and a PCT-wide evening nursing team. Allied health professionals provide an integrated service with Salford Royal Hospitals NHS Trust.

What areas of the patient experience should the PCT consider?

- The PCT should further assist general practices in successfully implementing and promoting an effective appointment system.
- Better information about the referral and triage system should be available in general practices for patients referred to Hope Hospital.
- The PCT needs to improve and monitor the quality of explanations given by health professionals to patients.
- Action is required to promote and ensure that confidentiality of patient information and care is not compromised.
- The PCT should develop action plans to improve the environment in premises that are not affected by the major re-development.

What is CHI's assessment of the PCT's systems for patient, service user, carer and public involvement?

This section describes how patients can have a say in their own treatment and how they and patient organisations can have a say in the way that services are provided.

What is CHI's main assessment?

The PCT, along with other agencies, consults with and involves local people in the planning of major developments for the future delivery of services, but the same level of commitment and activity is not evident in the PCT's other plans and strategies. There are many examples where field staff encourage patients to express their views about services, including identifying areas for improvement, but the activity is not shared and coordinated across the PCT.

CHI's assessment = ii (c)

What are CHI's key findings?

Working Together is a joint strategy with social services agreed in 1998 for involvement of the public in health and social care in Salford. The PCT has a public and patient involvement management group, with terms of reference agreed in November 2003. Following a board meeting in September 2003 to discuss the vision and principles of a PCT strategy, the management group is responsible for developing and implementing that strategy.

The Director of Public Health is the board lead for patient and public involvement, and a coordinator has been appointed and is accountable to the Head of Policy. The links between the coordinator and locality representatives are yet to be developed.

In some areas there is public involvement both at strategic and operational levels. The PCT held meetings to seek the views of local people and inform them of two major initiatives affecting the delivery of local health services where the public are contributing to developments: Salford Health Investment for Tomorrow (SHIFT) and Local Improvement Finance Trust (LIFT). Resources are allocated for such activity.

The PCT widely distributed a 2003 guide to the local health services in Salford. In the health centres, community pharmacies and some general practices there is a lot of information about services, and health promotion leaflets and posters are displayed on notice boards.

Projects such as the Government Sure Start programme and the promotion of breastfeeding, for example the Breast Mates project, enable service users to be involved in community groups. In the Lower Kersal and Charlestown Well-Being Centre, a number of agencies are working together in an integrated way to provide a choice of treatments. A Community Health Action Partnership has been established. The Centre provides an excellent example where local people and clinical staff have formed a local health focus group to plan and develop a health programme within the New Deal for Communities regeneration area.

A few general practices have their own patient forums. One practice has a board of governors to act as the patients' voice and others have suggestion boxes. There is a diabetes forum involving service users and carers, the Older Persons Partnership and, in Springwood School, there is a children's forum. The innovative work and evaluation

of these forums need to be shared across the PCT. Some dentists, pharmacists and optometrists are in the early stages of developing patient and public involvement and would welcome assistance from the PCT to promote this activity.

There is a designated person to manage complaints and a patient advice and liaison service (PALS) person, both of whom report to the Head of Policy. However, there is a lack of clarity in the roles and responsibilities, and some patients report a delay in communication from the PCT and poor information relating to the complaints process. Dissemination of lessons learned from complaints is patchy throughout the organisation and to the board.

Leaflets explaining the PCT complaints procedure are on display in many of the health centres and are available in six languages, but this fact is not promoted. Many of the general practices also display their own complaints procedure on notice boards. PALS is reaching out to the wider community and in general practices.

As part of the induction programme, staff receive information about the complaints procedure, but there is no specific training on customer care, complaints and diversity. Although the PCT commissions a locally based translation and interpreter service and is linked to the national Language Line service, this is not widely known throughout the organisation.

What areas of patient involvement should the PCT consider?

- Systems and processes need to be developed to coordinate patient and public involvement activities and disseminate good practice across all services.
- Roles and responsibilities in the management of complaints and PALS require clarification and monitoring, and a robust system for capturing information from complaints should be developed.
- PALS should further develop its relationship with GPs, dentists, pharmacists, opticians and optometrists.
- Training on customer care and complaints needs to be enhanced and implemented across the PCT.

What is CHI's assessment of the PCT's systems for risk management?

This section describes the PCT's systems to understand, monitor and minimise the risks to patients and staff and to learn from mistakes.

