Evaluation of Salford Together:
Adults Integrated Care Programme (ICP)

End of Programme Report: 30 July 2020

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Executive Summary:

Background: This report summarises the key findings, learning and recommendations from the end of programme evaluation of Salford Together’s Adults Integrated Care Programme (ICP). This ICP was funded by Greater Manchester (GM) Health and Social Care Partnership in October 2016 and comprised twelve, transformation ‘test of change’ projects, implemented between 2017 and 2020 (Table 1). These projects focussed on key priorities of integrated care including: 1) improving access to GP and community services; (2) providing care closer to home; (3) improving care pathways; and (4) developing Neighbourhood teams. The anticipated impact of the ICP programme included: improved patient and staff experience, patient outcomes and more efficient use of system resources, including urgent and emergency services.

Table 1: Summary of twelve Integrated Care Programme Test of Change projects and priority focus area

<table>
<thead>
<tr>
<th>Extended/ Intermediate Care</th>
<th>Pathways of Care</th>
<th>Neighbourhood Integration</th>
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</thead>
<tbody>
<tr>
<td>Urgent Care Team (UCT)</td>
<td>MSK/ Back Pain Pathway</td>
<td>Enhanced Care Team (ECT)</td>
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<td>Housing Support in Hospital</td>
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<td>Centre of Contact (CoC)</td>
<td>Enhanced Carer Support Service</td>
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<td>GP Streaming/Urgent Treatment Centre</td>
<td>Advice &amp; Guidance pilot</td>
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</table>

A partnership of seven Salford health, social care and voluntary organisations¹ (branded as Salford Together) is responsible for delivering the Adults Integrated Care Programme (ICP). The ICP built on Salford’s evolving programme of integrated care, its long history of prior work (particularly with older people), set within the context of GM devolution and NHS England’s national, ‘new models of care’ Primary and Acute Care system Vanguards (PACs). Prior to the ICP starting, Salford was one of the first areas of the country to establish its Integrated Care Organisation (ICO)², in July 2016, which saw structural integration and transfer of Adult Social Care from the Local Authority to Salford Royal NHS Foundation Trust. This was a key step to enabling the ICP aims.

Evaluation Approach: Embedded evaluation support from Haelo initially (2017-2019) and AQuA latterly (from September 2019) involved theory-based, formative evaluation using Rapid Cycle Evaluation (RCE) methodology (Parry et al, 2013). This was designed to inform the development and implementation of individual projects, using a range of quantitative and qualitative methods, and structured RCE meetings with relevant stakeholders to review emergent findings, theory of change and enable timely and targeted action. The summative evaluation is a collation of project and system data, alongside insights from (n = 15) qualitative interviews³ with senior leaders from all the partners involved in the programme and learning from project milestone and RCE meetings. In addition to the qualitative work within ICP projects, Salford Together commissioned Healthwatch to undertake independent

¹ Salford City Council, NHS Salford Clinical Commissioning Group, Salford Royal NHS Foundation Trust, Salford Primary Care Together, and GM Mental Health NHS Foundation Trust (formerly GM West) and in 2018, Salford Community and Voluntary Services.
² Salford Royal became the prime provider for all adult health and social care, and mental health (through a sub-contract with GMMH formerly GM West) (NHS Providers, 2017). More than 2,000 ICO health and social care staff now work within one organisation, SRFT.
³ AQuA commissioned SQW to undertake qualitative interviews with senior leaders involved in Salford Together ICP (Nov 2019-Mar 2020)
collation of patient experience through case studies which are reported separately https://www.salfordtogether.com/category/casestudies/

This evaluation report focuses on three primary evaluation questions below, and where possible considers the key themes of the GM ‘Taking Charge’ evaluation\(^4\) led by the Greater Manchester Health and Social Care Partnership (Appendix 1).

1. To what extent the intended outcomes of the projects and programme have been achieved?
2. To what extent the mechanisms for improvement were an effective means of achieving them?
3. What key learning could be transferred to other programmes or environment?

**Key Evaluation Findings:**

**Question 1: Intended outcomes of Integrated Care projects and overall programme achieved?**

Large scale change and population-wide improvement initiatives are known to take considerable time to deliver results. The context within which they take place is also important. Salford has seen considerable change since the Integrated Care Programme began in 2016, including the Integrated Care Organisation (ICO), the Mental Health Trust merger, Salford Primary Care Together model change and the establishment of Primary Care Networks (PCNs).

The complexity and challenge of demonstrating impact and attribution in large scale change programmes, within relatively short time frames cannot be underestimated. Salford Together’s Integrated Care Programme involved multiple initiatives, often overlapping goals, as well as other system initiatives taking place during the same time (Appendix 2).

**Integrated Care Programme Level Outcomes**

At a programme level, direct attribution of changes in key system metrics presents challenges, particularly in in the absence of a defined counterfactual (i.e. knowing what would have happened if an initiative was not in place). Several ICP projects were also smaller tests of change in specific neighbourhoods, and therefore not expected to have impacted at scale. This evaluation reviewed two of the ten key outcome indicators set out in the GM Investment Agreement for the funding. Non-elective admissions (NEL) and A&E attendances are reported monthly at the Adults Advisory Board, using Service Level Agreement Monitoring (SLAM) data (Harding, 2020).

The latest figures available at the time of reporting (November 2019) indicated programme targets for NEL admissions (all ages) for 2019/20 were likely to be met and exceeded.\(^5\) The

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\(^4\) The Adults ICP was designed for the needs of Salford population/system and pre-dates the GM Evaluation of “Taking Charge.”

\(^5\) Latest GM investment agreement data made available to evaluation team in July 2020 (using SLAM data) reports NEL admissions -4.8% below plan based on 12 month rolling position at Mar-20 and A&E Attendances -2.2% below plan based on 12 month rolling position at Mar-20. The impact of COVID19 was reported to have resulted in March 2020 having lowest admissions since 2017 and lowest A&E attendances recorded. This makes comparison difficult.
A&E attendances programme target was, however, not likely to be met if the observed trend of rising A&E attendances continued. It is important to note that these forecasts are set within the context of a large increase (14,607) in the registered population of Salford since baseline, and the specific role that Salford Royal plays within the local health care system (and prior to COVID-19). When A&E attendances were considered alongside the Salford population increase, a decline of 0.7% was reported (Harding 2020).

The AQuA analytics team compared A&E attendances for Salford CCG residents with those of fifteen Clinical Commissioning Group (CCG) boroughs in England, identified as suitable comparators with Salford. Hospital Episode Statistics (HES) data was only available for the full years of 2017/18 and 2018/19. The analysis indicated reductions in A&E attendances for both Salford and other CCG boroughs as a whole, but the reduction in Salford was at a greater rate. This means that if Salford had the same rate as the overall peer group there would have been just under 3,400 more attendances in the year. This comparison provides useful insights for the programme team, but it is not possible to attribute direct causation to the Integrated Care Programme given the other relevant concurrent system initiatives. Data limitations precluded undertaking this comparison using other indicators.

Salford Together was perceived by senior leaders who took part in interviews (n=15) to operate as a genuine partnership, with a shared vision and set of values, although at times Salford Royal was perceived to have the strongest voice. Coterminal boundaries of many of the key partners, and an effective formal governance structure, supplemented by good interpersonal relationships between partnership leaders were also noted as key facilitators. The governance arrangements in particular were credited with helping to maintain overall momentum during organisational change and turnover of personnel. Leaders reported a culture of innovation, wanting to remain ‘ahead of the game’, with a sense that partners could test new approaches with evaluation and monitoring built into ways of working, and a willingness to halt any unsuccessful approaches.

Partnership working and a shared vision were, however, perceived by senior leaders to be more evident at a senior level than at operational levels. There was a perception of senior leaders that the workforce now has a more collaborative culture, but there is still progress to be made amongst frontline and operational teams in terms of both implementing integrated ways of working and achieving culture change.

A range of positive impacts on health and wellbeing for the local Salford population were identified by leaders, but the scale, sustainability, and timing of some impacts was reported to remain uncertain. There was less perceived impact of the programme at a system level, but cautious optimism that greater impact might be achieved over a longer timeframe. Examples provided included: cashable savings for CCG’s from tackling medication wastage and rate of growth of A&E attendances and emergency admissions fallen or plateaued despite a rising population. Reduction or stabilisation in admissions to residential care and an improvement in the quality of residential care was also reported. Salford was noted to have moved from being 150 out of 151 local authorities in terms of the numbers of care homes that were rated as inadequate or required improvement by the CQC to 75th. The need
to carefully manage expectations regarding realistic and achievable impact within Transformation Fund and evaluation timescales was also noted by some. Several consultees cautioned against attributing too much weight to underachievement of outcomes, noting that ambitious targets were set and time was needed to effectively implement and realise larger scale impact.

**Integrated Care Programme - Project Level Outcomes**

A detailed summary of reported outcomes and impact from each of the twelve ICP transformation projects highlights the range, complexity and scale of projects implemented during the course of the two year programme (Table 4, Section 4). Some projects involved ‘tests of change’ in selected neighbourhoods initially (e.g. Enhanced Care Team and Back Pain) and others developed and scaled up new initiatives across the city (e.g. Urgent Care Team, Falls Prevention and Centre of Contact). The VCSE Voices Matter project focused on ensuring voluntary and community sector (VCSE) representation on decision making bodies within the Salford Together partnership. The neighbourhood teams and local care approach is currently in implementation stages, with work planned in 2020/21, although this was paused temporarily as teams were diverted to COVID-19 pandemic response. A range of positive outcomes were reported across the ICP projects relevant to the key aims of the programme, including:

1. **Better use of system resources:**
   - Reductions in A&E attendances were reported in four of the transformation projects including, Back Pain, Enhanced Carer Support, Falls prevention, and Enhanced Care Team. The issue of small numbers involved and/or concurrent initiatives were often noted which limited causal attribution and demonstrating potential system wide impact.
   - Reductions in non-elective admissions (NEL) were reported in two projects: Enhanced Carer Support and Enhanced Care Team. The issue of small numbers was also noted.
   - Reduction in secondary care referrals reported in Back Pain project (lower than anticipated) and no growth in requests for Magnetic Resonating scans against national picture of increasing use.

2. **Improved patient outcomes:**
   Improvements in patient outcomes and quality of life measures were reported in several projects including the Enhanced Care Team, the Enhanced Carer Support project. The Urgent Care Team reported achieving their aim of settling patients at home (and avoiding A&E attendances) in 76% of caseload.

3. **Improved patient and staff experience:**
   - Healthwatch were commissioned independently by Salford Together to capture patient experience of being involved in the Integrated Care Programme. Case studies of positive experiences have been reported [https://www.salfordtogether.com/category/casestudies/](https://www.salfordtogether.com/category/casestudies/).
The Enhanced Care Team highlighted the multi-disciplinary approach as one of the key success factors of the service. Almost all carers taking part in an Enhanced Carer Support survey reported high levels of satisfaction and positive impact on their life. The Back Pain project reported high levels of patient satisfaction with a back pain triage clinic appointment and an increase in self-reported expertise of physiotherapy staff in treating back pain patients.

**Question 2: Mechanisms for Improvement as effective means to achieve programme outcomes?**

Rapid Cycle Evaluation (RCE) meetings reported to provide opportunities for key project stakeholders to review emergent findings, act accordingly and revise proposed theory of change. A review of reported learning from individual project RCE meetings identified common challenges relevant at a programme level. These are summarised and where possible, mapped to GM themes:

- **Structures, Governance and Accountability:**
  - Uncertainty about governance and reporting structures, new roles, service aims, (e.g. ECT, UCT, Centre of Contact, Mental Health projects)

- **Workforce:**
  - Recruitment and retention issues: staffing and capacity issues for some new models of working (e.g. UCT, Centre of Contact, Falls Prevention projects)
  - Communication and Engagement challenges: particularly in relation to referrals and/or GP engagement (e.g. MSK, UCT, ECT, Mental Health projects)
  - Estates challenges: accommodation limited to enable co-location and joint working (e.g. Back Pain, GP Streaming).

- **Impact:**
  - Demand/forecasting impact and data availability: initial predictions being either too high or too low, based on limited availability of data (e.g. ECT, community rehab for falls higher uptake than expected, postural stability intervention for falls lower uptake than predicted, SMI register much bigger than expected, Advice & Guidance lower uptake in primary care).
  - Attribution of causation: Falls, ECT, UTC are linked interventions e.g. ECT and UTC refer into falls pathway, Back pain has concurrent GP Streaming project.
  - IM&T systems: in particular GP systems (EMIS and Vision) and interoperability across system (e.g. ECT, Mental Health). The introduction of new General Data Protection Regulations during this time also required some plans to be re-developed.
  - Data: Access, quality and complexity: e.g. (Mental Health, Enhanced Carer Support, and ECT).

This formative evaluation approach was designed to help project teams understand the extent to which projects were delivered as intended and make timely adjustments to their plans. The value of a formative approach has been noted in providing early signals of what is working well and aspects which require improvement or review. It also provides useful
insights where anticipated benefits have not been realised, for example, where referrals to new services were lower than expected, in the case of the Enhanced Carer Support project, the Enhanced Care Team, the Urgent Care Team, the Falls Prevention pathway (low intensity) and uptake of the Advice and Guidance in primary care.

The final evaluation milestone meeting with Salford Together stakeholders (Oct 2019) explored the extent to which core aims of the ICP programme were perceived to have been achieved. Summary themes indicated that stakeholders perceived it to have been an aspirational aim, which had not been fully achieved yet, but there were pockets of success/progress and evidence of successful testing/piloting as well as good relationships and levels of engagement.

**Question 3: Learning and Recommendations from Salford Together’s Integrated Care Programme:**

Rapid cycle evaluation has provided the Integrated Care Programme project teams with a robust methodology to understand the factors which both facilitate and impede successful implementation and outcomes within individual projects and their potential contribution at a programme level.

Key facilitators identified by stakeholders at the final evaluation milestone meeting included: leadership and clarity of vision, pre-existing relationships within Salford (and associated trust/commitment/communication), transformation funding, willingness and opportunities to think and do things differently, and the iterative evaluation approach which enabled adaptation of plans.

Common reported barriers to change included: data challenges of access, quality and complexity; challenges of accurate demand forecasting due to limited data available; lack of clarity among stakeholders about new roles, responsibilities and governance; stakeholder engagement challenges; staff recruitment and retention; limited estates accommodation to enable co-location of teams; and IT systems interoperability impeding implementation. These themes were echoed in the final milestone meeting alongside the challenge of balancing transformation with externally mandated pressures (e.g. A&E and non-elective admissions targets), risk appetite, earlier inclusion of VCSE would have been preferable, cultural issues, and challenge of developing measurement/evaluation. Local and national changes were also identified including the creation of the Northern Care Alliance.

Interviews with senior leaders from Salford Together (n=15) were mapped to the key GM Transformation Evaluation Themes by SQW. The perceived benefits of robust governance arrangements in Salford, shared understanding, history of partnership working and perceived innovation were noted. The later inclusion of the voluntary sector (in 2018) and perceived culture of innovation in Salford as well as an on-going desire among partners to “stay ahead of the game” were also highlighted. Challenges reported included maintaining progress on culture change and integrated working among frontline/operational staff as well as evidencing impact within Transformation funding timeframes.
The rapid cycle evaluation approach has been reported to have informed timely decision making with several of the ICP projects continuing as planned, or with adaptations. Relevant business cases have been developed. These include the Urgent Care Team (UCT), MSK Back Pain, Falls Pathway, Enhanced Carers Service and Housing Support. The Advice & Guidance project has recently been developed in relation to the current COVID-19 pandemic. Insights and shared learning across the programme indicate a number of key recommendations. These have been organised in four key areas, (1) programme design and measurement, (2) implementation and engagement, (3) neighbourhood learning and (4) evaluation approach:

Programme focused recommendations: focused
- Future work to consider alignment of project and programme level outcomes and impact with pre-set system metrics to better understand the individual and cumulative project activities, including patient and staff perspectives. It is important to note that there is another year to deliver the system metric ambitions out-with the programme.
- Prospective consideration of other datasets in addition to the current programme metrics using Service Level Agreement Monitoring (SLAM) data.
- Regular review of associated programme metric charts annotated with project activity to explore potential contribution of projects over time.
- Exploring the feasibility of a defined counterfactual at the outset of programme, although it is acknowledged that obtaining comparable data often presents considerable challenges. The programme monitoring did include projected figures for a ‘do nothing’ scenario.

