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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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Newham findings ONLY

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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 focuses on findings from Newham. 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.

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. Some locum staff have been in the same role for some time and they are well integrated within their organisation, but mostly where there were high numbers of locums we also found higher turnover, which can affect relationship-building and commitment towards shared long-term goals.

6. **Frontline professionals' efforts to foster dialogue and create connections**
   There is much work, often on the initiative of frontline professionals, on **creating connections 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. This relationship is 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;
- Broken 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).

Access to EMIS (the data system used by GP practices) for locality teams in Newham has made a positive impact. The switch from RIO to EMIS has happened relatively recently and using shared records is still a learning process. Newham's Extended Primary Care Teams (EPCTs) staff mentioned that GPs did not always check records before referring a patient, in part defeating the purpose of a shared system.

Unlike other RR services in WEL, Newham's Rapid Response Team (RRT) has developed as a multidisciplinary community health team, where patients can also self-refer. The service is well recognised and the team has seen referrals increase by over 70% in the past year. 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. Co-location of the RRT in the East Ham Care Centre may help explain their stronger relationship with EPCTs based there compared to the Vicarage Lane teams.

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.

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. As one community nurse from Newham put it, "*It's like an oil-tanker that takes six miles to stop. That's how big the NHS is, so if you change something you've got to give it time to happen*".

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 but, where this role exists, it often has limited capacity. Limited influence of in-reach nurses in Newham hospital has led Newham's Rapid Response Team to redeploy their in-reach staff to a different project, training nursing and residential homes.

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 across all three boroughs:

- **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);
- **A lack of awareness of EOLC among GPs**.

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. Newham's Peer-learning OT meetings) 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. 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 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 can decrease their commitment to change.

Some of the most interesting examples of organisational development to improve coordination, dialogue and collaboration were led by frontline staff:

- **OT Collaborative in Newham** – senior OTs across organisations in the borough meet every three months to discuss borough-wide issues;
- QI initiative led by BHT and ELFT's EPCTs to flag and discuss failed discharges.

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.

Contents

1. 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. The programme includes nine partner organisations:

- Newham, Waltham Forest and Tower Hamlets Clinical Commissioning Groups (CCGs)
- Barts Health NHS Trust
- North East London Foundation Trust (NELFT)
- East London Foundation Trust (ELFT)
- London Borough of Newham (LBN)
- London Borough of Waltham Forest (LBWF)
- London Borough of Tower Hamlets (LBTH)

These partners agreed to come together to build a model of integrated care that looked at the whole person – their physical health, mental health and social care needs. They agreed a common set of principles which continue to inform their approach to integrated care and aimed to provide nine key interventions, underpinned by five components and enablers.

A two-year qualitative evaluation of WEL was carried out between September 2014 and August 2016 (Eyre et al. 2015; 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 were set up, a deep chasm remained between strategic thinking and operational delivery. Since the publication of the WEL evaluation report (Eyre et al. 2016), there has been less emphasis on integrated care work at cross-borough level. The WEL Integrated Care programme was subsumed within the Transforming Services Together (TST) programme in 2015. TST was established in September 2014 to improve the local health and social care economy in Newham, Tower Hamlets and Waltham Forest, in line with the challenges set out in the NHS Five Year Forward View, local and regional plans and guidance. TST aims to deliver improvements in productivity and ensure the quality of urgent and emergency care across the health economy, as well as helping the local system to cope with significant anticipated growth in demand over the next 5-10 years. The focus on integrated care has somehow been weakened and local authorities have been less involved in this programme.
Following the development of the TST strategy, NHS England mandated the establishment of STPs (Sustainability and Transformation Plans). An STP is a plan to achieve sustainability across a geographical 'footprint'. STPs are not new statutory bodies and supplement rather than replace the accountabilities of individual organisations. Seven boroughs across Northeast London formed the North East London (NEL) STP, now renamed the East London Health and Care Partnership (ELHCP).[1] The ELHCP is still

developing, with the most recent set of plans being submitted at the end of March 2017. It has recently set up a board with an independent chair.

Within this crowded policy context, and in light of the fact that there is limited work under the WEL programme,[2] the researchers and stakeholders agreed to focus on borough-level work on integrated care across the WEL geography. The aim 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 persisting gap between strategic thinking and operational delivery highlighted by Eyre et al. (2016). The focus is on understanding organisational change, assess current organisational development work and identify frontline staff's organisational development needs.

In particular, following scoping work (May-August 2017), it was agreed the study would look at specific pathways to understand collaboration patterns within and across multidisciplinary teams from acute, community and social care. **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 case studies to assess the level of horizontal (across different roles/ teams within either community or acute) and vertical (looking at the whole pathway and collaboration between acute and community) integration/ coordination.