What is CHI's main assessment?

The PCT recognises that effective risk management is an integral part of providing quality clinical care for patients. Activity is mostly reactive. Planning and assessment of risk need developing. Operationally there is excellent work implementing an effective incident reporting system that leads to service improvements and learning.

CHI's assessment = ii (b)

What are CHI's key findings?

There is a risk management committee, which is a sub-committee of the board and is chaired by a non-executive director. Membership includes the chair of the professional executive committee and three executive directors. The committee reports to the board and the professional executive committee. All aspects of risk are in the remit of this committee. Reports are received from the clinical governance steering group, which, in turn, has a number of sub-committees, including health and safety, infection control, significant event expert review panel, control assurance and medicines management, which also report to the professional executive committee. There is lack of clarity in the structure, and, at the time of this review, the PCT agreed a significant change in this committee structure, which will also require an amendment to the strategy.

The strategy, adopted by the board in July 2003, is to address clinical and non-clinical risk issues across the PCT. The risk management committee, clinical governance group and internal audit committee agreed the strategy prior to the board. There is no patient or public involvement in its implementation.

The Director of Nursing is the designated lead for risk management, and the Deputy Director manages the clinical governance team, which has a risk management component and a designated manager. Good links are established with the acute trust to share information about risks.

Incident reporting, known as significant event reporting, is well understood by directly employed staff and some GPs. The events are graded using the National Patient Safety Agency's matrix, and investigations are undertaken for significant events, known as red, events.

In the PCT newsletter, reference is made to significant events. There are 35 significant event facilitators who enable anonymous third party reporting if necessary. Feedback from events is given to individuals, and staff report that it is a supportive framework for incident reporting, with counselling offered if necessary. Lessons are shared, but some only in teams and not widely across the PCT. There is evidence of some improvements to services as a result of analysis of significant events, but there is very limited involvement of patients in risk management.

There is no risk register, but the PCT realises that this needs to be addressed urgently to influence a proactive approach to risk management and the decision making process.

The risk assessment process is not robust and systematic and, therefore, plans to minimise risks are limited. More risk assessments in the work place are required. There are shared protocols with social services for child protection, however the PCT needs to ensure that all staff have access to up-to-date guidance. In the joint loan store with social services there are protocols and access to the PCT and social services incident reporting system.

Analyses of complaints, PALS activities and significant events, are highlighted in the clinical governance development plan and annual report as processes for quality improvement. A regular joint report to the trust board and dissemination of this information throughout the organisation is unclear.

Assessment for level one accreditation for the Department of Health's clinical negligence scheme for trusts (CNST) has not yet been undertaken.

There is investment in providing personal safety training. Risk management is part of the induction programme, although many staff raised concerns regarding personal safety. Significant event training is given to staff in the PCT and sometimes in the general practices. Training is yet to be systematically offered to the contracted services personnel.

What areas of risk management should the PCT consider?

- The PCT needs to implement a risk register as soon as possible.
- Robust systems and processes for risk assessments need to be implemented across the PCT.

What is CHI's assessment of the PCT's systems for clinical audit?

This section describes how the PCT ensures the continual evaluation, measurement and improvement by health professionals of their work and the standards they are achieving.

What is CHI's main assessment?

There is a strategic framework for clinical audit but limited implementation and involvement of clinicians across the PCT. Dissemination of results of audit activity is minimal.

CHI's assessment = ii (a)

What are CHI's key findings?

There is an audit committee with terms of reference that state that it will support the clinical effectiveness group, which receives copies of the minutes. At the time of this review, reporting arrangements for this committee are changing. The chair of the professional executive committee is the lead for clinical audit as part of the clinical governance brief. There is no lay representative on the committee.

The Deputy Director of Nursing and Risk manages the clinical governance team and, since October 2003, there is a designated clinical governance manager who is responsible for clinical effectiveness and audit. In addition there are facilitators who support GPs with using an information system to capture data and audit activity within the practices. Recruitment to new posts for data quality assistants is underway.

There is a clinical audit strategy with an outline action plan, agreed in October 2003, although the document states it is draft version three, and the consultation process and communication pathway is unclear. A few staff are unaware of its existence, and there is some confusion between clinical and finance audit.

