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Organisational development towards integrated care: a comparative study of Admission Avoidance, Discharge from hospital and End of Life Care pathways in Waltham Forest, Newham and Tower Hamlets

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Executive Summary - Tower Hamlets findings ONLY
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Researcher in Residence: **Sonia Bussu (UCL)**

Principal investigator: **Martin Marshall (UCL)**

Executive Summary

Background

The Waltham Forest and East London (WEL) Integrated Care programme was one of the 14 successful applicants to achieve pioneer status for integrated care in May 2013. WEL brought together commissioners, providers and local authorities covering the area served by Barts Health NHS Trust (BHT) – the largest NHS trust in the UK, serving a population of almost a million people and covering the London Boroughs of Waltham Forest, Tower Hamlets and Newham.

A two-year qualitative evaluation of WEL was carried out between September 2014 and August 2016 and looked at different ways of understanding - and motivations for – integrated care across the organisations involved in the programme. This work highlighted how, although governance structures had been set up, a deep chasm remained between strategic thinking and operational delivery.

The WEL programme was subsumed within the Transforming Services Together (TST) programme in 2015. TST was established in September 2014 and covers the same geographical areas as WEL. The programme aims to deliver improvements in productivity and ensure the quality of urgent and emergency care across the health economy. More recently, NHS England mandated the establishment of STPs (Sustainability and Transformation Plans).

Within this crowded policy context, the research team and stakeholders agreed to focus on borough-level work on integrated care across the WEL geography. The purpose of this third year of the qualitative evaluation was to understand in greater detail the delivery of integrated care on the ground and contribute to unpicking the gap between strategic thinking and operational delivery highlighted by the previous phase of the WEL evaluation. We looked at specific pathways to understand collaboration patterns within and across multidisciplinary teams from acute, community and social care, and to identify sustainable organisational development strategies. **Admission avoidance**, **discharge from hospital** and **end of life care** pathways were identified as high on partner organisations' agenda (also in light of current work at STP level) and selected as cases to assess the level of vertical (across acute and community care – i.e. looking at the whole pathway) and horizontal (across different health and social care roles/ teams in each part of the care system – i.e. multiprofessional teams) integration.

Findings

This report only looks at findings in Tower Hamlets. However, the key findings and recommendations apply across the WEL area as similar challenges and enablers were identified at the frontline level. The evaluation highlighted six overarching themes:

1. **Barrier between acute and community**
   The **barrier between acute and community** continues to hinder coordination of care, with different organisations increasingly focusing on different parts of the health system, limiting

opportunities for staff to rotate and understand the whole pathway and reinforcing silo-working. Examples of patients discharged without the required medication/ equipment were often cited, as well as cases of inappropriate or missed referrals to community teams. These issues are the result of a knowledge gap, particularly evident in the acute sector, on community pathways and provision.

2. **Cultural and organisational differences between health and social care professionals**

Health and social care staff have different professional and organisational cultures, as well as responding to different organisational pressures. Social workers perceive healthcare staff as risk-averse and feel their own role is about promoting independence; healthcare professionals feel social workers might struggle to deliver the care patients need because of limited capacity and financial pressure. District nurses (DNs) in particular often mentioned they felt they had to "pick up the pieces", as their patients' social needs were not always adequately addressed.

3. **Managing patients' expectations**

Participants highlighted the problem of patients often having unrealistic expectations of what level of care they could expect, which led to complaints when these expectations were not met. This issue appears to stem from miscommunication between professionals (particularly between acute and community staff) and a lack of understanding of what care is provided in the community, and more generally what different roles in different care settings do. For instance, interviewees mentioned several instances in which upon discharge from hospital patients were promised that a district nurse would visit immediately or that they would have immediate access to care, equipment and medication that could not be promptly provided outside hospitals.

4. **Multidisciplinary ethos**

The **ethos of multidisciplinary work is embraced widely**, although a **genuine multidisciplinary approach is often difficult to deliver in practice**. Co-location helps where there are shared professional and organisational vision and goals – and ideally one management line. Where this does not happen, people continue to work in their usual ways and they are not necessarily more collaborative or accountable to each other. The role of **care navigators** is seen by many participants as crucial to ensure greater coordination between health and social care as well as improving communication between community teams and GP practices.

5. **Investing in permanent staff can help build mutual trust within and across teams**

The role of agency staff both in health and social care is one aspect to consider carefully in the context of organisation change and continuous reconfigurations. New services are often staffed with locums because of time-limited funding. Some locum staff have been in the same role for some time and they are well integrated within their organisation. However, in general where there were high numbers of locums we also found higher turnover, which can affect relationship-building and commitment towards shared long-term goals. As new services (i.e.