This work addresses three interlinked research questions:

1. What are the barriers and enablers that frontline staffs are encountering in trying to deliver more integrated and coordinated care?
2. What organisational development is supporting them and how?
3. What are frontline staff's organisational development needs and how could these be addressed?

A table in appendix summarises the methods, detailing participants, sample size and recruitment.

In this report we present findings from Newham only. However, many of the findings are common to all three WEL boroughs and there is scope for joint actions, in particular to address issues of vertical integration (acute-community).

1.1 Newham

Newham is establishing a Newham Provider Board to support the creation of a provider partnership, encompassing providers across health and care, which will be include commissioners and providers of acute, community, mental health, social care and primary health services, represented by the following organisations:

- Bart's Health NHS Trust (BH)
- East London Foundation Trust (ELFT)
- London Borough of Newham (LBN)

- Newham Health Collaborative (NHC)
- NHS Newham Clinical Commissioning Group (NCCG)

There exists a commissioner-provider forum which has met a few times, and Newham is looking to formalise this as the Newham Provider Board.

This Board will work alongside an Alliance Board (once established) covering the whole system-level delivery in Newham. Various working groups have been set up to deliver schemes. Early priorities include:

- Building on MSK (musculoskeletal) alliance framework already in place and lessons learnt to be incorporated in subsequent service developments;
- Procurement of urgent care services as the next building block with a competitive tender planned from September 2017;
- A formal gateway assurance process for structured collaboration for community services.

An Associate Director of Joint Commissioning has been successfully appointed to further align the health & social care commissioning functions for Mental Health, LD, CHC and Children's services. This role will overlook joint strategic procurement plans and aims to ensure development of joint strategies and implementation.

2. Findings

This section presents findings that have emerged from participant observations and interviews with frontline professionals from acute, community, and social care in Newham involved in the three pathways under study (22 one-to-one and group interviews with members of staff in different roles). We carried out a broad thematic analysis that would help us develop an understanding of how pathways of admission avoidance, discharge from hospital and end of life care happen on the ground and how multidisciplinary teams function and collaborate. The aim is to assess the degree of vertical (between acute and community) and horizontal (multiprofessional teams/ health-social care) integration on the ground and identify staff's organisational development needs and suggest OD strategies that can support them. There have been a number of important strategic developments at the governance level across all WEL sites; however, on the frontline level – which is the focus of this work – similar themes, challenges and opportunities have emerged across all pathways and in all three boroughs.

Initial findings were further refined and interpreted with frontline teams participating in the study.

Fieldwork has unveiled organisational fragmentation, which inevitably affects collaboration and coordination, increasing risks of overlap and duplication. Staff have shared a number of recent cases from their professional experience, which reflects recent empirical literature, whereby patients are forced to navigate a myriad of health and social care teams, having to repeat their stories to many different health and social care professionals, and often experiencing long gaps between services

without being given relevant information about next steps. Staff often mentioned delays in transfer of care due to finding places in care homes. The residential care market has been under pressure due to increasing regulation and the national living wage.

Within a stretched system where teams are often understaffed there is limited time for staff to keep up with the fast pace of organisational change; understand and properly take advantage of new roles and services; and work on developing more collaborative routines.

Six overarching themes emerged strongly across all three boroughs and pathways:

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. The lack of understanding of community provision among ward staff is one the issues interviewees often mention when discussing failed discharges. Examples of patients discharged without the required medication/ equipment were often cited, as well as cases of inappropriate or missed referrals to community teams. Intermediate care roles that might help bridge this gap (i.e. *in-reach nurses*, or nurses with a community background working in the hospital) need more resources and visibility in order to perform their role effectively.

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. The social workers we interviewed often perceived healthcare professionals as risk-averse, while they saw their own role as promoting independence. In contrast, healthcare professionals felt that social services' decisions were increasingly influenced by limited resources. Research participants also recalled examples of patients refusing care packages even when they needed support, because of the stigma attached to social services or simply because they were unwilling to pay towards the care package. Interviews unveiled a belief among healthcare professionals that social workers "give up too easily" when a patient referred to them refuses social care. If these patients need support but do not receive it, it is often DNs that "pick up" the pieces and have to carry out care tasks when they visit them (i.e. buying some milk, tidying up the patient's home, or personal care were often mentioned). By the same token, social workers felt that health practitioners' understanding of needs was underpinned by a paternalistic or overprotective culture. Understanding how to enable health and social care staff to negotiate these different cultures and pressures when working together will be crucial to support implementation of integrated care on the ground.

