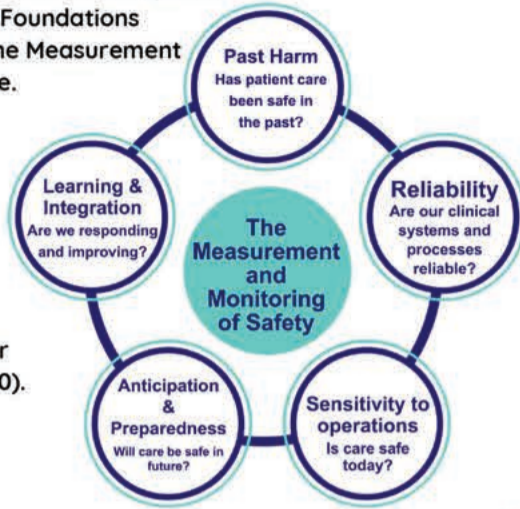


## INTRODUCTION

The Safer Salford programme is a system-wide, quality improvement focused initiative that began in 2016 in the wake of the Francis and Berwick reports (2013) and Salford's involvement in the Health Foundations Making Safety Visible programme which had the Measurement and Monitoring of Safety framework at its core.

This learning provided the drive for a partnership of health and social care system leaders in Salford to begin to 'collaboratively develop and test a roadmap by 2018, for Salford to become the safest health and social care system'. This has developed over the years into the vision of 'an integrated system working together to improve safety for everyone living in Salford' (AQuA, October 2020).

Safer Salford was supported in its work by its improvement partner The Advancing Quality Alliance (AQuA), formerly Haelo.



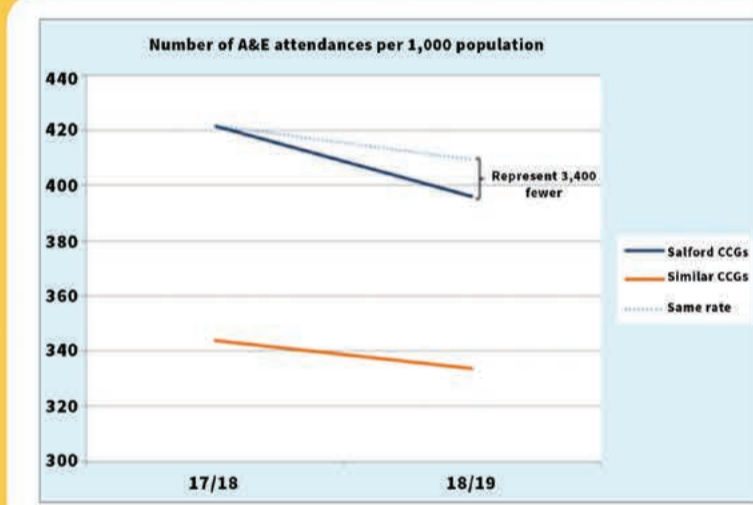
## WHAT DID WE DO?

As national policy was beginning to align behind "vanguards" to provide integrated care, all six local health and care partners made a commitment to the 250,000 residents of Salford to deliver safer care across the city.

## WHAT HAVE WE ACHIEVED SO FAR?

Understanding the difference made by multi-faceted initiatives such as Safer Salford can be difficult, particularly in relation to knowing what would have happened if the programme had not been in place.

- Due to data limitations, the evaluation team undertook a "difference in difference" comparison between Salford and other comparator localities for A&E attendances. The number of A&E attendances for Salford Clinical Commissioning Group residents was compared to those of CCGs in the 15 boroughs in England deemed to be most similar to Salford. Data suggests that had the non-Salford rate been observed in Salford then there would have been just under 3,400 more attendances in the year.
- 3000 fewer patients at risk of an adverse medicines event.
- New handover bundle supporting safer transfers with the % tripling since January 2018 and 80% requests for advice dealt without requiring a referral (pilot scheme).
- Measured increase in QI skills and capabilities in care homes.
- Changes in leader perceptions of working at a system level.
- An increase from 47% to 85% homes rated "good" or "outstanding" overall by Care Quality Commission between 2017-2019.
- Convened system partners to build relationships and develop priorities to support focused change - In June 2020 Salford has improved to 32nd out of 151 localities compared to being 150th out of 151 localities in 2017.



## HOW DID WE DO IT?

An observational narrative of several key measures from the Safer Salford Intelligence Dashboard (Falls, Medicine Related Admissions and Sensitivity to Operations) was undertaken by the AQuA analytics team using Statistical Process Control (SPC) charts and methodology. These focused on indicators potentially relevant to programme activity. A retrospective baseline period of January 2015 to March 2016 was applied to provide a proxy 'before and after' intervention period.



Limitations of this approach are acknowledged, not least that attribution is challenging, and activity within the system was not all funded, nor delivered by Safer Salford. Falls and medicine related admissions show a step-change improvement, sensitivity to operations measures (i.e. information or capacity to monitor safety on hourly or daily basis show little change, or deterioration).

## WHATS NEXT?

The journey continues to be responsive and agile. Salford's choice to adopt a cross-system approach to safety, particularly back in 2016, when integrated care and new models of care were in an early stage of development, has been seen by many to have been a progressive stance. The challenges and complexity of measuring and monitoring safety at this scale are, however, well documented and have been recognised by the Safer Salford Leadership Group. This is echoed in the reflections of the AQuA delivery team. Safer Salford has provided an opportunity to learn and better understand cross-system safety. The level of integration has been noted to be a key aspect of a safer system, however, measurement remains challenging. As of 2019-2020 consideration for next steps are:

1. To distil learning to date to inform the design, governance and evaluation of future Salford safety improvement programmes.
2. To further develop a suite of system safety measures building upon the innovative Salford Safety Intelligence Dashboard ensuring that improvement programme metrics are aligned with this. Economic measures could be incorporated.
3. To consider a targeted communication and engagement strategy to promote shared understanding of Safer Salford across the partner organisations and to celebrate its achievements.
4. To consider how capability in patient safety, improvement and change can be built across Salford and sustained in the face of operational pressures.
5. To explore ways to involve a wider range of stakeholders, including those with lived experience who receive health and care services in Salford.

## ENGAGEMENT & CO-DESIGN

Engagement and co-design have been key to the success of this project.

### ENGAGEMENT

Salford residents helped select the priority areas to focus on at a Citizens Panel event, attended by over 80 residents interested in the provision of healthcare in Salford. This directly informed our approach in 2019-20/2020-21 as work packages were developed.



### CO-DESIGN

Salford patients have been directly involved in the design and development of a new handover bundle through lived experience interviews and follow up calls to explore the impact of handovers. It is our intention to continue involving patients in the development of a handover bundle as a core component of safety. In 2020/21 a Lived Experience Panel is being developed to support the work of Safer Salford.



## AUTHORS & CONTRIBUTORS

Francine Thorpe, Director of Quality of Innovation - Salford CCG  
 Claire Vaughan, Head of Medicines Optimisation - Salford CCG  
 Elizabeth Bradbury, Director - AQuA