Rapid Response; Discharge to Assess) tend to have more flexible criteria, it can be harder for professional in temporary positions to adapt to and fully embrace the new ethos and work practice, and some felt uncomfortable with what they perceived as "unclear criteria". By the same token, replacing locums with permanent staff might require upfront investment in induction and training and might affect short-term performance of the team, if newly recruited staff does not have the same level of experience.

6. **Frontline professionals' efforts to foster dialogue and create connections**
   There is much work, often on the initiative of frontline professionals, on **creating connections, multidisciplinary forums and collaboratives** in order to deliver better and more coordinated care. This work should be understood and supported better.

Key themes for each pathway

Admission Avoidance

An effective admission avoidance pathway should be based on a holistic approach to care and relies on the relationship between community nurses and therapies, GPs, and community social workers. At the time of fieldwork, this relationship was experiencing a number of challenges, including:

- Limited resources, particularly within social care;
- Understaffed healthcare teams with high turnover and difficulties in recruiting and retaining staff, and particularly DNs;
- A task-orientated approach to care, often due to heavy patient caseloads;
- Difficult communication between community teams, GPs, and social workers, whereby staff struggles to get hold of other professionals;
- Pressure on staff from increasing admin tasks and having to fill in different forms electronically and on paper (some felt there was often unnecessary duplication of information).

TH's **Admission Avoidance team** is now well-embedded in the Royal London's A&E department. The **Rapid Response team** is having a positive impact and is making a substantive difference to patients' care, as it works increasingly effectively with the PRU (Physician Response Unit). RR service's flexible inclusion criteria can at times generate confusion about the boundaries of the service and there are some overlaps with DNs' caseloads. Overall, there is growing awareness that, if non-elective admissions are to be reduced, it is important to move away from a task-orientated approach and towards more holistic care.

There is increasing commitment and ongoing work towards alignment of CHT/EPCTs and social services' Community Health Team, with future developments including a DN being co-located with LBTH staff. There is ongoing work at a governance level to increase coordination between health and social care (i.e. joint triage of health and social care through SPA led by a Band 7 nurse) but major barriers remain, i.e. data sharing and access to each other's caseloads; different approaches to commissioning; different ways of/ standards for assessing needs.

Discharge from hospital

While there is much focus on Delayed Transfers of Care, with Barts Health Trust supporting consultant-led projects such as **Perform** in all three main hospitals in the WEL area (i.e. Royal London, Newham Hospital, and Whipps Cross Hospital), the interviews highlighted concerns about patients being discharged too early or without the required medication, leading to hospital readmissions.
This is often seen as the result of broken communication between ward staff and community teams. There is limited understanding of community pathways and community provision among hospital staff, because community services are different from borough to borough and medical staff tend to rotate often, making in-depth inductions and training quite challenging.

Community services undergo frequent reconfigurations. These changes are not always adequately communicated and understood across the system and the pace of change is often perceived to be too fast.

Increasingly separate acute/ community careers and limited opportunities for rotation further deepen the barrier between the hospital and community care settings. In-reach nurses – nurses with a community background working in the hospital in a community capacity – could act as a bridge between hospital wards and community services. However, in-reach nurses working at the Royal London have limited capacity; while in rhetoric their role is appreciated by hospital nurses in particular, in practice they seem to have limited visibility and influence at board rounds and often lack adequate work space. This also applies to the **Screeners**, a relatively new role part of the AADS (Admission Avoidance and Discharge Services) team. Screeners are based at the Royal London and take and triage direct referrals from wards and in-reach nurses. At the time of fieldwork they did not have a permanent office and, although they have now been allocated a small space, they continue to lack the required IT resources to perform their tasks effectively.

End of Life Care

EOLC is a key priority across the WEL area, after end of life care services at The Royal London, Newham and Whipps Cross Hospitals were rated as 'Inadequate' by the Care Quality Commission (CQC) in 2015. Overall, many interviewees agreed that some important conversations need to happen about:

- Linking up Integrated Care and EOLC programmes;
- Rethinking the concept of EOLC where "uncertain recovery" might prove more helpful, in light of growing numbers of elderly frail people;
- GPs taking more responsibility over a patient EOL's journey (e.g. having clear conversations from the start; enabling patients to make informed decisions at different points in their journey etc.);
- Rethinking the approach to patient choice over place of death based on the current approach to birth, whereby people are encouraged to make a birth plan in the knowledge that many things might change and different choices might have to be made.

Fieldwork has unveiled a number of issues that can impact delivery of EOLC:

- **A task-orientated approach to care** affecting identification of end of life patients;
- **A lack of consistency of EOLC provision in the community;**

- **Filling in fast-track forms still seen as a challenge** that professionals would rather delegate to others;
- Limited awareness of need for and capacity of **therapies for EOLC patients** (specialist palliative OTs).