A database of undertaken and planned audits exists. Audit activity predominately appears to be associated with the major developments and in the collection of data to inform the decision making process. Many are not related to standards or evidence-based practice. Some of the audits are related to patient satisfaction.

Some staff and general practices are involved in clinical audits, but this is not consistent across the PCT. The activity is not coordinated and, in most instances, it is not linked to the clinical effectiveness agenda. There is little evidence of multidisciplinary audits. The PCT acknowledges that the systems need to be more robust for prioritising audits and need to link with education and training.

There appears to be limited resources available to support audit across all staff groups.

There is some analysis of audit and the consequent improvements in patient care, however this is not systematic. There is no evidence of a coordinated process for sharing the learning from clinical audit. Some innovative work is evident, for example dentists supporting health visitors to work with mothers to improve the care of babies' teeth. The results are shared nationally.

Training and development appears to be specific to some individuals and not widespread across the PCT. The PCT acknowledges that audit training is an area for action.

What areas of clinical audit should the PCT consider?

- The structure, process and systems for clinical audit need to be reviewed, implemented and communicated, and support should be available to all staff to enable comprehensive participation in audit.
- Systems and processes need to be developed and monitored for the dissemination of audit findings and resulting changes in clinical practice.
- Systems and processes need to be in place to ensure progress and outcome reports of all clinical audits are reported to the appropriate audit committee.
- The PCT should develop a training programme for clinical audit for directly employed and contracted staff.

What is CHI's assessment of the PCT's systems for clinical effectiveness?

This section is about the way the PCT ensures that the approaches and treatments it uses are based on the best available evidence, for example from research, literature or national or local guidance.

What is CHI's main assessment?

There is considerable commitment, enthusiasm and activity at all levels in the PCT to ensure that the care and treatment for patients is relevant and evidence-based. Structures are in place, but there is a lack of clarity of the links with other activities. There are examples of good practice but these are not always shared, and the link between strategy and practice is not robust.

CHI's assessment = ii (c)

What are CHI's key findings?

There is a clinical effectiveness group that meets monthly. It has terms of reference, is chaired by the Director of Public Health and reports to the clinical governance committee. At the time of this review, reporting arrangements were changing. There is an effectiveness sub-group, but the link with the main group is unclear. The chair of the professional executive committee is the designated board lead but is not a member of the clinical effectiveness group.

Within the clinical governance team, under the direction of the Deputy Director of Nursing and Risk, there is, since October 2003, a designated clinical governance manager for clinical effectiveness and audit. There is also a nominated link person in each locality.

A clinical effectiveness strategy exists since December 2002. Early in 2004, the clinical effectiveness group discussed the annual report prior to dissemination. Both the PCT's business plan and the clinical governance development plan incorporate a section on action required in clinical effectiveness. There is no systematic approach at corporate level to involve the public in the clinical effectiveness programme.

The PCT is working with the local acute trust to ensure the drug formulary used in secondary care is consistent with recommendations in primary care.

The PCT is a Government pilot site for research management and governance in PCTs, and, with additional resources, provides support through a service level agreement to neighbouring PCTs. There are a number of research projects with the local acute trust, including joint research programmes on diabetes and stroke, and partnerships with Central Lancashire and Manchester universities. The benefits of the extra resources are yet to be fully realised, and the development of evidence-based protocols with involvement of the public is in its infancy.

The effectiveness of Lower Kersal and Charlestown Well-Being Centre is monitored and evaluated by Manchester Metropolitan University.

There is major commitment and enthusiasm to developing integrated care pathways, and a large number are under consideration. However, there is little involvement of and linkage with the clinical effectiveness group. Pathways for elective hip

replacement, fractured neck of femur and intravenous therapy at home are piloted and in place, with quality improvements identified. The care pathway initiative is being used extensively in the mapping, re-design and commissioning of services.

The appropriate local implementation teams within the PCT consider national service frameworks. The management of older people's services is now delivered differently as a result of the National Service Framework for Older People. National Institute for Clinical Excellence (NICE) guidance is distributed to relevant departments. There is no robust system for monitoring implementation of evidence-based practice. GPs appreciate the introduction, training and updating on national service framework and National Institute for Clinical Excellence (NICE) guidance given by the PCT in the Afternoons in the Park funded learning sessions.

Policies and protocols are available electronically on the intranet and in paper form and include guidance on good prescribing practice.