Implementation and engagement focused recommendations: 
- Early set up of future integrated care programmes to include a robust assessment and optimisation of known enablers, and plan for mitigation of known barriers.
- A targeted and resourced engagement and communication strategy at the outset is prioritised and reviewed regularly.

Neighbourhood focused recommendations: 
- The AQuA delivery team’s early insights suggests enablers for neighbourhood teams included a clear focus which reflected their local priorities, central project management administration support and regular meeting dates. Shared learning was also reported to be facilitated through development of support at Salford and neighbourhood level.
- It is recommended that future work includes follow up of neighbourhood leadership teams’ views and experiences of the programme, their individual projects, support they received and impact on integrated working, including mapping any change in their networks.

Evaluation focused recommendations: 
- Inclusion of a formal ‘readiness for evaluation’ assessment is undertaken prior to project commencement (where possible). This could provide project teams with better understanding of the nature of available data, IT issues, and level of stakeholder
engagement required to optimise project design and feasibility. Enhanced patient experience capture at the programme level is also recommended.

- Inclusion of economic indicators within the formal evaluation framework.
- Inclusion of a quality appraisal assessment process of individual project level evaluation reports to develop capability, promote standardisation and quality of reporting to ensure robust nature of data available for summative review. The time and resource required to adequately resource this support needs to be considered.
- Review of the project level and programme level logic models and driver diagrams assumptions to inform future development of the integrated care programmes.
- Review project teams’ experiences of the evaluation approach to understand the extent to which the parallel ambition to increase capability and capacity within the team was, in fact, realised and where improvements can be made.
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1. Introduction to the Report

This report provides a summary of the evaluation approach, key findings, learning and recommendations from the final evaluation of Salford Together Adults Integrated Care Programme (ICP). This programme was funded by Greater Manchester (GM) Health and Social Care Partnership in October 2016, building on Salford's history of integrated care work. Anticipated programme impact included: improved patient and staff experience; improved patient outcomes; and improved efficiency of system resources. Twelve transformation ‘test of change’ or new models of care projects promoting partnership and integrated working, were implemented between 2017-2019, some in targeted neighbourhoods, others as city-wide initiatives. These focused on Salford’s priorities of integrated care: (1) Improving access to GP and community services; (2) Providing care closer to home; (3) Improving care pathways; and (4) Developing Neighbourhood teams.
2. Background: Salford Together – Adults Integrated Care Programme

Salford is an urban area situated within Greater Manchester, with a population of around 242,000, made up of five localities (with neighbourhood teams) for health and social care: Ordsall and Claremont (including Langworthy, Seedley and Weaste), Swinton, Broughton, Eccles and Irlam (including Cadishead) and Walkden and Little Hulton (including Boothstown and Worsely).

Figure 1: Map of Salford with five neighbourhood localities

Salford’s population aged over 50 years is expected to increase from 75,600 in 2014 to 97,100 in 2035 (Salford Together, 2020). Alongside this, there is expected to be a 2.5 times increase in people aged over 65 living with one or more long-term conditions by 2050. Approximately 21% of the Salford population currently have a long-term condition. Nearly three quarters of Salford people live in areas classed as deprived, when compared nationally. Health and wellbeing outcomes are generally worse than national averages in Salford. For example, life expectancy is lower than the average for England, with a difference of up to 14 years across the City.

Delivering effective integrated care has become a major priority for all health and social care systems across the country, but defining and achieving integrated care has proved challenging. A review paper noting 175 definitions of integrated care in common use illustrates this point (Gail & Armitage et al., 2009). The Nuffield Trust (2011) highlights important distinctions between ‘integration’ and ‘integrated care’, proposing that integrated care “… is an organising principle for care delivery with the aim of achieving improved patient care through better coordination of services provided. Integration is the combined set of methods, processes and models that seek to bring about this improved coordination of care.”

2.1 History and Context of Salford Together– Adults Integrated Care Programme (ICP)

In Salford, health and care organisations have been working together to deliver the Adults ICP, described as ‘an ambitious and ground-breaking programme’ of work to deliver new, integrated care models between 2016 and 2020. Integrated care in this context means health and social care services and professionals working seamlessly together, with services delivered locally where possible. It also means people’s experiences will feel better co-ordinated with more joint planning around their individual needs.
Salford’s Adults Integrated Care Programme is delivered by a partnership called ‘Salford Together.’ It originally comprised five key partners: Salford City Council, NHS Salford Clinical Commissioning Group (CCG), Salford Royal NHS Foundation Trust, Salford Primary Care Together, and Greater Manchester West NHS FT at that time (subsequently it became Greater Manchester Mental Health NHS Foundation Trust). However, in 2018/19 Salford Community and Voluntary services were added through a memorandum of understanding. The Integrated Care Programme contributes to delivery of Salford’s Locality Plan⁶ which describes partners’ shared system vision for improved health and wellbeing for people in Salford. This plan links the understanding of needs with a coordinated system-wide response.

The Salford system’s work on new models of integrated care started in 2014 when an Integrated Care Programme for Older People began. This established a jointly agreed plan between partners and brought together funding for health and social care (within a section 75 pooled budget). The focus of this Older Persons programme was:

- Better access to community assets to help people retain their independence
- An integrated health and social care contact centre to ensure people can access right care.
- Neighbourhood multi-disciplinary groups (MDGs), providing proactive care planning and case management for individuals most at risk of being admitted to hospital or needing higher levels of care.

In July 2016, Salford was one of the first areas of the country to establish its Integrated Care Organisation (ICO). The ICO brought over 2,000 health and social care staff together when adult social care staff moved from the council to Salford Royal. A timeline of key events leading up to Salford Together’s current Adults Integrated Care Programme and associated transformation projects are set out in Figure 2 below. The origins of this programme lie in an award of £18.2 million by Greater Manchester Health and Social Care Partnership to support the development of new models of care in Salford. As formation of the ICO preceded the Integrated Care Programme, it was not included within the scope of the current evaluation, although it is integral infrastructure to support programme delivery.⁷

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⁶ Locality Plan Vision: “Start, live and age well in Salford – Citizens will get the best start in life, will go on to have a fulfilling and productive adulthood, will be able to manage their health well into their older age and die in a dignified manner in a setting of their choosing. People across Salford will experience health on a parallel with the current “best” in Greater Manchester, and the gaps between communities will be narrower than they have ever been before.”

⁷ The ICO provided a vehicle and infrastructure to transformation and internal review reports were published at 100 days and at one year, which included workforce feedback.
Figure 2: Key Events in the evolution of Salford Together’s Adult Integrated Care Programme

A more detailed overview of significant events in Salford's journey towards their Adult’s Integrated Care Programme is provided in Table 2.

Table 2: Key Events in Salford's Integrated Care Approach

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<tr>
<th>Year</th>
<th>Event</th>
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<tr>
<td>April 2015</td>
<td>Salford becomes one of eight national Primary and Acute Care NHS England Vanguard to test new models of care.</td>
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<td>March 2016</td>
<td>Review of Older Persons Programme to inform next steps for Integrated Care.</td>
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<td>April 2016</td>
<td>The pooled budget was extended to adult services and a new Integrated Care plan for adults was developed.</td>
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<td>April 2016</td>
<td>New arrangements were put in place for Salford GPs and City Councilors to work alongside each other to meet formally to plan/monitor local services. An Advisory Board of Salford Together partners also formed to oversee integrated care transformation.</td>
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<tr>
<td>July 2016</td>
<td>More than 2,000 staff from Salford NHS organisations and Council were brought together to create one of the first Integrated Care Organisations (ICO) in England.</td>
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<td>Oct 2016</td>
<td>£18.2million transformation funding awarded to Salford by Greater Manchester Health and Social Care Partnership to support developing new models of care.</td>
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<td>2016</td>
<td>All city’s GP practices agreed to work more closely together in five neighbourhoods.</td>
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<td>2016</td>
<td>Salford Primary Care Together established; a Community Interest Company, responsible for driving collaboration among GP practices, known to be a component of integration.</td>
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<td>2017 - 2019</td>
<td>Implementation of a programme of projects to test new models of care with embedded evaluation (provided by Haelo and latterly AQuA)</td>
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<td>2019</td>
<td>The pooled budget was extended to create an Integrated Fund, which encompassed children’s and public health. Governance structures and commissioning architecture was revised to reflect the Integrated Fund developments.</td>
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2.2 Evidence and policy context for Integrated Care

Salford Together committed to driving improvements in outcomes within the context of both the NHS Long Term Plan (2019) and the responsibilities delegated to Greater Manchester (GM) as part of devolution. Both the NHS Long Term Plan and GM’s ‘Taking Charge Plan’
have integrated care at their core. The former plan includes ambitions for care closer to home, supported by multidisciplinary pro-active care, and the latter a focus on people and places rather than the different organisations that deliver services. There is evidence that co-location of a multi-professional team is a key enabler to a multidisciplinary approach (Behavioural insights, 2018). The Social Care Institute for Excellence’s (SCIE) scoping research in 2017 to develop integrated care standards reported that improved outcomes where professionals and practitioners from different sectors worked together around individuals’ needs (SCIE, 2017).

Whilst evidence for integrated care is evolving, improving individual experiences as a result of better co-ordinated care is known to be important to people taking part in local consultations. Salford has undertaken a number of engagement exercises to understand public views and affirm integration approaches. In 2016, at the start of the programme views about integration were gathered from 935 people by the CCGs engagement team. In 2017, the ‘Big Health and Care conversation’ engaged 4,200 people using a range of methods. A survey including 1,671 Salford people was reported to indicate an appetite for change (Salford Together, 2018):
- The vast majority of people (more than 90%) were reported to be receptive to the idea of change around more community/home based services
- Respondents reported to understand the strain on current services and need for change.
- People resonated with the idea of maximising their own or their dependents’ independence by taking more self-care responsibility
- Salford Together partners need to build and maintain trust with Salford people as transformation plans develop in the future
- Include consistency of future care for service uses/patients

2.3 Overview of Adults Integrated Care Programme: Individual Projects
Salford Together’s vision for adults’ integrated care is to deliver significant improvements in experience and outcomes by:
- Promoting prevention and independence
- Providing person-centred health and care services, delivering more care in communities
- Supporting staff through new models and integrated systems
- Using pooled resources more efficiently

The Adults Integrated Care Programme was set up in 2016/17 with these ambitions in mind, focused on the following four priority areas:

1. **Improving access to GP and Community Services**, so people can get the help and treatment they need when they need it.
2. **Providing more services that can help at home or in the community**, so people can receive care and support near to where they live.
3. **Improving care pathways**, so people get convenient and timely access to diagnostics and treatment for long-term conditions.
4. **Developing Neighbourhood teams**, which bring local health and social care professionals together to plan and provide joined up care.

Salford’s ICP programme was comprised of twelve individual transformation ‘test of change’ projects focused on delivering these priorities. These projects were implemented between August 2017 and January 2020. A detailed summary is provided in Table 3. It is worth noting the complexity of this programme of new models of care transformation projects, with specific and at times overlapping aims, theory of change and anticipated benefits and impact. Project logic models are provided in Appendix 3 and Salford Together Integrated Care Infographic in Appendix 4. Associated projects from the Neighbourhood Leadership Development are currently being implemented.

In addition to the Salford Together ICP funded projects, a number of inter-related partnership system- initiatives were implemented within the same time period (Appendix 2). Of particular relevance is the Population Health Programme of transformation (started in 2018/19) which included a focus on children and community assets. Also towards the end of the ICP a community mental health redesign programme commenced called ‘Living Well’. It is worth noting that this is not an exhaustive list and many additional innovation projects were completed using similar test and change approaches.

2.4 Governance, Leadership and Implementation: Adults Integrated Care Programme

A comprehensive Governance structure was agreed to oversee transformation through an Integrated Care Provider Board and an Adults Advisory Board (AAB). This included the following key features designed to enable and enhance implementation:

- **Implementation methodology** which encompassed programme/project management, Quality Improvement techniques and Rapid Cycle evaluations, supporting robust formative evaluation and associated actions. This was supported by business intelligence and analytics with agreement of population health metrics, and testing of a local risk stratification model.

- **Public and staff engagement** commenced with Salford’s Big Health and Care Conversation with engagement of over 4,200 people and staff to discuss and gather feedback to inform plans for improving Health and Care in Salford in 2017. Further engagement with people, carers and stakeholders was undertaken to redesign the offer of home care support, which was implemented in July 2018. Workshops have also been held with Voluntary Community and Social Enterprise Sector (VCSE) to gather sector views and develop working relationships. A Memorandum of Understanding with VCSE was agreed in 2018/19.

- **Leadership and Organisational Development** were supported through the appointment of a dedicated Organisational Development lead and used insights from McKinsey 7S framework to advance the readiness of staff for further integrated working. A bespoke, multi-day, induction programme was developed for all the staff.

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8 Adults Advisory Board is a forum where Salford partners (Salford CCG, SCC, SRFT, GMMH, SPCT, PCNs and CVS) will jointly recommend the overall strategic direction for the integration of adult health and care services in Salford. The Board is advisory to the Adults Commissioning Committee which holds commissioning decision making responsibility.
involved in the new services delivered within the Integrated Care Programme. Although this was not a specific project, it was considered to be a key enabler for the programme.