There are several important efforts to improve awareness and more coordinated delivery of EOLC, with **palliative champions** being one highly positive example.

Recommendations

Based on discussions with frontline teams, we developed two main sets of recommendations for future organisational development work that addresses issues of both vertical and horizontal integration.

1. **Vertical integration between acute and community care.** Communications barriers are a serious issue affecting all aspects of a patient's journey and often causing failed discharges. Staff from both acute and community settings felt that:

a) **Well-resourced and visible in-reach nurses** (nurses with a community background working in the hospital and attending board rounds to identify patients for discharge to community teams) could help bridge the communication gap, provided they have adequate resources, visibility and recognition in the hospital;
b) **Regular meetings between DNs and discharge teams** in the hospital could ensure hospital staff are familiar and up-to-date with community pathways and provision;
c) **Compulsory training for junior doctors** (not just junior GPs) with community teams would ensure medical staff can gain an understanding of different roles in the community;
d) Organisations should consider reinstating **rotations across acute and community**, also as part of staff's early training, particularly for roles such as OTs and Physios. Rotations can help staff gain a better understanding of the whole pathway and address the issue of silo-working;
e) **Collaboratives** for similar roles across acute, community and social care could help staff gain a better understanding of different roles and whole care pathways, as well as building relationships of trust across different parts of the care system;
f) Providers and commissioners should **support existing forums/ spaces/ peer-learning meetings** that can encourage dialogue and reflections among different roles/ teams involved in the same pathways (e.g. TH's Discharge Forum) and assess how they can help staff develop new ones where needed.

2. **Horizontal integration** (multiprofessional teams across health and social care). Co-location is not enough to facilitate more integrated care and support the change towards more holistic and patient-centred care. Staff suggested that commissioners and management from provider organisations should:

a) Work with frontline staff to find ways to enable and support **trusted assessment** across health and social care professionals, by aligning organisational guidelines and priorities and embracing a culture of learning rather than blaming.;

b) Support staff to plan **joint visits** and **assessments** (e.g. DNs and therapies; healthcare professionals and social workers) to help them develop a more holistic approach to care and build mutual trust;
c) Enable and support **distributed leadership** that, as demonstrated by the growing success of the palliative champion schemes, can be instrumental in embedding new practices and raising awareness though peer-support and training;
d) When co-locating social workers in a healthcare team or vice-versa, make sure you learn from previous failed experience of co-location, in order to support staff and ensure sustainability. Previous efforts (across WEL) often failed because:
   - high staff turnover and poor handovers affected reliability and mutual trust
   - a lack of capacity meant social workers were no longer very visible within the healthcare team they were originally allocated to
   - co-located staff were not able to access their own data system or support and advice from their colleagues and they gradually relocated to their own organisation's office
   - having different management lines created tensions within the co-located team
   - staff from different organisations, even when co-located, continued to work in silos.

Concluding thoughts: to achieve positive and sustainable organisation change frontline professionals should be on the driving seat

Overall **commissioners might want to work more closely with frontline staff** before making decisions about service (re)development and team reconfigurations to gain a better understanding of whether/ what changes are needed and agree a feasible timeline that takes account of capacity and resources on the ground. There is a tendency to make decisions over reconfigurations of new teams and services by relying mainly on numbers of referrals to these services over a short period of time as the main measure of success, without a full analysis of what the implications and unintended consequences might be for frontline staff (and hence for patients). Frontline professionals often feel change is imposed on them and there is a general perception that changes to services are introduced to mimic other organisations without enough understanding of the local context. This affects staff's morale and decreases their commitment to change.

Some of the most interesting examples of organisational development to improve coordination, dialogue and collaboration were led by frontline staff. These are good cases of distributed leadership, where professionals on the ground are successfully addressing, on their own initiative, tangible needs.

- **Discharge Forum** – monthly meetings to discuss complex discharge cases across roles and organisations that take place at the Royal London and involve staff from the hospital, community services, GPs, social workers, and the voluntary sector (Age UK);
- **Palliative champions meetings** organised by lead nurses in different localities in Tower Hamlets to raise awareness about palliative care and end of life pathways and strengthen joined-up working, with designated palliative champions in each team taking responsibility over training colleagues.

The six principles identified by the literature on organisational change management in healthcare (**Align vision and action**; **Make incremental changes within a broader transformation strategy**; **Foster distributed leadership**; **Promote staff engagement**; **Create collaborative interpersonal relationships**; **Continuously assess and learn from cultural change**) should underpin any new change programme. As recognised by this literature, a bottom up approach takes longer and might be more complex, but it will increase the chance of sound and sustainable implementation.