Some staff are able to access a computer and the internet in their workplace. All PCT staff, directly employed and contracted staff, have access to the library situated in the PCT headquarters building. The library is open during the day Monday to Friday, but there is 24-hour access to online databases. In parts of the PCT journal clubs exist.

There are a number of opportunities for staff to access critical appraisals and internet skills training sessions, including making use of the skills of the research governance manager and a library trainer.

As a result of benchmarking, changes are implemented in the continence assessment service provided by the district nurses.

What areas of clinical effectiveness should the PCT consider?

- The development of clinical pathways needs to be linked to the work of the clinical effectiveness group.
- A robust system needs to be developed to monitor the implementation of evidence-based practice.

What is CHI's assessment of the PCT's systems for staffing and staff management?

This section covers the recruitment, management and development of staff. It also includes the promotion of good working conditions and effective methods of working.

What is CHI's main assessment?

Staff are enthusiastic and enjoy working in Salford and for the PCT. There is tremendous effort and success to recruit appropriate staff and support them by improving their working lives. The same level of engagement with dentists, optometrists, opticians and pharmacists is in its infancy but this is acknowledged by the PCT.

CHI's assessment = iii

What are CHI's key findings?

The HR committee meets monthly and has delegated powers as a sub-committee of the board. At the time of this review, information in the form of minutes and reports to the board is changing. The committee does not feed into the clinical governance committee structures but there are representatives on associated working groups.

The Director of Human Resources is the designated lead for staffing and staff management and is responsible for the HR directorate. Within the directorate there is a deputy director, an HR manager for performance with responsibility for the Improving Working Lives initiative, a recruitment officer and a number of other staff.

A range of strategies and plans exists to support the HR strategy that was ratified by the board. There is a workforce development plan, and GP workforce issues are discussed by the professional executive committee. To implement the national Agenda for Change, the PCT, with the acute trust, is appointing a project manager.

The PCT is innovative in working with other trusts, social services and universities to address the workforce requirements of the PCT. An excellent example is the introduction of the assistant practitioners programme, but there is uncertainty regarding the placement of trainees and their future employment, and this needs addressing. Several operational posts in the therapy and learning difficulties service are jointly funded, but differing terms and conditions for staff are creating some difficulties. An international recruitment programme for employment of GPs is arranged with a neighbouring PCT.

Although there is good progress in achieving appraisals for all GPs, this is not the situation for the remainder of practice staff and directly employed staff.

CHI is concerned at the vulnerability of some staff because of the general lack of security measures in some of the buildings, and the PCT needs to address this urgently.

There are a number of policies to support staff, and many staff enjoy working in the PCT and appreciate the benefits of Improving Working Lives initiative. A non-executive director leads on this, and the PCT is accredited at practice level. There is an A to Z directory to inform staff about the initiative and it is distributed in a booklet and it is

available on the intranet. Staff appreciate the support given to flexible working hours, help with child minding and the allocation of time for personal health promotional activities to improve staff wellbeing and minimise stress.

What areas of staffing and staff management should the PCT consider?

- The PCT should further consult with the stakeholders on the effectiveness of the trainee assistant practitioners' placements and develop a retention plan for this group of practitioners.
- The PCT should continue to work with social services to address the varying terms and conditions of service.
- An action plan needs to be developed to ensure that all staff are appraised and the process is linked to personal development plans.

What is CHI's assessment of the PCT's systems for education, training and continuing personal and professional development?

This section covers the support available to enable staff to be competent in doing their jobs while developing their skills, and the degree to which staff are up-to-date with developments in their field.

What is CHI's main assessment?

The PCT is very proud of its commitment and recent developments for education, training and personal development of its staff, but recognises further coordination of activity is required. Pharmacists, optometrists and dentists who undertake work for the PCT are yet to be fully involved in the PCT's education programmes to meet the PCT's agenda to improve the quality of services. The benefit of the teaching status of the PCT is not yet maximised operationally.

CHI's assessment = ii (c)

What are CHI's key findings?

The Teaching and Learning Director is a board level post that heads the teaching and learning directorate. Effort is made to create a robust infrastructure in the department. There is an education and training working group. The board and the professional executive committee discuss the 2003 to 2005 training and learning strategy.