Table 3: Integrated Care Programme of Transformation 'test of change' projects (August 2017-January 2019)

<table>
<thead>
<tr>
<th>Project</th>
<th>Description/ Aim</th>
<th>Start date/ Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. MSK/ Back Pain Pathway</td>
<td>To implement an evidence-based pathway for management of back pain, including provision of specialist back pain clinics in community settings. <strong>Aim</strong>: To improve patient journey and reduce unwarranted urgent care activity/diagnostics.</td>
<td>Aug 2017 Completed</td>
</tr>
<tr>
<td>2. Enhanced Carers Service</td>
<td>To identify carers within acute setting who would benefit from an intensive six week package of support. <strong>Aim</strong>: To ensure efficient discharge, prevent readmission and enable carers to be linked into local support opportunities.</td>
<td>Aug 2017 Completed</td>
</tr>
<tr>
<td>3. GP Streaming in A&amp;E / Urgent Treatment Centre</td>
<td>To identify patients who do not require A&amp;E and stream to a co-located GP led primary care service. <strong>Aim</strong>: To relieve pressure on emergency department.</td>
<td>Sept 2017 Completed</td>
</tr>
<tr>
<td>4. Falls prevention pathway</td>
<td>To implement single point of entry for people identified at risk of falls, with streaming to appropriate falls intervention. Included enhanced prevention - support / education/ awareness raising in communities, delivered by partners from Salford Community Leisure and VCSE. <strong>Aim</strong>: To reduce directly standardised rate of falls admissions among over 65s to GM average.</td>
<td>Mar 2018 Completed</td>
</tr>
<tr>
<td>5. Housing Officer</td>
<td>To test housing officer support in a hospital setting as part of the Integrated Discharge Team. <strong>Aim</strong>: To help with timely and safe discharge from hospital.</td>
<td>Apr 2018 Completed</td>
</tr>
<tr>
<td>6. Advice &amp; Guidance (A&amp;G)</td>
<td>To pilot the A&amp;G function of Electronic Referral System (E-RS) in three high volume specialities. <strong>Aim</strong>: To develop simplified communication processes to improve quality of information transferred between clinicians and maximise value to patients.</td>
<td>Apr 2018 Completed</td>
</tr>
<tr>
<td>7. Salford Urgent Care Team (UCT)</td>
<td>To implement city wide MDT responding to urgent health and care needs in communities within 2 hours of referral providing up to 72 hours support before discharge or referral /signposting. <strong>Aim</strong>: To avoid A&amp;E conveyances and attendances and manage people where appropriate at home</td>
<td>May 2018 Completed</td>
</tr>
<tr>
<td>8. Enhanced Care Team (ECT)</td>
<td>To implement an Enhanced Community Service for higher risk patients (identified using new model of risk stratification). MDT provides tailored interventions for up to 12 weeks. <strong>Aim</strong>: To reduce A&amp;E attendances and admissions and pressure on primary care.</td>
<td>May 2018 Completed</td>
</tr>
<tr>
<td>9. Centre of Contact</td>
<td>To develop and strengthen the Centre of Contact through testing of a multidisciplinary triage team, team training programme, and line-management responsible for developing the service. <strong>Aim</strong>: To improve service user experience, and to reduce professional visits and ‘handoffs’ between services.</td>
<td>Jan 2019 Completed</td>
</tr>
<tr>
<td>10. Mental Health in Neighbourhoods</td>
<td>To review and update Severe Mental Illness (SMI) registers in GP practices and invite patients for physical health checks, where required. Also explored patient journeys of cohort of people referred and not accepted to CMHT to understand needs and how/if they are met. <strong>Aim</strong>: To increase physical health checks for those with an SMI</td>
<td>Jan 2019 Completed</td>
</tr>
<tr>
<td>11. Neighbour-</td>
<td>To develop Health and Care Leadership teams. <strong>Aim</strong>: To bring</td>
<td>Jan 2019</td>
</tr>
<tr>
<td>Project</td>
<td>Description/ Aim</td>
<td>Start date/ Completed</td>
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<tr>
<td>hood (NBH) Leadership</td>
<td>neighbourhood teams together to consider population health needs and support innovation/ integration/ service redesign to meet local needs. Includes harnessing community assets/ addressing unwarranted variation.</td>
<td>On-going</td>
</tr>
<tr>
<td>12. VCSE Voices Matter</td>
<td>An approach to ensure VCSE sector partners embedded within neighbourhood leadership and also integrated care developments.</td>
<td>Jan 2019</td>
</tr>
</tbody>
</table>

Jan 2019
3. Evaluation Context, Approach & Method

Haelo\(^9\) was originally commissioned (2017- March 2020) by Salford Together to undertake an independent evaluation of their Adults Integrated Care Programme (ICP). This included identifying the impact and outcomes of the individual work streams as well as the process of implementation, in order to develop a cycle of learning to inform future stages of implementation. Following review with Salford Together team in October 2019, AQuA proposed an approach which included both formative and summative evaluation of the programme and, where possible, would align to the key themes of the GM ‘Taking Charge’ Evaluation\(^10\) (Appendix 1). It has been noted that the ICP was midway through implementation when these themes were identified.

Embedded evaluation support from AQuA/Haelo has included development and co-production of comprehensive evaluation protocols, education and training of project managers and delivery of individual project evaluation reports. This approach was intended to:

- Continue to build internal capability and Quality improvement skills;
- Provide support to project teams in defining project goals; and
- Access to a central point of expertise for understanding the impact of the programme.

The evaluation teams in Haelo and AQuA have included a wide range of roles and specialisms, including the Evaluation Manager, Research Officers, Head of Innovation and Consultancy, Associate Director, Senior Improvement Advisor, Measurement and Analytics team.

3.1 Evaluation Approach

The evaluation approach has focused on providing the following two components:

1. **Formative Evaluation:** the on-going theory-based evaluation of twelve transformation projects and the feedback of learning back into the development of the projects and overarching programme (Figure 2).
   - The main methodology used for this element is Rapid Cycle Evaluation (RCE) designed specifically for improvement projects (Parry et al, 2013). This involves regular, structured ‘milestone’ and RCE meetings between the evaluation manager, key individuals from the services, data analysts and the Programme Management Team to review emergent data and knowledge and facilitate rapid implementation.\(^11\).

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\(^9\) Haelo was an innovation and improvement centre which hosted improvement experts, clinicians, improvement fellows and researchers.

\(^10\) This evaluation centres on the Adults Integrated Care Programme and its multiple transformation projects. While there is some overlap with GM ‘Taking Charge’ evaluation, there is not exact alignment with GM’s focus on Local Care Approach. Salford’s local care approach is still evolving, with work on-going in 2020/21.

\(^11\) Detail regarding the data collected and learning from these meetings is available from AQuA and the ICP team upon request.
AQuA have focused on delivering and co-producing a clear and consistent approach to work stream evaluations, and provided a range of support to project managers and teams to develop and conduct evaluations, write final reports, access expertise in data analysis and statistical methods, and additional survey and qualitative data collection and analyses.

Figure 3: Rapid Cycle Evaluation Approach

**Summative Evaluation:** a retrospective, reflective evaluation of the programme once its activity has been completed. Three principal evaluation questions are addressed within this report:

1. To what extent the intended outcomes of the programme have been achieved?
2. To what extent mechanisms for improvement were an effective means of achieving them?
3. What key learning could be transferred to other programmes or environments?

As part of AQuA’s quality assurance process, a panel of academic experts was also set up to undertake an independent peer review of the evaluation protocol, delivery plan and final evaluation report. Where appropriate or possible it was also agreed that this report will align to the themes set out in the GM ‘Taking Charge’ evaluation specification (Appendix 1).

### 3.2 Programme Evaluation Methods and Activity

**Quantitative Data:** AQuA has collated quantitative data across projects and provided commentary and analysis. Details on project level data collection are included in individual project evaluation reports. The evaluation scope included key indicators from the Salford Integrated Care Programme (Transformation) set out in the GM Investment Agreement.

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12 This was an important feature as AQuA were also providing Leadership Development for the Neighbourhood teams and supporting strategic communications.
13 It should be noted that some inconsistencies in reporting and gaps were identified such as some outcome measures, response rates and stakeholder follow-ups.
The programme identified A&E attendances and non-elective admissions (NEL) as indicators to measure the potential impact of the individual ICP Transformation projects. The expectation was that the programme would deliver reductions in attendances and admissions; this presents two significant challenges in measuring impact. Firstly, what is the baseline that you are measuring reductions against? The numbers of A&E attendances and NELs have been increasing as the population ages, are the interventions focused on the whole of the population, or specific subsets? Secondly, if you are looking at a number of projects focused on reducing hospital activity, how do you know which interventions have been successful? These issues are common to interventions focused on reducing emergency activity in a hospital setting and can limit causal interpretation. It is therefore important to consider these outcome measures alongside project process measures and qualitative feedback on the impact and effectiveness of interventions. Some of the projects designed to reduce hospital activity also involved interventions with small numbers of patients making impact evaluation difficult.

Qualitative data: AQuA has collated qualitative data from multiple sources. Key themes from qualitative data gathered as part of the formative project evaluations have been identified, including learning captured from the Rapid Cycle Evaluation) and milestone meeting October 2019.

Stakeholder insights from interviews with senior leaders from Salford Together about their views and experiences of the Integrated Care Programme have also been collated. SQW, an independent consultancy, was commissioned by AQuA to undertake these interviews (November 2019 to March 2020) to inform AQuA's evaluation of Salford Together. This involved 15 in-depth interviews (approx. 1 hour) undertaken with a range of senior leaders from each of the Salford Together partners, with a range of experience about the ICP (Appendix 5 – Interview Schedule). Qualitative analyses involved initial review of the transcripts and de-brief involving SQW’s three interviewers. Transcripts were coded based on the Greater Manchester Transformation Fund evaluation themes with additional codes added as required. Analysis was conducted on the basis of the codes, the roles and organisations of interviewees, and lexical searches of the transcripts (using MAXQDA software).

A ‘sense check’ meeting was held with the Salford Together programme manager and team (May 2020) to review draft findings and learning from the final evaluation report. AQuA's independent Evaluation Panel are have also been commissioned (May 2020) to undertake a review and provide advice on the final evaluation report.

Salford Together commissioned Healthwatch to independently undertake the collection of qualitative information in the form of case studies for 6 of the 12 ICP projects. These are available here: https://www.salfordtogether.com/category/casestudies/

The CCG engagement team also regularly independently collected case studies for the Enhanced Care Team project.
4. Evaluation Findings

Evaluation findings address the three primary evaluation questions.

**Question 1: Intended outcomes of Integrated Care projects and overall programme achieved?**
The evaluation sought to understand the extent to which the intended outcomes of the Integrated Care projects and overall programme were achieved. Twelve individual transformation projects were implemented between 2017 and 2020 as part of Salford Together’s Integrated Care Programme.

**Project Level Outcomes and Impact**

A detailed summary of individual project aims, outcomes and learning captured by the project teams in their final evaluation reports is provided in Table 4. A range of positive outcomes were reported by individual projects relating to the three key aims of the ICP programme:

1. **Better use of System Resources:**
   - Four of the transformation projects (Back Pain, Enhanced Carer Support, Falls Prevention, and the Enhanced Care Team) reported delivering a reduction in A&E attendances
   - Two of the projects (Enhanced Carer support and Enhanced Care Team) reported delivering a reduction in non-elective admissions (NELs)
   - The Urgent Care Treatment Centre reported that A&E attendances and Non elective (NEL) admission rates remained static during the course of the project; the project team highlighted that this was set within the context of rising rates across England.
   - The Back Pain project reported a reduction in secondary care referrals (although lower than target). No growth in requests for MR scans was also reported set against a national trend of increasing use.

2. **Improved Patient Outcomes:**
   - Several projects including Enhanced Care Team and the Enhanced Carer Support project reported improvements in patient outcomes and quality of life measures.
   - The Urgent Care Team reported achieving their aim of settling patients at home without having to attend A&E in 76% of caseload.

3. **Improved Patient and Staff Experience:**
   - The Back Pain project reported high levels of patient satisfaction for the back pain triage clinic including venue, clinicians and management offered. There was also an increase in self-reported expertise of physiotherapy staff in treating back pain patients.
   - The Enhanced Care Team highlighted the multi-disciplinary approach as one of the key success factors of the service.
The VCSE Voices Matter\textsuperscript{14} project team reported a number of positive outcomes to the Adults Advisory Board (AAB) on the Salford Together Transformation programme of work, including providing positive contributions and challenge to the partners, being a conduit for effectively engaging with communities, and sharing of local insights and intelligence.

Given the limitations associated with measuring impact through avoided attendances and admissions discussed above, the formative evaluation also assessed the extent to which projects were delivered as intended. The Adults Integrated Care Programme was an ambitious and complex programme, implementing and testing new and innovative models of care, aimed at large scale change, involving a range of different multi-disciplinary teams, patient groups and settings, in a limited amount of time. Qualitative data from Rapid Cycle Evaluation and milestone meetings combined with insights from senior leader interviews highlighted the enablers and challenges experienced by individual project teams. For example, lower than anticipated referrals or uptake of new services\textsuperscript{15} affected the potential scale and impact of subsequent outcomes from these projects.

Many of these projects were testing new models of care and were therefore still in development; some were only implemented in selected neighbourhoods (e.g. Enhanced Care Team). The VCSE Voices matter project was focused on ensuring there was VCSE representation on decision-making bodies within the Salford Together partnership and neighbourhood teams. The local care approach is still evolving, with work on-going in 2020/21.

\textsuperscript{14} A Memorandum of Understanding (MoU) was developed between the Voluntary, Community and Social Enterprise (VCSE) Sector in Salford and the partner organisations in Salford Together, which was formally adopted in 2018 and runs until 2021. This gives the VCSE sector an equitable role in Salford Together as a key strategic partner in activities to achieve the outcomes described in the current and future Salford Locality Plan.

\textsuperscript{15} Enhanced Carer Support project, the Enhanced Care Team, the Urgent Care Team, the Falls Prevention pathway (low intensity intervention).
Table 4: Salford Together - Adults Integrated Care Programme: Summary of individual project outcomes, impact and reported learning

<table>
<thead>
<tr>
<th>ICP Project</th>
<th>Aim(s)</th>
<th>Outcomes/Impact</th>
<th>Learning</th>
<th>Integrated Care Priority</th>
</tr>
</thead>
</table>
| 1. MSK/ Back Pain Pathway     | To implement a pathway redesign for low back and radicular pain to meet national best practice guidelines. Target 10% reduction in A&E attendances, non-elective admissions & OP follow up, 20% reduction in diagnostics (MRI scans) | System Resources:  
  - Reduction in ED attendances of 22.7%. Unable to attribute to MSK pathway redesign as confounded by concurrent GP streaming intervention.  
  - Reduction of 4% in secondary care referrals from Salford CCG to Spinal OP.  
  - No change in ED conversions to admission–conversion rate.  
  - SRFT MRI requests remained static.  
  - Project became business as usual as change in delivery at no extra cost.  
Patients/ Staff:  
  - Increase in self-reported expertise of physiotherapy staff treating back pain patients.  
  - High levels of patient satisfaction of venue, clinicians and management offered during a back pain triage clinic appointment. | Need to test data capture and quality prior to starting  
  - Need to create single entry point rather than several points to different pathways.  
  - Need fully costed communications and engagement strategy.  
  - Need budgeted marketing strategy to ensure correct referrals from outset.  
  - Challenges securing accommodation for service due to pressure on estates.  
  - This project became business as usual. | Pathways of Care |

| 2. Enhanced Carer Support     | To identify carers who need support at a time of crisis and will benefit from intensive 6-week support package to ensure efficient discharge of cared for, preventing readmission and enable carers to be | Project Delivery:  
  - Target met with 275 Carers identified.  
  - 73% were newly identified Carers. 58% were eligible for the service. 80% of eligible carers commenced Enhanced Carer Support package.  
  - System Resources:  
   - Reductions in A&E attendances and NEL | Need more time for launch, training, marketing.  
  - Communications and engagement time needs to be considered.  
  - Challenge of embedding carer’s services in health care setting where staff mainly patient-focused and may not | Pathways of Care |
# ICP Project

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<tr>
<th>Aim(s)</th>
<th>Outcomes/Impact</th>
<th>Learning</th>
<th>Integrated Care Priority</th>
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<tbody>
<tr>
<td>linked.</td>
<td>admissions reported in the 3 months post intervention, however, small numbers preclude attribution. Small numbers and lack of a comparator group, also precludes detailed cost-benefit analysis. <strong>Carers and Staff:</strong> • 98% of carers taking part in a survey (n=43) reported satisfied/very satisfied with support provided by the EC support team. 93% reported positive impact on their life. The career STAR outcome tool also showed positive impact in a number of domains.</td>
<td>always see the value of carer support or that this is part of their service model. • Practical challenges with lack of accommodation to work at hospital. • Data collection challenges, complexity and evolving data capture.</td>
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| 3. GP Streaming in A&E / Urgent Treatment Centre | To reduce attendances at A&E, and reduce waiting times within EDs | **System Resources:** • Approximately 25-30 patients were seen daily by the service GP, supporting ED access targets • Reduction in investigations requested, but admission rates not significantly reduced. • Pilot assessed as not cost-effective. Service remodeled and reduced primary care offer in A&E continued. Second phase still under evaluation. | **Learning included estates and signage to support implementation and streaming function** | Pathways of Care/Urgent Care |