3. **Managing patients' expectations**
   Fear of **complaints** is a recurrent theme in the interviews with healthcare professionals. It is difficult to embrace change and have a less risk-averse approach in a context where patients

and, more often, their families are quick to file in complaints that might reflect poorly on competing organisations. **Further discussions with some frontline professionals helped us unpack this issue. The problem would seem to stem from patients having unrealistic expectations because of miscommunication between professionals (particularly between acute and community staff) and a lack of understanding of community provision and what different roles do, with hospital staff at times "promising" services that cannot be delivered in the community.** For instance, interviewees mentioned several instances in which upon discharge from hospital patients were promised that a district nurse (DN) would visit immediately or that they would have immediate access to care, equipment and medication which could not be provided promptly outside hospitals. Other professionals, often in different care settings and organisations, were then left to manage their patients' frustration.
Some interviewees felt that organisations often played a "blame game", rather than fostering a learning environment.

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. In the case of Extended Primary Care Teams (EPCTs) in Newham for examples proximity of nurses and therapies (OTs and Physios) has helped staff have more direct communications (and faster internal referrals), but it is not always making their approach to care more holistic and integrated. Joint assessments and visits of district nurses and therapists within the same EPCT do not happen as often as some staff would like. This might be due to different professional cultures as much as to logistics, as DNs cannot plan visits in the same way as therapies do.[3] A discussion on initial findings with one of the EPCT teams unveiled that joint visits and assessments of nurses and therapies are not necessarily a regular occurrence but do happen whenever needed. This might mean that some teams are developing more effective ways of managing staff's time and coordinating joint assessments.

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. Locums are often paid more and some interviewees currently employed as locums mentioned that they feel this might raise expectations from permanent staff that they should do tasks that the latter might not want to carry out themselves. Locums tend to be more experienced practitioners (higher Band) so they are often expected to be highly efficient (e.g. less induction time required) and more reliable (i.e. they will tend to take less sick leave etc.). Some locum staff can be in the same role for some time and they are very well integrated in the organisation, but mostly where there were high numbers of locums we also found higher turnover, which can affect relationships and commitment towards shared long-term goals. As new services (i.e. Rapid Response) tend to have more flexible criteria, it can be harder for professionals in temporary positions to adapt to

and fully embrace the new ethos and work practice. In Newham, the Rapid Response team (RRT) is made of almost entirely permanent staff. The RRT management has invested in training and staff development, which has led to a close-knit and effective multi-professional team.

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. Some permanent health practitioners also do "bank shifts" with others teams working in the same borough (e.g. RRT's physio working with EPCTs). Covering different roles in the system allows staff to informally transfer information about other services.

In the rest of this section we first describe each pathway and identify the teams involved, describing how they work together, what is improving, and what the key challenges are. In each case, we first briefly set the context, based on recent policy documents and strategies. In Section 3 we identify staff's organisational development (OD) needs and share suggestions from frontline professionals on what OD strategies could help them move towards more integrated care.

2.1 Looking at pathways: Admission Avoidance

Much of the work around integrated care centres on reducing non-elective admissions, through developing risk-stratification tools to identify high-risk patients and services that can respond to urgent calls in the patient's home. The literature to date has not found much evidence of the effectiveness of risk-stratification tools (see literature review in full report). Rapid response teams play a key role in recent admission avoidance strategies. A Rapid Response team delivers unplanned care and urgent care services in the patient's home to avoid hospital non elective admissions. The RR team provides a rapid assessment and immediate treatment and represents an alternative to hospital admission when acute episodes of care are required that can be managed within the community, where clinically appropriate.

Unlike other RR services in WEL, Newham's Rapid Response Team (RRT) has developed as a multidisciplinary community health team, where patients can also self-refer. The service is well recognised and the team has seen referrals increase by over 70% in the past year. RR service's flexible inclusion criteria can at times generate confusion about the boundaries of the service and raise expectations from DNs in community teams that RR would regularly respond to patients that should normally be on EPCTs' caseload (e.g. wound dressings; unscheduled DN visits). Co-location of the RRT in the East Ham Care Centre may help explain their stronger relationship with EPCTs based there compared to the Vicarage Lane teams, with whom dialogue is less seamless. See Table 2.1 for a comparison of RR services across WEL.

Another central role is played by EPCTs. These generally include district nurses and therapies (OT and physios) and Care Navigators. These are non clinicians supporting complex adults and helping them navigate the health and social care system, ensuring they get the required support to attend hospital

appointments and have access to the benefits and care they are entitled to. Their role is increasingly embedded in the system and both DNs and GPs have come to rely heavily on them as a bridge between different professionals and the patient.

Interviews with EPCTs staff revealed their expectation to have social workers co-located with the team but this is not happening. However, conversations with management highlighted that the agreement to have co-located social workers only concerned the Virtual Ward pilot (led by community matrons), which was terminated following an audit highlighting overlap with the RRT. It was agreed that resources would be diverted to the RRT, including one dedicated social worker that would be based at the East Ham Care Centre where the RRT sits. During fieldwork it emerged that the social worker does no longer appear to be co-located there or is hardly very visible. EPCTs and RRT staff agree that having dedicated social workers for each team would be really beneficial.