Links and initiatives with other trusts, social services and universities are evident. There is a joint post with the University of Manchester Dental Hospital and links with the deanery through the GP tutor. As a pilot site for research management and governance, links with a number of academic establishments are a core element of the work. PCT staff associated with research management and governance are part of the teaching and learning directorate.

Personal development plans are in place for many staff, including the non-executive directors and GPs. Through education and development, the PCT is endeavouring to be creative and address some workforce issues. Links with education and finance from the Greater Manchester Confederation enables trainee assistant practitioner training. At the time of this review, the PCT announced a successful bid with a neighbouring PCT to train dental therapists and hygienists to diploma level.

Investors In Excellence partnership and the learning contract initiatives are introduced by the PCT to engage staff and promote commitment to learning.

Some mandatory training takes place centrally and in the localities, but there is no robust system for recording and monitoring attendance.

Resuscitation, child protection and diversity issues are not always addressed in induction, and regular training and updating is spasmodic and needs addressing across the PCT.

The PCT supports GPs financially to attend a monthly learning event known as Afternoon in the Park. The sessions are appreciated by the doctors and are used to network and keep up to date on clinical guidelines and protocols. There is little evidence that the same opportunities for learning exist for other staff in general practices, dentistry, pharmacy and optometry.

Within the teaching and learning directorate there is a library and resources service that is accessible during weekdays to all directly employed and contracted staff. There is also an outreach service for staff to request literature to be sent to the individual's workplace. Education and learning opportunities for directly employed staff are advertised electronically and on notice boards. E-learning modules are developing. Staff report there is support from the PCT for further education and training.

The PCT's teaching status increases resources and opportunities to develop education, but these are not fully maximised for the benefit of staff.

What areas of education and training should the PCT consider?

- Mandatory training subjects should be specified and an action plan developed to ensure regular delivery and monitoring of attendance.

What is CHI's assessment of the PCT's systems for using information?

This section describes the systems the PCT has in place to collect and interpret clinical information and to use it to monitor, plan and improve the quality of patient care.

What is CHI's main assessment?

There is substantial investment in resources for information management and technology, with a clear strategic direction that leads to improvement. Development and progress to disseminate and use information to monitor and improve performance across the PCT is not yet effective and dynamic in its implementation.

CHI's assessment = ii (a)

What are CHI's key findings?

The information and IT departments are located in the finance directorate. Designated facilitators in the clinical governance team manage the data within GP systems.

The Director of Finance is an executive on the board and is the designated lead for clinical information management. The senior team comprises of the Head of Information, Head of IT, Information and IT Security Manager and Director of Health Informatics. A meeting of senior managers is held monthly and chaired by the Director of Finance.

The Head of Information chairs the information governance group, which has 18 members. There are terms of reference and the group reports to the clinical governance risk management group. The accountability structures are in the process of change. There is a multiagency local implementation strategy board for health information, chaired by the Director of Finance.

As a result of a review of structures, a director of health informatics is appointed jointly with the local acute trust and is responsible for health information across the city of Salford.

The information strategy is two years old. However, the PCT acknowledges that it needs updating to reflect national initiatives and the significant investment in information and IT for the delivery of the local programmes in Salford in the new centres financed by the Local Implementation Finance Trust (LIFT) initiative and the Salford Health Investment for Tomorrow (SHIFT) initiative.

Existing clinical information systems for the services provided by the PCT are limited and generally do not provide useful live information that can be used in a meaningful way to review and improve performance. Staff, particularly those working in different teams, find the lack of integrated systems frustrating and problematic. This also applies to general practices.

Quantitive data reports are produced, but their dissemination and usage to monitor and improve performance is unclear. For the child immunisation programme there is an example where the use of information influences and improves performance.

Many directly employed staff use paper documents, but work is in progress to introduce electronic patient records. Laboratory results from the acute hospital are received electronically by most general practices, and some practices are moving towards a paperless system. Data quality audits are undertaken. Some staff told CHI that support from the PCT in the management of information and IT is improving.

The chair of the professional executive committee is the Caldicott (patient confidentiality) guardian, and there is a committee to consider confidentiality issues. The inability of staff in some services to share information across agencies, due to the absence of a protocol, frustrates staff.

Many staff have access to a computer but many share with a number of colleagues. For some staff there are access difficulties, but common passwords are used to overcome the problems.

There is an e-learning suite in the PCT headquarters. Training is available in the use of computers and specific systems management and staff are supported in studying for the European Computer Driving Licence (ECDL). The PCT also provides system training in general practices.