<p>| 4. Falls prevention pathway | To implement a single point of entry and assessment process for people identified as ‘at risk’ of falls, with streaming to appropriate level of falls intervention – high or low intensity. | <strong>Project Delivery:</strong> • Single point of access established. Falls prevention communication and engagement completed, including volunteer champions to promote and support falls prevention. <strong>326</strong> total referrals to Postural Stability (low intensity) between April 2018 and March | <strong>Lower referrals to Postural Stability (low intensity) than expected</strong>: Multiple reasons including change in GP’s direct referral to Salford Community Leisure Waiting list at triage <strong>Variation in uptake/</strong> | Pathways of Care |</p>
<table>
<thead>
<tr>
<th>ICP Project</th>
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</table>
|             | Also includes community involvement and care homes. To reduce the directly standardised rate of falls admissions among over 65s to the GM average. | 2019 (12 months) mean of 27 per month. 10 courses had completed and the average completion rate was 61% at time of reporting.  
• **3669** total referrals to Community Rehabilitation (high intensity) between April 2018 and March 2019 (12 months); a mean of 305 per month. 75 – 80% of referrals are suitable for therapy and go on to receive the Otago programme.  
• Referrals to Community Rehabilitation with pharmacist led medicines review and multi-factorial interventions (High Intensity) exceeded planned increase by 29% and although positive, had not been costed.  
• Low intensity referrals (postural stability) did not increase as expected.  
• 200 community volunteers engaged and trained in 6 key messages of falls prevention. **System Resources:**  
• Rate of hospital admissions due to falls injuries reduced by 9.7% from previous year and 4% reduction in the rate of fracture neck of femur admissions.  
• GM average reported to be static with Salford improving by 10%. The rate of falls related admissions reduced per 100,000 of the population in Salford from 3289 in 2015/16 to 2898 in 2018/19. **Patients and Staff:**  
• completion rates not factored into targets,  
• Unplanned increase (29%) on Community Rehab Referrals (high intensity). Appropriate referrals, but not costed, team capacity for triage and delivery compromised, waiting list impacted, staff recruitment/retention issues. 24 hour triage target not met.  
• Testing new roles  
• Frailty: New GM approach  
• Neighbourhood Teams: Need to cross-reference referrals to and from ECT. |
<table>
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<tr>
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</table>
|             |        | **Community Rehabilitation** - Reported improvements in Tinetti score and Timed Up and GO scores for majority of patients (numbers not reported). Vast majority of patients self-report positively on mobility and benefit from the programme.  
**Postural Stability** – High rates of satisfaction reported and improvements in test scores pre and post programme (numbers not reported). |          |                         |
| 5. Housing Support in Hospital | To implement a single point of contact and specialist knowledge for any housing advice and resettlement support at SRFT and to reduce the amount of time patients are delayed from being discharged as a result of housing issues, prevent re-admissions, improve patient experience. | **Project Delivery:**  
- 279 referrals with three people referred three times and 16 people referred twice.  
- 215 people were in scope.  
**System Resources:**  
- 129 referrals identified that may have waited up to three days for an assessment- estimated 387 bed days saved.  
Reported less variation in the number of days delayed discharge. One repeat re-admission reported by project team.  
**Patients and Staff:**  
- Staff survey respondents (n=7) reported change in the speed/efficiency of discharge for those affected.  
- Healthwatch collected two patient case studies, recall issues reported. | **A number of barriers to discharge and potential risks to effectiveness of approach identified.** | Extended Care |
| 6. Advice & Guidance (A&G) | To pilot and evaluate the use of an A&G system between primary and secondary care: | **Project Delivery:**  
- Utilisation of A&G services has been significantly lower than anticipated across all specialties providing the service during  
**If electronic record system (eRS) selected for A&G, limited capacity within support teams - delay to rolling out** |          | Extended Care |
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<tr>
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|             | To reduce the number of first outpatient appointments (OPFA) by 2376 and follow up outpatient appointments (OPFU) by 3168 per year (full year implementation effect) across three pilot specialties: cardiology, respiratory and gastroenterology. | the pilot phase. **System Resources:**  
- The limited impact of A&G on referrals and outpatient appointments can be attributed to a number of factors: the delay in bringing target specialties “live” on Electronic Record System (eRS), an initial assumption in the PID that all outpatient referrals would initially be required to go via an eRS service prior to a referral and lower than anticipated uptake from primary care. | A&G across specialties/ Trust  
- Need more innovative payment systems to reward quality of care, rather than specialties financial reward by volume of appointments provided.  
- The provision of A&G is viewed as “extra” work, this is more so in secondary care than primary care, although it is a factor in both settings. |  

| 7. Salford Urgent Care Team (UCT) (12 months evaluation – 18 month project) | To intercept potential conveyances to A&E and manage people where appropriate at home (originally 5 day service, extended to 7 day from Nov 2018). Up to 72 hour intervention. | **Project Delivery:**  
- NWAS remains the biggest referrer to the service accounting for 67% (1,228) of the total 1,822 referrals received between May 2018 and April 2019.  
- Lower than anticipated referrals, particularly from GPs.  
**System Resources:**  
- SRFT A&E attendances and NEL admissions remained static. ED attendances increased across England in same time period; therefore no increase is potentially positive finding.  
- 1188 patients (76%) seen on the UCT caseload did not have a subsequent A&E attendance within 72 hours – deflecting A&E attendances in the majority of cases, enabling people to be treated in their own home and avoiding trip or stay in hospital. | Referrals lower than predicted  
- Staffing e.g. clarity of role and expectations, skill mix, no MDT huddles happening (Nov 18)  
- IT challenges  
- Communication, governance and reporting structures | Extended Care |
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|             |        | Also releasing ambulance crews back into Salford. **Patients and Staff:**  
  • Small number of surveys collected by Healthwatch (number not specified) indicating positive aspects but patients may not be fully aware of what to expect from service. Healthwatch’s independent collection of patient experience through four case studies echoed uncertainty in patient expectation of service  
  • Online Staff survey (n=44) across, Urgent care, Rapid Response and Homesafe Teams. Despite issues with recruitment and integration across the three teams, feedback indicates that generally staff feel supported in their roles and are able to effectively manage their clinical caseloads.  
  • Reported that Urgent Care Team have deflected c2500 A&E attendances per year |          |              |
| 8. Enhanced Care Team (ECT) 3 neighbourhoods Eccles & Irlam (Aug 2018) Swinton (Apr 2018) Walkden | To test a new Multidisciplinary services and the people targeted were not those at the most high risk of admission i.e. intended to be preventative | Project Delivery:  
  • Delivered range of multi-disciplinary support to patients over 12 months  
  • Targets for patient uptake not met, only 50% of referrals suitable for intervention (75% uptake target may have been unrealistic).  
  • 636 referrals made over 12 months.  
  • Challenges in maximizing service offer in | Risk Stratification tool: reported not suitable for identifying patients for the service at launch, improvements made but benefits not realised for 9 months.  
  • Post project reflections noted that A&E and NEL may not be | Neighbourhoods |
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<tbody>
<tr>
<td>Little Hulton (May 2019)</td>
<td></td>
<td>three neighbourhoods: problems with initial risk stratification tool, lower than expected GP referrals, information governance concerns prevented some practices signing up. IT challenges (Vision), referrals from all sources lower than expected.</td>
<td>the best measure of success for this type of intervention as large number of patients did not have high levels of pre-acute activity.</td>
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<td>• Of 636 referrals, 324 (51%) had subsequently been accepted onto the caseload.</td>
<td>• Lacked appropriate levels of referrals, struggled to gain momentum and lack of clarity about patient targeting.</td>
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<td>• Service struggled initially to recruit staff to all posts within the team and there has been a significant increase in staff turnover since February 2019 due to uncertainties around the future delivery of the service.</td>
<td>• Role clarification and specifications that better reflect responsibilities needed - not clearly defined.</td>
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<td></td>
<td><strong>System Resources:</strong></td>
<td><strong>IM &amp; T issues (in particular Vision) impacted on productivity/wider roll out.</strong></td>
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<td>• Of 133 patients discharged for 3 months, there was a 38% (-23) reduction in A&amp;E attendances and a 26% (-9) in NEL admissions. NB relatively small proportion (n =37) of patients in this cohort had any NEL activity in three months prior to joining the caseload, Reductions mean that the initial targets set for the reduction in NEL activity in the PID have been met although it should be noted that this is within the context of a lower number of referrals.</td>
<td>• Staff feedback - lack of clarity and leadership of the service.</td>
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<td>• For 81 patients in the 6 month cohort reduction in A&amp;E attendances of 35% (-33) and in NEL admissions of 37% (-24).</td>
<td>• Aims of the service may not have been clearly communicated or understood by all stakeholders- e.g. GP referral criteria.</td>
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<td>• GP audit indicates service reduces pressure from primary care whilst patients are on the caseload, but GP consultations start to rise again post discharge.</td>
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<td>• Families expressed concern about the removal of ECT support after 12 week period.</td>
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<td>Just over half of these patients had NEL activity prior to joining the ECT caseload (54%, 44).</td>
<td>• Service user engagement needed to explain ECT to optimize uptake.</td>
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<td>• Reductions indicate positive outcomes for patients who have received ECT service, but limitations to analysis as unable to attribute causality to the ECT intervention.</td>
<td>• Multi-disciplinary approach has been highlighted as one of the key success factors of the ECT service.</td>
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<td>• Patients and Staff:</td>
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<td></td>
<td>• N =150 pre-post patient experience surveys undertaken (46% of accepted patients). N=133 QoL measures collected</td>
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<td>• Reported significant gains in patient’s perceptions of how informed they felt about their medicines and their care and how supported they felt to manage their own conditions.</td>
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<td>• An improvement in overall scores for patient reported quality of life (using AQuA developed tool) was reported. The difference seen in the overall QoL score is statistically significant.</td>
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<td>• The biggest improvements were seen for ‘my ability to do my usual activities’ and ‘how I feel about myself and my ability to cope’.</td>
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<td>• Development and testing of appropriate QoL tool was a significant output from project.</td>
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<td>• Additional patient experience in the form of five case studies was collected by Salford CCG. Online staff survey (number unspecified) of all staff working within the</td>
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<td>service, 84% agreed that they had built trust and good relationships with other colleagues in team. 75% reported pharmacy role had added value to their practice. Benefits for patients noted.  • Although generally scores were positive in terms of how staff had worked together, one of the lower scoring areas was around clarity of roles  • lack of role clarity was also a recurring theme at the RCE meetings, with a number of staff commenting that the service could have benefited from clearer guidance on role remits and that in some cases this had resulted in an inconsistency of interventions with patients across the team</td>
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<td>9. Centre of Contact</td>
<td>To train call handlers to respond to social care and district nursing enquiries,  To develop MDT triaging for these service  To increase the number of calls dealt with at first contact</td>
<td><strong>System Resources:</strong>  • Centre of Contact dealt with 67% of all district nursing calls handled: 59% screening officers; 8% by nursing coordinators in last 12 months (numbers not reported).  • Call handling reported to have improved – call wait time reduced from 1min 14 seconds to 42 seconds in last 12 months  <strong>Project Delivery:</strong>  • Two band 6 nurses and three temporary screening officers were recruited  • Training programme for screening officers</td>
<td>• MDT working requires dedicated time and space, for staff to build relationships  • Internal referrals are a heavy bureaucratic burden.  • Further, detailed mapping of centre of contact activity is required in order to understand the impact that new models could have on other parts of the health and social care system.</td>
<td>Extended Care</td>
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| 10. Mental Health in Neighbourhoods Locality wide | To deliver high quality mental health care within an integrated Neighbourhood model, in line with National Guidance to increase physical healthcare for those with an SMI | Project Delivery:  
- Successfully engaged with 18 GP Practices. Over time 4 of 18 practices have disengaged.  
- 18 SMI registers have been reviewed with a total of 1,144 clinical cases cross referenced and discussed.  
System Resources:  
- Identified 836 were appropriate for the annual health check. 308 were not appropriate.  
- Everyone in Swinton/Little Hulton area who had face to face contact with the mental health lead offered and engaged in the health conversations if appropriate.  
- 53 people engaged in an intervention and remain engaged.  
Patients and Staff:  
- Online survey (numbers not reported) of partners reported benefits such as improved understanding of mental health, | Culture in primary care and working practices leading to delays/missed opportunities  
- IT challenges (Vision reported not fit for purpose)  
- Coding quality and challenges  
- Time for engagement of individual practices. Email not effective – time implications  
- Data challenges and complexity  
- Staffing issues/ workload  
- Gaps and duplication: lack of clarity about responsibility for physical health care provision across primary/secondary  
- Lack of local policy for CMHTS  
- Training needs on MH training and confidence in delivering physical health care to people | Neighbourhoods |
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<td>relationships and access to advice and guidance relating to mental health queries.</td>
<td>with SMI</td>
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<td>• Another reported benefit of partnership working was the ability to share information such as missing data within Primary Care, informing practice and reducing duplication.</td>
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<td>11. Neighbourhood (NBH) Leadership Locality wide</td>
<td>To develop and enable integrated neighbourhood health and social care leadership and delivery teams to improve local health outcomes and experiences.</td>
<td>• Core neighbourhood staff meeting monthly and developed project around their identified local priority. These include social isolation, social networks, and high intensity users of community services.</td>
<td>AQuA delivery team reported perceived change from first Salford wide events (April 19) led by AQuA and Salford team, by October 19 neighbourhood leadership teams had own slot.</td>
<td>Neighbourhoods</td>
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<td>• New relationships formed and work to jointly understand neighbourhood needs to arrive at agreed priority to work to improve as a team.</td>
<td>Early AQuA insights note barriers: consistency and capacity of leadership team, with some covering more than one neighbourhood.</td>
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<td>• VCSE sector partners embedded within neighbourhood leadership and integrated care developments.</td>
<td>Early AQuA insights identified enablers: agreed date/ time for each neighbourhood, some central support via PM for admin, agreeing purpose and improvement projects. Creating support which worked at Salford and neighbourhood level helped learning/ sharing.</td>
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<td>• AQuA delivering a programme of leadership training and support due to complete 2020.</td>
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<td>• Delivered through a series of Salford wide learning events and attending each neighbourhood meeting.</td>
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<td>• Not possible to run neighbourhood meeting as action learning sets due to teams requiring prior development.</td>
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<td>• Incomplete baseline data from the System leadership questionnaire precludes – pre-post comparison.</td>
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| 12. VCSE Voices Matter     | Locality wide                                                          | To support Salford’s voluntary, community and social enterprise sector to be key contributors in Salford Together Integrated Care Programme with the explicit ambition of ensuring VCSE representation on strategic decision-making bodies, steering groups, and boards within the partnership. | • Salford CVS became core member in 2018.  
  • Salford CVS and VCSE ‘VOCAL’ representation at AAB reported to have enabled positive contributions/challenge to development of transformation work of Salford Together.  
  • CVS reported to have central role in rapidly evolving Integrated Health and Social Care Neighbourhood work.  
  • VCSE Voices Matter reported to be one of main conduits for effective community engagement for Salford Together.  
  • The VCSE Voices Matter work reported to have facilitated sharing of local knowledge/insights with Salford Together partners. | Neighbourhoods |
**Integrated Care Programme Level Outcomes and Impact**

As outlined above, it is difficult, at a programme level, to attribute changes in activity metrics to the impact of specific projects against a backdrop of rising demand and other interventions focused on reducing similar activity. In addition, some of the transformation projects were smaller tests of change in specific neighbourhoods and are unlikely to have impacted at programme level. The formative and summative evaluation approach provides useful insights to understand the potential contribution of individual project interventions to programme aspirations.

At a system level, the delivery and assurance of the Salford Integrated Care Programme (Transformation) is measured against ten agreed outcome indicators set out in the GM Investment Agreement. Project measures were aligned to these pre-set measures. This report reviews two outcome indicators, non-elective admissions (NEL) and A&E attendances which relate to project level activity. Latest forecasts reported at the February 2020 Adults Advisory Board, using data from Service Level Agreement Monitoring (SLAM) indicates that programme targets for NEL will be met by the end of 2019/20; however targets for A&E admissions are not likely to be met. Further details are provided below. It is important to note, that these projections are set within the context of a large increase in the registered population in Salford (Harding, 2020). Projected figures for a ‘do nothing’ scenario also provides a useful indicator of underlying demand.

- **Non-elective admissions (NEL):** The ICP programme’s target is to not exceed 38,117 NEL admissions, equivalent to 3.8% (+1,439) change in emergency admissions (all ages) from the 2015-16 baseline and to contain future growth.
  - Latest forecasts available at the time of reporting (November 2019) suggested NEL will be -3.9% (-1,493) below plan, with average admission rate at its lowest since GMIA monitoring started (35.2 per day per 100,000 population in Nov 2019).
  - When NEL activity is considered against the registered population increase (14,607); early indications suggest a decrease of -1.1% compared to 2018/19.
  - It is also reported that the forecast shows a reduction of 2,357 NEL in 19/20 when compared with a projected ‘do nothing’ scenario.

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16 Routine monitoring of the indicators is in place and is reported to the Integrated Care Advisory Board each month. Additional analysis has now been included to show the split of acute activity by pooled / non-pooled specialties.

17 Latest GM investment agreement data made available to evaluation team in July 2020 (using SLAM data) reports NEL admissions -4.8% below plan and A&E Attendances -2.2% below plan based on 12 month rolling position at Mar-20. The impact of COVID19 was reported to have resulted in March 2020 having lowest admissions since 2017 and lowest A&E attendances recorded.
- **A&E attendances**: The trend shows that A&E attendances are rising; if this continues then the number will be above the programme plan target by the end of 2019-20.
  - The reported forecast predicted that A&E attendances will be 0.1% (+101) above plan, with average attendance rate at 109.5 per day.
  - However, when activity is considered against the population increase, a decline of 0.7% from the baseline year is reported.
  - It is worth noting the programme plan targets changed in 17/18 as baseline did, because the forecast showed a higher number of attendances than anticipated.
The AQuA team independently analysed NEL attendances (April 2011- Jan 2020) and A&E attendances (April 2017- Oct 2019) using HES data and found no discernible difference in trends for Salford compared with GM or England.

The AQuA team compared A&E attendances for Salford CCG residents with those of fifteen Clinical Commissioning Group (CCG) boroughs in England, identified as suitable comparators with Salford. Hospital Episode Statistics (HES) data was only available for the full years of 2017/18 and 2018/19. Analysis indicated reductions in A&E attendances for both Salford and for the other CCG group as a whole; but the reduction in Salford was at a greater rate. Had Salford had the same rate as the overall CCG peer group then there would have been just under 3,400 more attendances in the year. If we assume the average cost for these attendances is £148 then this equates to financial savings of approx. £0.5m. This provides some validation of results reported by project leads for the programme team, but is a high level observation which doesn’t prove direct causation.

AQuA’s interviews with fifteen senior leaders across Salford Together highlighted the positive impact on health and wellbeing for the local population. Perceptions varied on the scale, sustainability and timing of the impact. The impact reported at a project level did not translate to perceived demonstrable impact at a system level. There was cautious optimism that impact might be achieved over a longer timeframe. There was a sense that expectations need to be carefully managed regarding what is realistic and achievable within Transformation Fund and evaluation timescales. This is discussed further in the section on learning.

Question 2: Mechanisms for Improvement as effective means to achieve outcomes?
Formative evaluation support from Haelo and AQuA enabled project teams to develop logic models and driver diagrams to identify appropriate indicators and test assumptions (Appendix 3). This is an important aspect of this evaluation approach as it explored not just the outcomes (the ‘what’ worked) but the process (‘how’ it worked) and the mechanisms for success (the ‘why’ it worked).

Understanding the context that projects were operating within is crucial. The adoption of the IHI ‘Measurement for improvement’ approach, supported by the AQuA/Haelo team, was designed to enable the ICP programme team to build internal capability and observe any change in key metrics over time. The approach was intended to help project teams to assess
the impact of their intervention and to make more informed and timely decisions about future direction and sustainability.

Milestone meetings and Rapid Cycle Evaluation (RCE) meetings provided opportunities for programme stakeholders to review emergent findings and act to revise the proposed theory of change based on the causal links between inputs, activities and benefits and impact. Salford Together stakeholders identified a number of key themes in relation to ‘enablers’ of change within their facilitated Milestone Meeting (October 2019 - Appendix 6) including:

- Leadership (clear vision)
- Strong existing relationships (trust/commitment/communication)
- Funding
- Thinking and doing things differently
- Timing/environment
- On-going evaluation - iterative learning

A comparison of barriers to change identified by Salford Together Partners at the Milestone Meeting in October 2019 and those reported by the project teams in RCE meetings over time (Appendix 7) highlights areas of overlap, such as challenges of IT systems and data sharing and quality, staff recruitment and retention, communication and engagement. These barriers are summarised in Table 5 and mapped where possible to GM Evaluation Themes set out in Appendix 1.

### Table 5: Perceived barriers to change – RCE and Milestone Meetings – Mapped to GM Themes

<table>
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<tr>
<th>GM Themes</th>
<th>Salford Together Partners Milestone Meeting (Oct 2019) Reported Barriers</th>
<th>Project Teams Rapid Cycle Evaluation Meetings Reported Barriers</th>
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<tr>
<td>Structures, Governance and Accountability:</td>
<td>- VSCE engagement later than should be - IT systems and data sharing challenges - IM&amp;T systems unable to work together. - NCA creation - Data – not sure one version of the truth - Risk appetite - Changing environments national/regional - Realistic outcomes - contextual factors that would affect change - Lack of clarity about measurement - External pressures of dealing with the 'here and now’ e.g. A&amp;E pressure and also doing transformation, difficult to maintain spinning plates</td>
<td>- Several projects identified varying levels of uncertainty about governance, leadership and reporting structures. - Lack of clarity reported over new roles and responsibilities, service aims and new ways of working together, including gaps and duplication (e.g. ECT, Mental Health).</td>
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<td>GM Themes</td>
<td>Salford Together Partners Milestone Meeting (Oct 2019) Reported Barriers</td>
<td>Project Teams Rapid Cycle Evaluation Meetings Reported Barriers</td>
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| **Leadership/ Relationships/ Workforce:** | • Stakeholder engagement (GPs, and VCSE later than should have been)  
• Engagement/leadership of GPs  
• Culture/ individual behaviours  
• Turnover of staff and leadership  
• Estate – difficult to collocate  
• Workforce – availability/shortages of key staff groups, time to recruit  
• Individual behaviour change  
• System so big so it's hard to engage on a new session and ideas – hard to maintain communications  
• Co-creation, still some silo working | • Need for early engagement and communication with key stakeholders around governance, service aims and clear job role specifications.  
• Recruitment and retention issues were a feature of several projects.  
• Difficulty recruiting staff and high turnover in some roles led to delays and capacity issues (e.g. Urgent Care Team, Centre of Contact, Falls Prevention)  
• Communication and Engagement: Need fully costed strategy at outset to ensure sufficient buy-in and shared understanding about project aims and roles. Particularly in relation to lower than anticipated referral rates, GP engagement, and service users understanding of what to expect from new services. (e.g. Back Pain, Urgent Care Team, Enhanced Care Team, Mental Health)  
• Estates challenges: Several projects noted limited estates and accommodation available to enable co-location of teams and effective working (e.g. Enhanced Carer Support, Back Pain, and Centre of Contact). |
| **System Impact:** | • Started to make an impact in pockets but a way to go, *not scale*  
• Big conversation – some degree of engagement but not co-production  
• Tested new models of care – to varying degrees of success  
• Some integration at periphery of 'care' services while still feel a bit separate  
• Some increase in community assets but less clear if seeing right people - earlier prevention  
• Good integrated working at strategic level but less clear at a patient/service user /front line service level  
• Social care integration | • Demand/ forecasting impact: Many of transformation projects were innovation and/or testing new ways of working. Several reported initial predictions were either too high, or too low (e.g. actual uptake of Enhanced Care Team, community rehabilitation for falls higher and not costed, postural stability intervention for falls lower, SMI register much bigger than expected, A&G lower uptake in primary care.  
• Attribution of causation: Falls, Enhanced Care Team, Urgent Treatment Centre are linked interventions e.g. ECT and UTC refer into falls pathway, and Back Pain concurrent with GP Streaming.  
• IM&T systems: Persistent challenge of IT systems and negative impact |
GM Themes | Salford Together Partners Milestone Meeting (Oct 2019) Reported Barriers | Project Teams Rapid Cycle Evaluation Meetings Reported Barriers
---|---|---
| | on productivity and roll out noted in several projects, e.g. the GP systems (EMIS and Vision) (e.g. Enhanced Care Team, Mental Health) but also eRs in the Advice and Guidance project. | 
| | • Data access, quality and complexity: Challenges of data access, quality and complexity were noted in several projects (e.g. Mental Health, Enhanced Carer Support, Enhanced Care Team stratification tool, Urgent Care Team). | 

**Question 3: Learning from Salford Together’s ICP Programme?**
Rapid cycle evaluation has provided project teams with a robust methodology to understand the factors which both facilitate and impede successful implementation and outcomes within individual projects. Rapid cycle evaluation has been reported to have enabled timely decision making and the development of business cases for commissioning of on-going work. Further insights were provided by interviews with senior leaders from Salford Together (n = 15) about their views and experiences of the Integrated Care Programme. Interview findings were mapped to the key GM Transformation Evaluation Themes by SQW and summarised below, followed by illustrative stakeholder quotes.

**Perceived Structures, Governance and Accountability:**

- Salford Together was perceived to operate as a genuine partnership, with a shared vision and set of values, although at times Salford Royal was perceived to have the strongest voice.
- Effective governance, partnership working and accountability were facilitated by a strong history of partnership working and coterminous boundaries of many of the key partners.
- The formal governance structure was reported to ensure partners regularly and frequently discussed delivery against the shared priorities. Formal arrangements were supplemented by informal meetings and effective interpersonal relationships between key partners.
- The inclusion of the voluntary and community sector (via appointment of Salford CVS to the Adult Advisory Board) was widely welcomed by partners.
- There were reported challenges in terms of organisational change and turnover of personnel, but the governance arrangements meant momentum was maintained overall.
- Partnership working and a shared vision was reported to be more evident at senior levels than among operational and frontline staff.
“I think everybody’s pretty signed up or has a clear vision. I think there is a clear sense of purpose of what it is that we’re trying to achieve.” [SRFT interviewee]

“I think we probably vary a bit on how to get to that vision, but what’s interesting is that when we actually sit and talk around the table, we do most often quite easily navigate a solution.” [Other interviewee]

“We had a workshop recently in the Advisory Board to ensure that there is still consensus on the aims and that they are still strategically aligned to all partners’ [own aims].” [CCG interviewee]

“So, we have a strong system, that over a period of time has shown we can work well together and that’s important because it’s not easy to do…. we’ve tested over time that the system is stronger than individuals, because significant individuals at times in that few years have moved on, but the system has stayed strong.” [LA interviewee]

Perceived Leaderships and Relationships:

- As the first area within GM to receive Transformation funding, Salford is perceived to have played a leading role in developing partnership structures to deliver innovative change, providing learning and examples for others. There is an on-going desire amongst local partners to remain “ahead of the game”.
- Strong strategic relationships reported across the system, which have led to an increased understanding of how partners within the system work, and a clear shared vision.
- Shared ownership of priorities, challenges and strategy have led to the development of a culture of partnership working at a strategic level. While the strength and credibility of influential key individuals involved has been a driving factor of progress, the governance arrangements at partnership and organisational levels are seen as key for sustaining momentum. However, at an operational level, further work is needed to establish a partnership culture and achieve the associated benefits.

We have good relationships in Salford, however they used to be more bilateral, so the provider would speak to primary care, the commissioner would speak to the hospital, primary care would speak to the commissioner, etc. Now we have ‘one system relationships’ where we aren't siloed or bilateral anymore.” [CCG interviewee]

Parts of the work of Salford Together have certainly started to shape and change the way we all… work together as part of it, and have a shared vision for integration and a shared vision of making people’s lives better … I think different parts of the system have a slightly different view on how it can be done, but actually we’d started to do better and collaborate and challenge
each other and test things out with each other. That enabled things to change.” [Other interviewee]

Local Care Approach:

- The neighbourhood model implementation: priorities have been established and projects are being developed and refined for future delivery.
- The approach was reported to have already resulted in more integrated service pathways and a greater focus on some of the wider determinants of health.
- VCS involvement and strong leadership from neighbourhood teams, and particularly the inclusion of GPs within them, was perceived to have enabled progress at this early stage of development, with optimism about the future of the model.

“Salford, like every other area in GM, is not just one homogenous blob... the idea is about how do you use the demographic information, performance information, the knowledge that we've got about the community assets that sit within your neighbourhood, so that you can collectively develop what your own neighbourhood looks like.” [SRFT interviewee]

Perceived Programme impacts:

- Salford Together interviewees reported a range of positive impacts on health and wellbeing for the local population. However, they also raised questions over the scale, sustainability and timing of these impacts.
- There was strong perception that the workforce now has a more collaborative culture although there is still progress to be made, particularly amongst frontline and operational teams.
- There was less reported impact at a system level, but there was cautious optimism that impact might be achieved over a longer time-frame. There was a sense that expectations need to be carefully managed regarding what is realistic and achievable within Transformation Fund and evaluation timescales.

“The challenge we have is how we move from those cases where things have gone well, move from those smaller numbers to how to improve things across the city for everyone.” [CCG interviewee]

“Some of the projects, for example, if you took the Enhanced Care project. They delivered great things while they were there but actually it’s a six-week programme. What happens a year after they’ve had that intervention? Does it all just go completely back to normal again? So, we don’t know that sort of
data at the moment. We don’t know how sustainable the impact will be.” [CCG interviewee]

“If you look at a population health…you’re looking at a generation before you see the results of some of the work that’s being done.” [Other interviewee]

Perceived impacts on the local population and service users:

- Salford Together senior leader interviewees identified a range of schemes that they perceived have had positive impacts on health and wellbeing for the population. These included: Care for carers, the falls prevention project, review of the Severe Mental Illness Register (SMIR) and Enhanced Care Team.
- There were reports of reduced or stabilising numbers of non-elective admissions (one consultee reported that the number of admissions of residents of care homes had gone down by about a third) and A&E attendances (the same consultee reported that the number of A&E attendances from the care home population had halved in the last 18 months), as well as reduced/stabilising levels of permanent admissions to care homes, which some stakeholders were confident were reflected in quantitative data.
- A key issue for many consultees was the extent of change. There were reports of examples of positive outcomes for patients, particularly qualitative evidence and some indicative quantitative data, but stakeholders acknowledged that evidence of change was often limited compared to the scale of the problems. Overall there was a perception among consultees that there has been change for the better. However, some questioned the sustainability of change, highlighting that some changes will take longer to become evident, for example in terms of avoiding mental health crises, and that efforts will have to be maintained to ensure these outcomes are achieved. A significant number of consultees highlighted that self-care and patient behaviour is fundamental to transformative change in the health and social care system.

Perceived impacts on the workforce:

- Interviewees reported significant changes in ways of working in Salford as a result of the ICP programme, as well as strong pre-existing tradition of partnership working.
- One key indicator of change is the extent and quality of communication both between staff and organisations.
- For a small number of consultees, this improved communication combined with shared aims, is evidence of a stronger collaborative culture among the workforce.
- In some cases, integrated working had been facilitated by co-location of staff. Co-location was seen to be a practical way to support integrated working.
- There was also a perception among some consultees that some organisations had expanded their perspective through the integration work.
Consultees provided a range of examples of integrated working and associated advantages. Consultees also observed that the iterative learning culture that has been slowly established is increasing innovative capacity. For example, both GPs and the VCS have approaches that can support diabetic patients and they are willing to learn from each other about what is most appropriate for a patient’s needs. There was a sense of pride expressed by some consultees about the progress made. However, there was acknowledgement that there is still work to be done to achieve full, consistent collaboration, particularly in terms of operational teams. A few consultees highlighted the pressures that continue to militate against genuine collaborative working. This included capacity in light of growing demand and constrained resources, and the challenges of recruiting experienced, skilled staff such as advanced nurse practitioners and social workers.