There is little evidence that information is systematically used to monitor and benchmark clinical activity and performance.

What areas of using information should the PCT consider?

- There should be clear systems and processes for the identification of information requirements and dissemination to facilitate clinical governance activities and to monitor performance.
- An action plan needs to be developed to improve the integration of information systems with social services and among primary care clinicians.
- Following consultations with other agencies, the PCT should adopt and disseminate the agreed information sharing protocol to directly employed staff and support its implementation.
- The PCT should further develop the use of information skills of staff and improve access to personal computers.

What is the PCT's strategic capacity for improvement?

This section describes the ability within the PCT to monitor and improve the quality of patient care.

What is CHI's main assessment?

Dynamic leadership and a drive to move the health agenda forward is undertaken through significant developments requiring considerable resources and commitment. This is carried out in partnership with other trusts, the local authority, social services and the public. Health improvement programmes to meet and improve the health of the local population are influencing the decision making process.

What are CHI's key findings?

There is a strong, cohesive board and executive and senior management team leading the PCT. The Chief Executive is leaving the PCT but a new chief executive is already appointed, thereby minimising disruption to the service. The PCT appears to have an open style of management, with the Chief Executive meeting staff regularly. Issues of the competency of practitioners are addressed. Primary care is seen to encompass the population of Salford as a whole and not only those people requiring services for treatment for ill health. Non-executive directors take a lead role on a specific area and link in with the local community, particularly with vulnerable and minority groups.

The professional executive committee is established, with membership from across the professions, including dentists, optometrists, opticians and pharmacists and a representative from social services. The professional executive committee works closely with the management team and is developing its role and influence but recognises the need to prioritise and be proactive in clinical matters.

The chair of the professional executive committee is the lead for clinical governance and is supported by the Assistant Director of Nursing and Risk, who manages a clinical governance team that has recently been strengthened. There is a clinical governance framework that endeavours to link all components of clinical governance and a number of committees established in 2003. These are yet to be embedded into the organisation and there is a degree of duplication and confusion within the service. The PCT recognises amendments are necessary, and, in January 2004, the board ratified a new committee structure for healthcare governance. This new structure and the associated reporting arrangements need to be clarified, with documents amended and communicated throughout the PCT.

Information requirements of the board need to be specified to ensure the board receives meaningful relevant information for governance of all aspects of the work of the PCT including child protection.

Implementation of the locality management framework is in its infancy but progressing, with leads for each component of clinical governance identified and the establishment of local clinical forums. There are excellent comprehensive directories for the locality arrangements. Support for locality management is noted but, for some staff, it is a period of uncertainty, and reassurance on their role and responsibility is

required. Engagement of GPs, dentists, pharmacists, opticians and optometrists is variable across the PCT. Locality management is expected to involve all clinicians in local groups.

Joint working and partnership arrangements exist in a variety of ways with other trusts and the local authority, including social services and housing and voluntary organisations. There is a strong commitment and considerable effort invested into the principle of working together. For example, the post of director of public health is a joint appointment with the city council and a new appointment to the post of deputy director social services will also be the PCT director of joint commissioning. The Head of the Learning Difficulties service is a joint appointment to manage the integrated service.

There is an effective joint equipment loan store providing a service to the people of Salford regardless of the referring organisation or professional. The joint provision of intermediate care facilities with social services enables the effective management of discharges from the acute hospital trust.

Collaborative and joint working is also evident in the planning developments and future direction of the PCT to improve services, particularly in the Local Implementation Finance Trust (LIFT) initiative and Salford Health Investment for Tomorrow (SHIFT) initiatives and the work associated with regeneration. The Local Implementation Finance Trust (LIFT) initiative will establish a number of new centres across Salford that will provide health and other services to meet local need. The people of Salford are involved in the extensive consultation process, which occurs in many ways and settings.

There is an emergency planning committee and a head of health protection that links with the Greater Manchester Health Protection Unit.

The PCT library holds a range of health promotion literature and is responsible for distribution and responding to requests for information from staff. Health improvement and partnership working are the foundations of the establishment and continued support of the Angel Living Centre and Lower Kersal and Charlestown Well-Being Centre. Many examples of health improvement initiatives are evident across the PCT, some driven strategically from the Healthy City Forum and others instigated by clinicians.