Perceived impacts on the System:

- Senior leaders were only able to identify a limited number of system impacts. Examples included:
  - Cashable savings for the CCG from tackling medication wastage
  - Some indications the rate of growth of A&E attendances and emergency admissions has fallen or plateaued despite a rising population
  - Reduction or stabilisation in admissions to residential care and an improvement in the quality of residential care
  - Moving from being 150 out of 151 local authorities in terms of the numbers of care homes that were rated as inadequate or required improvement by the CQC to 75th
- Several senior leaders cautioned against attributing too much weight to underachievement of outcomes, noting that ambitious targets were set and it took a long time to work out how many of the new ways of working could be effectively implemented. They anticipate that as approaches become embedded, they will deliver change more quickly, but that it will take time for large-scale impact to be detected.
- Some of the key system changes noted relate to attitudes to integration. For example, the inclusion of the CVS in strategic governance was widely valued and expected to deliver additional value in future. It was widely assumed that in future, key strategies and decisions would incorporate all partners, such as the locality plan.
5. Learning and Recommendations

Salford Together’s partners have accumulated a wealth of learning about integrated care, being one of the first areas in the country to establish its Integrated Care Organisation, and through its long history of partnership working and ambitious programmes of integrated care. Salford Together’s vision for adults’ integrated care is to deliver significant improvements in experience and outcomes through prevention and independence, person-centred care, delivering more in communities, supporting staff through new models of integration and using pooled resources more efficiently.

The formative RCE approach adopted in this evaluation is reported to have enabled the rapid review of projects in real time, timely recommendations, and development of business cases for further work in 2020/21. Several of the ICP projects have continued as planned, or with adaptations, and relevant business cases have been developed. These include the Urgent Care Team (UCT), MSK Back Pain, Falls Pathway, and Housing Support. The Advice & Guidance project has been recently been developed in relation to the current COVID-19 pandemic. The reported advantage of the structured RCE approach and data capture meant that Salford Together partners could make evidence based decisions about next steps and development of the future ICP, as learning occurred, rather than waiting for the final summative evaluation. It is important to note the resource required to support the formative evaluation of a complex, multi-project programme, developing capability and capacity alongside delivery.

Senior leader insights, mapped to the GM thematic framework (Appendix 1), provide a useful opportunity to understand Salford Together partners’ experiences within the wider GM context and evidence base. Interviews indicate consensus around Salford Together operating as a genuine partnership, with a shared vision and set of values, although they also highlight Salford Royal is perceived to have the strongest voice at times. The inclusion of the voluntary sector as an equal partner in the Adult Advisory Board was widely welcomed by partners, and seen by some as progressive, although some participants in the Milestone Meeting would have liked to have seen their inclusion earlier. Governance arrangements were reported positively and important to maintaining momentum in face of organisational changes and key personnel turnover. The extent to which the drive and innovation reported by leaders can be maintained is an important question for Salford Together partners in their future plans. Reports by some senior leaders that shared vision and partnership working was less evident among operational and frontline staff is another important issue for Salford Together to consider within future integrated care initiatives. Salford is participating in a GM wide workforce survey as part of GM ‘Taking Charge’ evaluation which may help inform future communication and engagement plans.

Key findings and insights from projects across the ICP programme indicate a range of positive patient outcomes and experience, workforce and system efficiencies. Project teams also reported finding ways to implement projects within particular contextual constraints. There were, however, questions raised in stakeholder interviews over the scale, sustainability and timing of impacts. Senior leaders involved in Salford Together
acknowledged the time it takes for the impact of large scale change to be demonstrated. The challenge remains of attributing causation at the programme level in complex programmes of this nature which takes place within complex adaptive systems and with a range of concurrent initiatives taking place.

Large scale change and population-wide improvements are known to take considerable time to deliver results; some estimates suggest 5-7 years from the start of an improvement initiative (Ovretveit and Staines, 2007). The Kings Fund noted the value of a formative approach to evaluation at a system level in providing ‘signals’ about aspects that are working well or need improved or reviewed (Fillingham & Weir, 2014). This may also help generate ‘small wins’ and build momentum. The formative approach in this evaluation helped identify important barriers to integration across multiple ICP projects which, if allowed to go unchecked are likely to continue to pose risks or impede future work. Lack of clarity about governance, leadership and new roles and responsibilities, limited accommodation for co-location, as well as IT challenges and difficulties accessing quality data were noted. Limited engagement of key stakeholders was also reported to prove difficult in some projects. These factors correspond to the local preconditions identified as ‘enablers of integrated care’ by the Social Care Institute for Excellence (2017) such as the need for effective leadership and governance; the ability to engage communities and local resources; a well-integrated workforce; sharing of data and information and integrated commissioning.

The neighbourhood local care approach has been identified as a key enabler of Integrated Care in each locality. Leadership teams in the five neighbourhoods have been established, supported by a leadership training programme provided by AQuA. Recent work has highlighted the importance of supporting the development of a distributed approach to system leadership to enable clinicians and managers to have both the knowledge and skills to work effectively across system boundaries to deliver shared goals (West et al, 2014). This needs to co-exist with strong and effective organisational relationship, where organisational goals do not supersede system ones (Fillingham & Weir, 2014). Projects have been identified for implementation in 2020/21, although these are likely to have been impacted by the COVID-19 response.

The issue of ‘systems within systems’ noted by The Kings Fund (2020) is an important consideration for Salford given its role and relationships within the wider GM Integrated Care System. The scale and complexity of changes across Integrated Care Systems can also not be underestimated. Establishing different ways of working and new models of delivering care, with governance and structural change supporting change rather than driving it is pivotal (Charles, 2020). The role of new Primary Care Networks (PCNs) will also be an important. A key question for Salford as it moves to COVID-19 recovery will be the extent to which the maturity of Integrated Care Systems is associated with the ability to successfully mobilise and to both respond to the crisis as well as initiate recovery and move towards future transformation.

Salford Together’s evaluation approach was intended to build internal programme team capability, capacity and confidence with measurement for improvement and evaluation
methods. A number of evaluation limitations are important to note. Individual evaluation reports were a vital source of information for this final evaluation. There were however, some inconsistencies in reporting and some gaps identified, such as survey response rates and service user experience follow up. This may be related to the pace of implementation and reporting requirements as well as changes in evaluation personnel. The overarching issue of response bias in all evaluation work is another important consideration as those participants who took part may be atypical. Data access and quality issues were noted by project teams across the programme and the challenge of IT and interoperability was also identified in a number of projects. Salford Together was a complex programme, attempting large scale change within a relatively short time-scale. Small numbers within several projects, concurrent initiatives taking place in the locality and lack of defined counterfactual at the outset poses challenges for attribution of causation and demonstrating system impact at scale. It is understood that individual project monitoring incorporated economic considerations. However, this was not embedded within this evaluation framework; therefore questions about value for money cannot be assessed.

5.1 Recommendations
As noted earlier, several of the ICP projects have become business as usual or have been adapted and business cases developed. Insights and shared learning across the programme indicate a number of key recommendations. These have been organised in four key areas, (1) programme design and measurement, (2) Implementation and engagement, (3) neighbourhood learning and (4) evaluation approach:

Programme focused recommendations:
- Future work to consider alignment of project and programme level outcomes and impact with pre-set system metrics to better understand the individual and cumulative project activities, including patient and staff perspectives. It is important to note that there is another year to deliver the system metric ambitions out-with the programme.
- Prospective consideration of other datasets in addition to the current programme metrics using Service Level Agreement Monitoring (SLAM) data.
- Regular review of associated programme metric charts annotated with project activity to explore potential contribution of projects over time.
- Exploring the feasibility of a defined counterfactual at the outset of programme, although it is acknowledged that obtaining comparable data often presents considerable challenges. The programme monitoring did include projected figures for a ‘do nothing’ scenario.

Implementation and engagement focused recommendations:
- Early set up of future integrated care programmes to include a robust assessment and optimisation of known enablers, and plan for mitigation of known barriers.
- A targeted and resourced engagement and communication strategy at the outset is prioritised and reviewed regularly.
Neighbourhood focused recommendations:
- Optimising enablers for neighbourhood teams identified by AQuA including a clear focus reflecting local priorities, central project management, administration support, and regular meeting dates and shared learning opportunities. Follow up of neighbourhood leadership teams’ views and experiences of the programme, their individual projects, support they received and impact on integrated working is also indicated.

Evaluation focused recommendations:
- Inclusion of a formal ‘readiness for evaluation’ assessment is undertaken prior to project commencement (where possible). This would aim to provide project teams with better understanding to optimise project design and feasibility. This would include the nature of available data, potential methods of capture and IT issues, and level of stakeholder engagement required.
- Inclusion of economic indicators within the formal evaluation framework.
- Inclusion of a quality appraisal assessment process of individual project level evaluation reports to develop capability, promote standardisation, and quality of reporting to ensure robust nature of data available for summative review. The time and resource required to adequately resource this support needs to be considered.
- Review of the project level and programme level logic models and driver diagrams assumptions to inform future development of the integrated care programmes.
- Review project teams’ experiences of the evaluation approach to understand the extent to which the parallel ambition to increase capability and capacity within the team was, in fact, realised and where improvements can be made.
References


**Salford Together’s Adult ICP - Individual Project Evaluations Final Reports**

Author not specified (2019) Urgent Treatment Centre Options Paper.


Colman, B (2020) Centre of Contact Final Evaluation V1.7 ACSPB – 14 January 2020, AAB 25 February 2020


Acknowledgments

The evaluation team would like to thank all the patients, service users, staff, organisations and partners who participated in and/or helped facilitate the evaluation of the Salford Together Adults Integrated Care Programme (ICP) and its multiple, transformation projects.

Our special thanks go to the Salford Together programme and project managers, members of the individual project teams, and partners who co-produced individual project evaluations and reports, upon which this final report is based:

- Sarah Cannon, Senior Programme Manager, Integrated Care, Salford Royal Foundation Trust who provided key information and text for this report on the context and background to the Integrated Care Programme as well as contributions to individual project reports.
- June Roberts, Divisional Associate Director Transformation, Salford Royal NHS Foundation Trust
- Bev MacKay, Project Support Officer
- Pam Emmens, Project Support Officer
- Paul Hardman, Senior Project Manager (ECT)
- Sarah McKiernan, Senior Project Manager (UCT)
- Ben Colman, Senior Project Manager
- Bruce Poole, Salford Together VCSE Partnership Lead, Alison Page, CE, Salford VCS
- Tammy Young, Lead MH project (GMMH)

Haelo were originally commissioned in 2017 to undertake this evaluation, following amalgamation in 2019, AQuA has continued to provide evaluation support and expertise. During this three year period, the evaluation team have included: Evaluation Manager, Research Officers, Head of Innovation and Consultancy, Associate Directors, Senior Improvement Advisor, Measurement and analytics. Thanks and recognition of individual and cumulative contribution of the following individuals and teams is merited: Lynsey Dunn, Sarah Lavin, Simon Wickham, Paul Hawgood, Helen Kilgannon, Ruth Yates, Rachel Volland, Cathy Sloan, Julie Want, Helen Chadwick, Abigail Harrison, Nadine Payne, and Eve Allman. Dr Eileen McDonach commenced as Evaluation Programme Lead, February 2020.

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Thanks also to the Members of the Adult Advisory Board and funders, Salford Together.
## Appendices

### Appendix 1: GM ‘Taking Charge’ Evaluation Key Themes

<table>
<thead>
<tr>
<th>Themes</th>
<th>Sub-areas of enquiry</th>
</tr>
</thead>
<tbody>
<tr>
<td>Structures, governance and accountability</td>
<td>Establishing a local care organisation, including strategic and operational capabilities</td>
</tr>
<tr>
<td></td>
<td>Establishing or developing single commissioning functions between health and the local authority</td>
</tr>
<tr>
<td></td>
<td>Establishing shared vision, that is understood throughout the local health and care system</td>
</tr>
<tr>
<td>Leadership and Relationships</td>
<td>Role of leadership of the Local Care Organisation and single commissioning organisation</td>
</tr>
<tr>
<td></td>
<td>Role of relationships between the Local Care Organisation and the single commissioning organisation</td>
</tr>
<tr>
<td></td>
<td>Role of voluntary sector partners in the local care approach</td>
</tr>
<tr>
<td>Local care approach</td>
<td>Development of a neighbourhood model</td>
</tr>
<tr>
<td></td>
<td>Implementation of a neighbourhood model</td>
</tr>
<tr>
<td></td>
<td>Shift of balance of services delivered at home or in the neighbourhood, rather than in hospital settings</td>
</tr>
<tr>
<td></td>
<td>Asset-based and person-centred approaches</td>
</tr>
<tr>
<td></td>
<td>Focus on population and service user wellbeing</td>
</tr>
<tr>
<td></td>
<td>Development of integrated service pathways</td>
</tr>
<tr>
<td>Impacts on population/service users</td>
<td>Improved health and wellbeing outcomes (Living Well, Aging Well)</td>
</tr>
<tr>
<td></td>
<td>Improved access to services</td>
</tr>
<tr>
<td></td>
<td>Improved experience of accessing services</td>
</tr>
<tr>
<td></td>
<td>Empowerment, awareness and self-care</td>
</tr>
<tr>
<td></td>
<td>Reduced health inequalities</td>
</tr>
<tr>
<td>Impacts on the workforce</td>
<td>Developing a collaborative work culture</td>
</tr>
<tr>
<td></td>
<td>Improving staff morale and satisfaction</td>
</tr>
<tr>
<td></td>
<td>Developing staff skills through new ways of working</td>
</tr>
<tr>
<td></td>
<td>Improved recruitment and retention</td>
</tr>
<tr>
<td>Impacts on the system</td>
<td>Financial sustainability</td>
</tr>
<tr>
<td></td>
<td>Reducing pressure on acute and secondary care services</td>
</tr>
<tr>
<td></td>
<td>Strengthening primary and community care</td>
</tr>
<tr>
<td></td>
<td>Responding effectively to local need</td>
</tr>
<tr>
<td></td>
<td>Responding flexibly to changes in local need</td>
</tr>
</tbody>
</table>
## Table 6: Co-existing Salford partnership system initiatives 2016-19

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Description</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neighbourhood Integrated Practice Pharmacist Service</td>
<td>The service is contributing to managing the demand on primary care and supports improving outcomes from medicines use in Salford. SRFT reports directly to CCG.</td>
<td>September 2016</td>
</tr>
</tbody>
</table>
Appendix 3: Integrated Care Programme – Logic Models/ Driver Diagrams

Salford Together - Urgent Care Team Logic Model

<table>
<thead>
<tr>
<th>Situation/Need: Increasing ED attendance at SRFT</th>
<th>Outcomes – impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inputs</td>
<td>Activities</td>
</tr>
<tr>
<td>Transport</td>
<td>Referrals calls taken by ? Coordination of call outs Triage (phone with referrer) Handover See and treat Visits made On site diagnostics and problem solving Pt transported to EAU/IMC bed Direct access to EAU for diagnostics Develop criteria Review and define suitable data Infrastructure to host data Step down pathway and onward referrals Scope accommodation for team Establish steering group to review and make governance decisions</td>
</tr>
</tbody>
</table>

Centre of Contact Driver Diagram

To deliver an integrated, single entry point to access Health & Social Care services for Salford’s population by March 2020.

- Creation of effective IMT triage and assessment
- Integrated team working
- Further embedding care navigation
- Consistent levels of satisfaction

Team recruitment
- Review of triage and assessment process
- Consistent reporting and relevant communication of action plans
- Staff Development – All staff trained on appropriate systems
- Relevant HR and OD support
- Development of support plans for out of hours, neighbourhood and MDGs
- Review current STEA with service providers
- Review of referral pathways to services
- Communication and engagement
- Formalised reporting and measurement plan
- Agreed definition of ‘satisfaction’
- Regular communication and engagement
### Program: MSK/Spiatal Logic Model

#### Situation / Need:
Higher than national average data in admissions, injections and MRI scans in relation to back pain for Salford residents.

<table>
<thead>
<tr>
<th>Inputs</th>
<th>Activities</th>
<th>Outputs</th>
<th>Short</th>
<th>Medium</th>
<th>Long</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project Management Input</td>
<td>Clear referral pathways across primary and secondary care</td>
<td>STarT back used to risk stratify all patients with low back and radicular pain</td>
<td>Reduction in GP appointments for people with radicular and low back pain</td>
<td>Reduction in non-elective admissions for back and radicular pain</td>
<td>De-medicalisation of simple back pain</td>
</tr>
<tr>
<td>MOT Project Working Group</td>
<td>Standardised pathway for all patients with low back and radicular pain</td>
<td>Triage &amp; Treat Clinics in each neighbourhood</td>
<td>Decrease in referrals to SASS clinic</td>
<td>Reduction in the number of A&amp;E attendances for back and radicular pain</td>
<td>People self-managing simple back pain</td>
</tr>
<tr>
<td>0.2 WTE Clinical Lead</td>
<td>Revised injection pathways</td>
<td>Physically skilled in delivering CPPP</td>
<td>Reduction in number of MRI scans</td>
<td>Reduction in number of admissions for facet joint injections. Needs further discussion about what is measurable</td>
<td>People with back pain are making healthy lifestyle choices and using active lives, accessing community assets</td>
</tr>
<tr>
<td>1.0 WTE Band Ba physio</td>
<td>Education for GPs, A&amp;E staff, primary care practitioners and physiotherapists</td>
<td>Core therapies</td>
<td>Increase in conversion rate (to surgery) for spinal clinics</td>
<td></td>
<td>Reduction in levels of disability of people with low back and radicular pain</td>
</tr>
<tr>
<td>GP / Practice Staff time staff</td>
<td>Health promotion, healthy lifestyles and signposting to community assets for people with back pain</td>
<td>Combined Physio/Psychological Review Clinic</td>
<td>Reduction in number of sick notes issued for radicular and low back pain</td>
<td></td>
<td>Reduction in waiting time for people requiring surgery</td>
</tr>
<tr>
<td>Clinical rooms in neighbourhoods</td>
<td>Virtual access to SASS clinic</td>
<td>People with low back and radicular pain more active and self-managing</td>
<td>Reduction in number of repeat referrals to primary care clinics for patients with back and radicular pain</td>
<td></td>
<td>Reduction in number of repeat referrals to primary care clinics for patients with back and radicular pain</td>
</tr>
</tbody>
</table>

#### Assumptions:
- GPs will engage with the new pathway. There will be a deflection in some activity from MSK CATS to the STarT clinic. Tertiary referrals will not impact on access times to secondary care for Salford residents. Pathways will not create unmanageable pressure on pain or mental health services.
- Clinical staff can be resourced/trained up to deliver new service.

#### External Factors:
- Tertiary referrals
- Accommodation in SASS clinics
- GP engagement and buy in
### Program: Neighbourhood Enhanced Care Team, Logic Model

**Situation / Need:** Increasing aging population with complex co-morbidities and social needs

<table>
<thead>
<tr>
<th>Activities</th>
<th>Outputs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Programme Management Input</td>
<td>X number of assessments completed</td>
</tr>
<tr>
<td>Neighbourhood Leadership Team Input</td>
<td>X number of assessments completed</td>
</tr>
<tr>
<td>WITE AIP</td>
<td>X number of assessments completed</td>
</tr>
<tr>
<td>WITE Mental Health Practitioner</td>
<td>X number of assessments completed</td>
</tr>
<tr>
<td>WITE Allied Health Practitioner</td>
<td>X number of assessments completed</td>
</tr>
<tr>
<td>WITE Social Care</td>
<td>X number of assessments completed</td>
</tr>
<tr>
<td>WITE Health &amp; Wellbeing Support Workers</td>
<td>X number of assessments completed</td>
</tr>
<tr>
<td>PAI Extended Care</td>
<td>X number of assessments completed</td>
</tr>
<tr>
<td>Physician/Delegated</td>
<td>X number of assessments completed</td>
</tr>
<tr>
<td>PAI GP</td>
<td>X number of assessments completed</td>
</tr>
<tr>
<td>WITE within support</td>
<td>X number of assessments completed</td>
</tr>
<tr>
<td>WITE community pharmacist</td>
<td>X number of assessments completed</td>
</tr>
<tr>
<td>Clear pathways to access support for specialist services</td>
<td>X number of assessments completed</td>
</tr>
<tr>
<td>IT systems connect to neighbourhood GP practices</td>
<td>X number of assessments completed</td>
</tr>
<tr>
<td>IT introductions to allow access to all clinical systems (e.g. LH/ParkCare/FastMeds or Vision)</td>
<td>X number of assessments completed</td>
</tr>
<tr>
<td>Clinical space to hold clinics</td>
<td>X number of assessments completed</td>
</tr>
<tr>
<td>Office base</td>
<td>X number of assessments completed</td>
</tr>
</tbody>
</table>

### Assumptions

For feasibility:
- All GP will fully engage in referring individuals to the ward
- The team have appropriate skill to identify an appropriate assessment to identify more than acute situations in order to receive underlying chronic

### External Factors

- GP uptake
  - Referral process (timeliness/accuracy)
  - Prescribing across specialties
  - Assumptions/Facilities for team
- Referrals to services (availability/time/matches/progress)
- Staffing and working rules

### Outcomes – Impact

<table>
<thead>
<tr>
<th>Short-term</th>
<th>Medium-term</th>
<th>Long-term</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Relief”</td>
<td>“Improved Health &amp; Wellbeing”</td>
<td>“Independence”</td>
</tr>
<tr>
<td>Stabilisation of condition (though appropriate prescribing)</td>
<td>Patients health should improve with appropriate medication and specialist referrals.</td>
<td>Improved patient independence reported.</td>
</tr>
</tbody>
</table>
| Response to immediate health and social care needs identified by assessment. | Patients health should improve with treatment of identified health deficiencies. | Patients have better understanding of their conditions and their management, and feel empowered to take care of their health..
| Reduced anxiety and stress for patients and carers. | Improved health behaviours of patients after appropriate referrals to Health Improvement teams. | Results in fewer GP acute interventions and avoidable admissions. |
| Equipment lent in place as required. | Patients and Carers being supported with knowledge of their condition, and also the services available to them in the community. | Patients are able to remain living independently at home for longer. |
| Potential health crises avoided. | Patients and Carers being supported with knowledge of their condition, and also the services available to them in the community. | Improved care, wellbeing through empowerment and appropriate support for their role. Patient / Carers more knowledgeable regarding their treatment, expectations and processes of care. |
| Rapid return to appropriate services to avoid crises. | FGP visits avoided. | Improved care, wellbeing through empowerment and appropriate support for their role. Patient / Carers more knowledgeable regarding their treatment, expectations and processes of care. |
| Care planning management plan in place. | Emergency admissions and ED attendance avoided. | Improved care, wellbeing through empowerment and appropriate support for their role. Patient / Carers more knowledgeable regarding their treatment, expectations and processes of care. |

### Tailored Information to be provided on a 1-1 basis

- Monthly performance reports promoted and shared through appropriate channels

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<table>
<thead>
<tr>
<th><strong>Program:</strong> Salford Together ICP</th>
<th><strong>Logic Model</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Situation / Need:</strong> Salford has a very high rate of injurious falls amongst residents over 65.</td>
<td><strong>Outcomes – Impact</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Inputs</strong></th>
<th><strong>Addition</strong></th>
<th><strong>Change</strong></th>
<th><strong>Short</strong></th>
<th><strong>Long</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Falls Prevention Project Group</td>
<td>Production of a standardised web-based pathway across the system</td>
<td>Single point of referral, assessment and routine data reporting</td>
<td>Reduced fear of falling</td>
<td>Older people are able to remain living independently at home for longer</td>
</tr>
<tr>
<td>EPRI support to develop electronic pathways</td>
<td>Expansion of risk identification by other agencies</td>
<td>Additional 1000 people a year at risk of falls are identified</td>
<td>Improved strength and balance</td>
<td>Residents are more active for longer</td>
</tr>
<tr>
<td>Redesigned processes and increased staffing in CRT</td>
<td>Increased triage for people at low, medium and high risk of falls</td>
<td>Additional 1350 referrals screened by Falls Service</td>
<td>Better coordination of falls related services</td>
<td>Residents are aware of and managing their own risk of falls</td>
</tr>
<tr>
<td>Revision of referral thresholds within FLS</td>
<td>Rapid access to multifactorial falls assessment (MFA)</td>
<td>Additional 250 MFA’s per annum</td>
<td></td>
<td>Residents reporting falls to frontline staff regardless of level of / absence of injury</td>
</tr>
<tr>
<td></td>
<td></td>
<td>All MFA’s seen within 2 weeks</td>
<td>Reduction in number of falls</td>
<td>Reduction in number of falls</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Reduction in injury / hospital admissions to GM average</td>
</tr>
<tr>
<td>Expansion of postural stability and step up service</td>
<td></td>
<td></td>
<td></td>
<td>Reduction in fracture including fractured NOF</td>
</tr>
<tr>
<td>Inspiring Communities together staff resources and PPI</td>
<td></td>
<td></td>
<td></td>
<td>Reduction in admissions to care homes due to falls</td>
</tr>
<tr>
<td>CoMms &amp; Engagement Team capacity</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicines management staff and support</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Assumptions</strong></th>
<th><strong>External Factors</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>EPR support available and able to integrate information across services</td>
<td>Development of green care/assess and treat processes</td>
</tr>
<tr>
<td>Recruitment successful to create additional capacity</td>
<td>Salford Care Homes Initiative</td>
</tr>
<tr>
<td>Planned increases in service capacity meet need</td>
<td></td>
</tr>
<tr>
<td>Take up for volunteer training meets target</td>
<td></td>
</tr>
</tbody>
</table>

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Appendix 4: Salford Together Integrated Care Programme Infographic
Appendix 5: Stakeholder Interview Schedule (conducted by SQW)
Evaluation of the Salford Together – Integrated Care programme

Senior stakeholder interview guide

November-December 2019

AQa/Haelo are currently supporting the Evaluation of the Salford Together programme. The final phase of their work is an overarching evaluation of the programme, which is due to report in June 2020. The evaluation will also be shared as part of the Greater Manchester Evaluation of “Taking Charge”: The Greater Manchester Health & Social Care Plan.

SQW, an independent research consultancy organisation, has been commissioned by AQuA/Haelo to undertake senior stakeholder interviews during November and December 2019, to inform the final evaluation report.

SQW is interviewing approximately 10-12 senior local stakeholders who have been involved in overseeing or implementing the Salford Together programme of work.

Introduction

Have you read the information note and signed the consent form? Do you have any questions?

Reconfirm note taking, recording and transfer arrangements, and opt out arrangements.

Are you happy to continue with the interview?

Q1. Confirm name, role and organisation.

Q2. How have you been involved with Salford Integrated Care Programme? Probe on when became involved, how, what the role/responsibilities were/are, and any changes over time.

Structures, governance and accountability

Q3. Could you tell us a bit about how the Salford Integrated Care programme was established? Probe on who the key partners were originally and whether this has changed, then national and local factors relevant to establishment, who were the driving individuals/organisations, other relevant programmes/changes/initiatives at the time
Q4. What would you say are the key aims/objectives of Salford Integrated Care Programme? Probe for specifics, who set these, was there a process for developing them, have these been fixed or evolved

Q5. To what extent do you think the aims/objectives are clearly established across all of the partners? Probe on any variations across partners and/or objectives, reasons for variation, how was this achieved

Q6. I’m interested in your thoughts on the governance arrangements. Probe on structure and effectiveness of governance, who is involved in decision making, whether momentum was maintained, reporting arrangements between projects to programme, organisations to programme, programme to GM, issues tackled/resolved or on-going

Leadership and Relationships

Q7. How have relationships evolved between the partners over time? Probe on what relationships were like prior to ST, degree of formality of relationships, strategic alignment, operational engagement e.g. between frontline practitioners, what helped or hindered this?

Q8. Who has played a key role in leadership?

Q9. What key things do you think the leadership has delivered in terms of the development of the Salford Integrated Care Programme? Probe on effective programme structure and governance, shared vision for strategic/operational staff, opportunity for genuine change and understanding of how to achieve

Q10. Could you tell us what role the VCSE has played in the development of the programme? Probe on inclusion in formal structures, contribution to shaping aims, involvement in specific areas of delivery

Q11. [June Roberts, Tara Kearney and CCG interviewees only] What has the relationship been between GMHSC and the Salford Together partners? Probe on practicalities – meetings between whom, frequency, purpose – strategic alignment/shared aims, joint initiatives, areas of challenge
Local care approach

Q12. How has the neighbourhood approach been developed and implemented across the programme? Probe on their understanding of the neighbourhood approach, examples of where implemented, why, how

Q13. How effective do you think this approach has been? Probe on achievements and challenges, key learning

Impacts on the workforce

Q14. To what extent do you think Salford Integrated Care programme has helped to develop a collaborative work culture? Probe on work culture prior to ST, examples of how it is more (or less) collaborative e.g. which organisations, level (strategic or operational/frontline), topics, expectations of how this might evolve

Impacts on the population

Q15. What impact do you think Salford Integrated Care Programme has had on patient outcomes? Probe on impacts (asking for specific examples and sources of evidence/data) for:

   a. Improved health and wellbeing outcomes (Starting Well, Living Well, Aging Well)
   b. Improved access to services (acute/primary/community care?)
   c. Improved experience of accessing services
   d. Empowerment, awareness and self-care
   e. Reduced health inequalities.

Final questions

Q16. Any other outcomes?

Q17. Any final reflections?