Funding is provided by the PCT to support local cooking and weaning groups, providing resources to improve children's teeth and arrange the delivery of affordable food to deprived areas of the city.

Consultation is undertaken with the Jewish community to improve the uptake of the immunisation programme for children. By employing link workers, the PCT also supports an asylum and refugee research appraisal health project.

Re-design is at the centre of the direction, planning and commissioning of current and future services to meet the needs of the local population. This approach results in improvement in access to acute services, such as development of a minor surgery unit, 24-hour access in primary care with the establishment of PCT out-of-hours service, a rapid response team and evening nursing team. Specific care related groups are established but not all have patient or public representation.

Commissioning priorities are part of the corporate objectives and local delivery plan. The Director of Strategic Commissioning is a board level post and is head of the commissioning directorate. Commissioning is mainly undertaken by specific patient groups but, recognising that there is room for improvement, the establishment of a commissioning panel linked to the professional executive committee has been agreed. Salford local delivery plan and the PCT strategy identify some priorities and outcomes for commissioning.

The PCT, through its commissioning function with the provider trust, is endeavoring to review and change the delivery of mental health services to improve access. There is an executive commissioning group with the local authority to improve the decision making process for mental health, children's and older people's services.

Work is developing to improve prescribing and medicines management, and there is financial commitment to this work. There is a pharmacy team in the nursing and risk management directorate, which comprises a strategic pharmacist for medicine management, prescribing development manager, support technicians, prescribing facilitators, lead nurse and other staff. The function of the team is to assess risk, provide advice, education and training and to monitor and audit the use of medicines.

The medicines management group, chaired by the GP prescribing lead, reports to the clinical governance committee and professional executive committee. The GP lead and the Deputy Director of Nursing are also members of the professional executive committee. Structures and links across the PCT with the medicine management group, particularly with the community pharmacies, need to be strengthened. There is a strategy and action plan for medicines management for 2002 to 2004.

Reviews of prescribing for a number of prescribed medicines are undertaken. Reports are also received on trends within the PCT and other comparative data with other trusts within the strategic health authority

To help improve patient care, a patient medication review and minor ailment scheme is delivered by pharmacists in purpose designed premises in a deprived area of Salford. The scheme is expected to improve the dialogue between the pharmacist and GP and result in better medicine management.

Further information

The CHI clinical governance review took place between September 2003 and April 2004.

This report sets out the main findings and areas for action from the review. The PCT has been given a detailed summary of the evidence on which these findings are based.

The PCT will produce an action plan that will be available from:

Salford Primary Care Trust
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or from the Healthcare Commission website. The PCT's implementation of the action plan will be monitored.

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The Healthcare Commission should like to make clear that responsibility for the content of the report and its conclusions is the Healthcare Commission's alone.

An explanation of terms used in the report

clinician/clinical staff	a fully trained, qualified health professional - doctor, nurse, therapist, technician etc.
community care	health and social care provided by healthcare and social care professionals, usually outside hospital and often in the patient's own home
general medical services (GMS)	the services provided by general medical practitioners under Part II of the Health Act 1999
health action zone (HAZ)	regional initiatives set up by the government to improve health in targeted areas of poor health and deprivation HAZs are made up of members from the NHS, local authorities voluntary and private sectors, coordinated by a local 'partnership board'
health community	all organisations with an interest in health in one area, including the community health councils, and voluntary and statutory organisations
health improvement programme (HimP)	a locally agreed work programme to improve health and which delivers the national priorities and targets
independent contractors	GPs, dentists, pharmacists and opticians are independent contractors in that they deliver health services in return for payment by the PCT but they are not PCT employees (they are self employed)
personal medical services (PMS)	a locally, rather than nationally, agreed contract, which allows for new models of primary care services provision, including salaried GPs and collaborative management arrangements between practices and with other professions
primary care	family health services provided by GPs, dentists, pharmacists, opticians and others such as community nurses, physiotherapists and some social workers
professional executive committee (PEC)	a structure unique to PCTs, which ensures that working professionals are involved in strategic decisions about planning and delivering a PCT's services. PECs have up to 18 members. These include the Chief Executive of the PCT, a social services representative, clinical staff employed by the PCT and independent contractors — GPs, nurses, allied health professionals, dentists, optometrists and pharmacists

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