Thank interviewee for time. Remind of your contact details. Explain next steps will be to review all interviews and provide transcripts to AQuA.
### Question 1:

<table>
<thead>
<tr>
<th>What do you think are the core aims and objectives of Salford Together?</th>
<th>Have the aims changed over time and if so how?</th>
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</thead>
<tbody>
<tr>
<td><strong>Summary:</strong> innovation; integration; sharing resources; patient centred care/ improving patient experience; community/care closer to home</td>
<td><strong>Summary:</strong> generally, no; External factors have influenced focus/diverted attention; change of scope?</td>
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<tr>
<td><strong>Themes:</strong> pilot new ways of working; patient experience; life expectancy; improve quality/safety; streamlining resources; care closer to home; shift to community; working across boundaries/integration</td>
<td><strong>Themes:</strong> more service focused; focus diverted by wider context</td>
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- Share learning and skills
- Bringing provision together
- Shifting focus from crisis to prevention
- Having a focus on the population health and needs and strength of different neighbourhoods
- Improved efficiency and effectiveness and outcomes
- Bringing together local resources
- Removing barriers and obstacles and working across organisational boundaries
- Removing blind spots and sharing problems and solutions
- Creating a system that views the person as a whole
- Creating an innovative system

- Over past 12 months feels a bit more hospital centric – driven by national must do’s? (1b)

- To improve patient experience
- To increase value for money
- To improve quality of services for patients/service users
- To make Salford more sustainable and resilient

- Population health has been further reinforced since the start of the programme, changed slightly over time – terminology, ever changing environment introduction of the PCN’s, delivery of the long term plan – this wasn’t out at the time of the programme (1b)
- No but the environment has

- Salford £
- More acute service out into community
- Live well, age well (prevention agenda)
- To improve outcomes through testing a variety of new models i.e. UCT, ECT, falls etc.
- Bring partners together to explore and test new ways of collaborative working

- Feel that the focus has become more service focused rather than larger vision focus (1b)
- Vision big so focused on specific things to measure
- Learning re. challenges, IM&T, data, different organisation challenges, good that learnt from challenges
- 2 years ago more collective view – feel this has changed over time (1b)
<table>
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<tr>
<th>Action Points</th>
<th>Achievements</th>
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<tr>
<td>• Partnership working and co-production</td>
<td>• More time spent on managing demands on hospital, scope changed, iterative,</td>
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<td>• Care closer to home</td>
<td>older people to adults and now (population health CVS/VCSE (1b))</td>
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<td>• Shift from hospital to community</td>
<td>• Same aim, scope increased</td>
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<td>• Shift from residential to community</td>
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<td>• Person and community centred approach</td>
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<td>• A big conversation – engagement with public, listening, value of communities</td>
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<tr>
<td>• Transformation</td>
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<tr>
<td>o Pilot/test new ways of working</td>
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<td>• Wider population??</td>
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<td>• To create an integrated model for health and social care</td>
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<td>• Build a robust multiagency response to H&amp;SC</td>
<td>• Fluid, adapted, changed range, learnt from projects as world changed around</td>
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<td>• Increase focus on place</td>
<td>us</td>
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<tr>
<td>• Reducing duplication</td>
<td></td>
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<tr>
<td>• Increasing life expectancy and healthy life expectancy</td>
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<tr>
<td>• Tackle social determinants of health and health inequality</td>
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<tr>
<td>• Improving patient experience</td>
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<tr>
<td>• Increase VSCE response to H&amp;SC and involve (them in?) planning, designing</td>
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<tr>
<td>and delivery</td>
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<tr>
<td>• Saving money in secondary care</td>
<td></td>
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<td>• Shifting demand from secondary and primary care</td>
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<td>• Resilient community and less reliance on service, provide self-care</td>
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<td>• Cost effect provision</td>
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<tr>
<td>• Prevent and delay need for care</td>
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<tr>
<td>• Delivery of integrated health and social care for Salford citizens</td>
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<tr>
<td>• Reduce duplication and handoffs</td>
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<tr>
<td>• Streamline patient journey</td>
<td>• Other priorities have diverted focus e.g. SRFT-NCA, GMW-GMMH, PCNs</td>
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<tr>
<td>• Keep people as well as possible, help closer to home</td>
<td>emerging</td>
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<td>• Improve safety of care delivery by reducing hand offs</td>
<td>• Don’t feel aims have changed, different organisations have different</td>
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<td>• Create system of community assets to keep people well</td>
<td>challenges e.g. mental health become a distraction, national drivers</td>
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<tr>
<td>• Working better/smarter across organisations</td>
<td>come through, external pressures</td>
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<tr>
<td>• Improved neighbourhood focus</td>
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</table>
- Some improved outcomes – A&E presentation stabilised/static
- Advisory Board has clarified and consolidated a shared vision and purpose, *removed some blind spots across organisations*
- Care homes improvement
- Housing discharge a good example of sharing problems and coming up with ‘non health’ solutions

- Started to make an impact in pockets but a way to go, *not scale*
- Better quality care homes
- Improved care closer to home & preventative offer – care support
- Achieved organisational commitment – think as a system
- Big conversation – some degree of engagement but not co-production
- Increased VSCE response and offer
- Created ICO and systems leaders, *focused on transactional elements that gives the platform*
- Tested new models of care – to varying degrees of success
- Good relationships formed across partners, *not underestimate relationship, commitment to get meetings once a fortnight*

- Some integration at periphery of ‘care’ services while still feel a bit separate
- Some increase in community assets but are they seeing the right people – earlier prevention
- At a strategic level we have good integrated working but not sure at a patient/service user /front line service level
- Vision and drive/ *core aims and ambition* is there but maybe not translated at service level – *connectivity needs a refocus*
- We’ve tested a number of new models/ideas
- Social care feels less integrated than it did

- Staff turnover affected awareness of the joint vision?
- Specific service challenges may have effected vision and progress – all have differing challenges
- Felt like Salford Care Org – become dominant to provider Board (people drifted away from Provider Board
- Lesson learnt captured e.g. IG, GP practices/IM&T challenges, estates, data collection
- Successful outcomes – in testing, smaller scale, integrated teams
- Not achieved an integrated health and care system

- Have outcomes improved? Can we demonstrate this?
- Things have taken longer than anticipated and we still need to do further things?
- Engagement with across partners has vastly improved
- Balancing the money across the system? We’ve done some – would be worse if we didn’t do Salford together
- We’ve learnt from some of the transformation pilots
- Quality improved (e.g. nursing and residential care homes)
- Partially achieved demand reduction in hospital – activity not grown but not achieved full level ambition
- Summary 1 – made some impact on finances – bit not level of ambition
- Summary 2 – made some impact on engagement with public but not changed individual behaviour. (started work VCSE and work on strengths based approach)

- Achieved some of the commissioning agenda – working closer with the local authority
- Salford have mitigated some of the growth
- Case studies in individual projects have demonstrated excellent outcomes
- Not achieved 100% but there are pockets of good stories
- Ad care team, *increased quality of life*
- A&E at Salford

- Good integration at strategic level e.g. in this room, not convinced this has translated to the front line – core services at periphery still doing what they have always done – integrated services at the side
- GPs a big part of the system – I’m the only GP in the room and I’m here as a commissioner – role of PCNs
- Care homes used several times as an example of transformation but this was not resourced
Question 3: What have been the key facilitators/enablers of change? (green)

**Summary:** Leadership; clear vision; relationships (foundation already there); budget; thinking differently; timing; on-going evaluation

**Themes:** Leadership (clear vision); existing relationships (trust/commitment/communication); money; think/do things differently; timing/environment; iterative learning

- Original, clear vision
- Provider boards in the earlier days
- Positive forum
- Passion and commitment to do things differently (happy to try new things)
- Money (positive) to try new things, (negative) feels time limited – is a distraction from the systems change
- Strong partnerships developed
- Good foundations

- Relationships
- Money
- Infrastructures (ICO)
- Ready for change
- Multidisciplinary, challenge, learning
- Iterative evaluation

- Relationships really strong
- Trust amongst partners
- Organisations’ and Salford locality’s reputations
- Communication and engagement
- Listening to staff and public to generate ideas and buy in
- The people
- The money/Trans fund

- Commitment from most organisations/partners
- Appetite to try new things and open-mindedness to think about doing things differently
- Money
- Extra resources
- Strategic leadership to programme
- Involvement of CUS brought a different perspective

- Relationship – enabled us to move things forward
- Monitoring and rapid cycle evaluation
- Evaluation has enabled us to review impact as we go and we have been able to adapt along the way
- Partnership and engagement of senior leaders
- Senior leaders have been brave and let people get on with the work
- Vibrant VSCE sector
- Finance
- LCO networks/networking

- Neighbourhood approach makes more sense to people in Salford than a city wide approach
- Timing – is it the right time and environment
- Pooled budget
- On-going dialogue and shared vision
- Long history of working together
- Leadership – forward thinking and joined up

Question 4: What have been the key barriers/obstacles to change?

**Summary:** Stakeholder engagement (GP, VSCE); workforce issues; culture/individual behaviours; external pressures; risk appetite
### Themes:

**IT/Data sharing; workforce; culture; bravery/risk; stakeholder engagement; external pressures (A&E/BAU); lack of clarity (measurement)**

- Risk appetite – are we aligned as organisations or teams? Are we brave enough?
- Workforce – availability/shortages of key staff groups, time to recruit
- Individual behaviour change
- IT systems
- Data sharing
- Pressures of dealing with the ‘here and now’ e.g. A&E pressure and also doing transformation, *difficult to maintain spinning plates*

- Estate – difficult to collocate in a true manner
- Changing environments national/regional
- Workforce and culture change
- IT been a barrier in the test of change
- System so big so it’s hard to engage on a new session and ideas – hard to maintain communications
- Consistency of general practice voice around the table
- Co-creation, still some silo working

- External mandates and requirements cause distraction, ED, money, NEL/EL
- Capacity, staff turnover, short term contracts
- Engagement and buy in
- Culture, time to change

- Engagement/leadership of GPs/GP voice
- Data – not sure we have one version of the truth
- IM&T different systems unable to work together.
- Evaluation – we haven’t been clear about measurement/what has worked/hasn’t

- VSCE engagement later than it should have been
- IT systems and data sharing challenges
- NCA creation
- Workforce challenges – double running the transformation projects
- Turnover of staff and leadership

- IM&T
  - Realistic outcomes (? Bottomed out contextual factors that would affect change)
  - ? learning enough and being braver/responsive to the learning i.e. challenging of risk stratification

- *Get side tracked from transformation by organisational stuff*
- *underestimated the impact of contextual factors*
- *Reconsideration around governance*
Appendix 7: Salford Together Stakeholder Interviews: Identified Barriers and Enablers

<table>
<thead>
<tr>
<th>GM Evaluation Theme</th>
<th>Enablers Identified</th>
<th>Barriers Identified</th>
<th>Indicative Quotes (Enablers)</th>
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</table>
| Governance, Structures & Accountability     | • Emerging shared accountability among partners forged by the governance and reporting.  
• Practical experience of having managed pooled budgets  
• Salford Royal - Trust’s strong reputation  
• Political leadership of ICO were supportive of the transfer of adult social care provision from Council to Foundation Trust  
• Integration/ partnership working supported by coterminous geography of key partners  
• Joint quality strategy  
• Adult Advisory Board in particular was seen to be useful in bringing all partners, commissioners and providers together regularly.  
• Inclusion of Salford CVS. The CVS was proactive in getting their voice heard. Contribution seen as important and useful.  
• Formal governance supplemented by informal meetings/ discussions  
• Effective reporting system underpinned the governance  
• Transformation funding for PMO | • Commissioner – provider relationship – duplication of effort  
• Favoured efforts of Salford Royal (e.g. ECT – low engagement rates of GPs and service users)  
• Reduced frequency of AAB towards end of programmes  
• Concurrent organisational change: move to NCA and taking on PAT, Salford Primary Care leadership issues, move from GM West to GMMH tensions, Introductions of PCNs  
• Turnover of senior staff on Provider Board  
• Less clear shared vision of Salford Together at operational and delivery levels  
• Frontline workforce culture and behaviour  
• IT systems  
• Staff turnover, particularly skilled staff  
• Limited capacity and increasing demand – deprivation and inequalities. | “Without the history of working with all the partners…we wouldn’t have been able to achieve as much as we have done.” [CCG interviewee]  
“I think that it's really important that we've got a very long history of working in an integrated way around pooled budget arrangements in order to achieve the best outcomes we can with the limited money we've got available.” [LA interviewee]  
“I was really impressed when I first came to see [the Adult Advisory Board] actually all these partners get around the table every two weeks, and there’s a real commitment to that. So that has overseen the transformation programmes at a senior level.” [SRFT interviewee]  
“The other thing to say about that is the CVS has been a really useful part, [they have] felt like a real part of the system. Which I think is really important, but is something we need to build on going forwards.” [CCG interviewee] |
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<tr>
<td>GM Evaluation Theme</td>
<td>to manage complex programme and pooled budget credited with insulating social care from a significant overspend.</td>
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<td></td>
<td>• Willingness of partners to work innovatively and trial new approaches, and acceptance that not everything would work</td>
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<td>• Evaluation helped to underpin trialling of new approaches, ensuring partners were aware that early outcomes and learning (positive or negative)</td>
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<td>Leadership &amp; Relationships</td>
<td>• Strength of relationships across the system, formally and informally to maintain the agreed ICO partnership and alliance agreements, and dealing with challenging situations.</td>
<td>• ‘Power struggles’ in leadership teams (both internal and within the LCO)</td>
<td>“GM will come up with ‘you’ve got to do this’ … as a partnership we’ve really tried to either speak back to GM saying, ‘we’re on track and this is what we’re doing’ and [explain] how that aligns nationally.” [SRFT interviewee]</td>
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<td></td>
<td>• Length of time relationships had developed.</td>
<td>• First locality to receive Transformation funding – potentially risk averse</td>
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<td>• The commitment and influence of individuals involved</td>
<td>• Lack of real change at operational level – lack of regularity of Provider Board meetings, affecting progress at AAB</td>
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<td></td>
<td>• Stability of key individuals.</td>
<td>• Less integration of frontline clinicians than those at senior strategic level</td>
<td>We developed a kind of slide which had on it ‘why are we doing this’ because it’s easier just to get drawn in to the process all the time of ‘oh what do we need to do next, what does governance look like, what’s the legal documents look like’, etc. and we had this thing about ‘why are we</td>
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<td></td>
<td>• The reported “light touch” involvement of GMHSCP was</td>
<td>• Lack of engagement with frontline staff</td>
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<td>• The VCS described as “critical”, “vibrant” and “proactive” as a sector. Dedicated funded engagement role enabled a relatively strong voice for the CVS. Individual representatives</td>
<td>• Partnerships with primary care were seen as less strong due to changes to primary care</td>
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<td>GM Evaluation Theme</td>
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|                     | from VCS described positively as being key influencers and bringing positive challenge.  
• Shared aims and values, underpinned by strong relationships, were at the core of Salford Together, and have proved more important in maintaining progress than formal structures and processes  
• Leadership and GP representation  
• Challenges in partnership working with GMMH, due to changes in the contracting of mental health provision  
• VCS had not been engaged with early enough in the process of developing the LCO, and the sector’s potential to add value had not been fully appreciated. | doing this, what is going to be better for the people of Salford as a result of doing all these things? And that kind of became our mantra in any difficult conversations: we believe this is going to achieve better outcomes. And we still go back to that and say, has it done what it said on the tin really?” [LA interviewee] |

| Local Care Approach | Role of the VCS, due to their knowledge of the neighbourhoods they work within.  
• VCS representatives, supported by Salford CVS, have reportedly been very involved in the development of priority projects and have engaged with local people to support this.  
• Geographical footprints of neighbourhoods align with PCNs.  
• Establishing integrated neighbourhood teams and providing funding to address specific issues in locality supported sense of ownership.  
• GPs were specifically credited with providing a vital leadership role:  
• Support from Salford Together to | Misalignment with council wards and three CMHTs – danger of duplicating services  
• Existing siloes e.g. inability to share data across organisations as an example of this - GDPR as a key challenge in integrating neighbourhood systems.  
• Limited capacity of professionals to undertake leadership and operational responsibilities in neighbourhoods.  
• Capacity to attend meetings, e.g. GPs (virtual meetings potential solution for disengagement) | “I think we have an enormous amount of work to do with those neighbourhoods to bring them into fully functional neighbourhoods that have accountability, that have the ability to use their finances in a way they feel will benefit that particular locality best. But in terms of the structure we’ve actually been really, really blessed.” [SRFT interviewee]  
“[they have] found five strong GPs to be involved and they are key” [Other interviewee]  
“It’s not us telling them how to run
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<td>develop neighbourhood teams’ priorities and design projects.</td>
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<td>their neighbourhood, we’ll give them support to be able to be successful in understanding engaging and developing the model for how they’ll work in their neighbourhood.” [SRFT interviewee]</td>
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<td>• Neighbourhood teams have received leadership training from AQuA to support them to develop the neighbourhood model.</td>
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*SRFT interviewee*
## Appendix 8: List of Abbreviations (Alphabetical)

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>AED</td>
<td>Accident and Emergency Department</td>
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<tr>
<td>AQuA</td>
<td>Advancing Quality Alliance</td>
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<tr>
<td>ECT</td>
<td>Enhanced Care Team</td>
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<tr>
<td>GM</td>
<td>Greater Manchester</td>
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<tr>
<td>ICO</td>
<td>Integrated Care Organisation</td>
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<tr>
<td>ICP</td>
<td>Integrated Care Programme (Adults)</td>
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<tr>
<td>LOS</td>
<td>Length of Stay</td>
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<tr>
<td>MDT</td>
<td>Multi-Disciplinary Team</td>
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<td>MSK</td>
<td>Muscular-Skeletal</td>
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<tr>
<td>NEL</td>
<td>Non elective admissions</td>
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<tr>
<td>NHS</td>
<td>UK National Health Service</td>
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<tr>
<td>SPCT</td>
<td>Salford Primary Care Together</td>
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<td>ST</td>
<td>Salford Together</td>
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<tr>
<td>UCT</td>
<td>Urgent Care Team</td>
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