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

- Limited resources, particularly within social care, following drastic cuts to local government;
- 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 for DNs;
- Broken communication between EPCTs, GPs, and social workers, whereby it takes time 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);
- The switch from RIO to EMIS for community services has happened only recently and using shared records is still a learning process. Newham's EPCT staff mentioned that GPs did not always check records before referring a patient, in part defeating the purpose of a shared system.

One positive aspect that was often mentioned was the multidisciplinary approach of the locality teams, where therapies and nurses are co-located. Some participants felt they still worked in silo and opportunities to carry out joint assessments and visits were not as frequent as they would like, but sitting next to each other and being able to refer patients to each other directly was a positive development. There is also 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.

Table 2.1 – *Rapid Response service in each borough*

Rapid Response Teams	**Tower Hamlets**	**Newham**	**Waltham Forest**
Hours	0800-2000 7 days a week, including Bank Holidays	0800-2000 7 days a week, including Bank Holidays	24 hours service

Staffing	Usually 4 Nurses (including prescribers) and a therapist on each weekday shift (includes triage nurse) Works closely with PRU service (see TH's map below)	1 Band 8 and 4 Ban 7 nurses (all prescribers); 5 Band 6 nurses; 1 Band 6 physio; 1 Band 6 OT (locum); 1 part-time GP; 4 geriatricians from Newham Hospital (part-time or ad hoc support)	14 permanent staff: ✓ Prescribers from both hospital and community background; ✓ Health Care Assistants; ✓ Admin
Service description	✓ Based at Mile End hospital; ✓ All referrals triaged by a nurse; ✓ Most referrals via SPA; ✓ Following clinical triage, response made within 2 hours	✓ Co-located with east Ham Care Centre's EPCTs; ✓ All referrals triaged by a nurse (RRT also staffs SPA for the whole borough); ✓ Response within 2 hours for urgent referrals; ✓ Patients on caseload for two weeks or more from referral; ✓ Support residential homes	✓ Based at Woodbury Unit, next to Whipps Cross Hospital's Urgent Care Department; ✓ Clinical triage 20 minutes from receipt of referrals; ✓ Response within less than two hours for very urgent referrals/ 2-12 hours for less urgent ones; ✓ Out of hours palliative care and nigh sitting; ✓ Out of hours 111 calls; ✓ Support patients for up to 3 days; ✓ If patient known to service, undertake visit if care plan requires review; ✓ Support residential homes

Map of Admission Avoidance Pathway in Newham

Admission Avoidance Pathway in Newham

What roles are involved and what do they do?
What works?
What can be improved?

Barts Health Trust
East London Foundation Trust
GP
London Borough of Newham
Voluntary sector

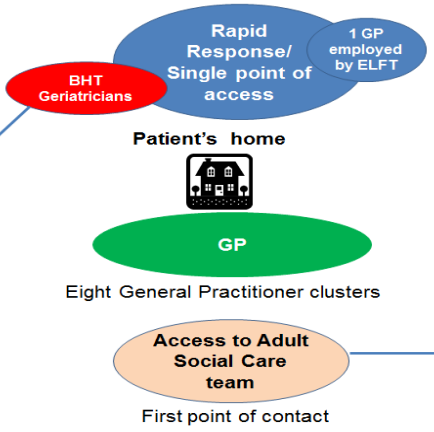
UCL

Services and Teams

Rapid Response Team

- 8am-8pm 7 days per week service that provides rapid assessment and treatment of acute episodes within a patient's home – typical referrals UTI; blocked catheter; falls
- Patients should be medically stable and resident in Newham/ registered with GP
- Referrals from health and social care professionals, such as GP's, hospitals, care homes and social services; patients can self-refer
- Response within 2 hours for urgent referrals
- Onward referrals as appropriate
- Patients on caseload for two weeks or more from referral
- Clinical triage – 1 RR nurse in charge of triaging all referrals to Single Point of Access through to appropriate community services
- Multidisciplinary team (1 Band 8 and 4 Band 7 nurses – all prescribers; 5 Band 6 nurses; 1 Band 6 physio; 1 Band 6 agency OT; 2 in-reach nurses initially based in hospital – since July 2017 redeployed to train care homes as part of pilot project) supported by 1 part-time GP; 4 geriatricians from Newham Hospital
- Based in East Ham Centre and working closely with EPCTs located there

The Barts Health Trust **geriatrician role** within the RR team was initially envisaged to be full time but that has not translated into practice. **Two geriatricians** regularly work with the team: one for two full days a week; one on Mondays but cannot always guarantee presence because of high levels of hospital workload following weekends; two more consultants offer support on *ad hoc* basis.



Extended Primary Care Teams (EPCTs)

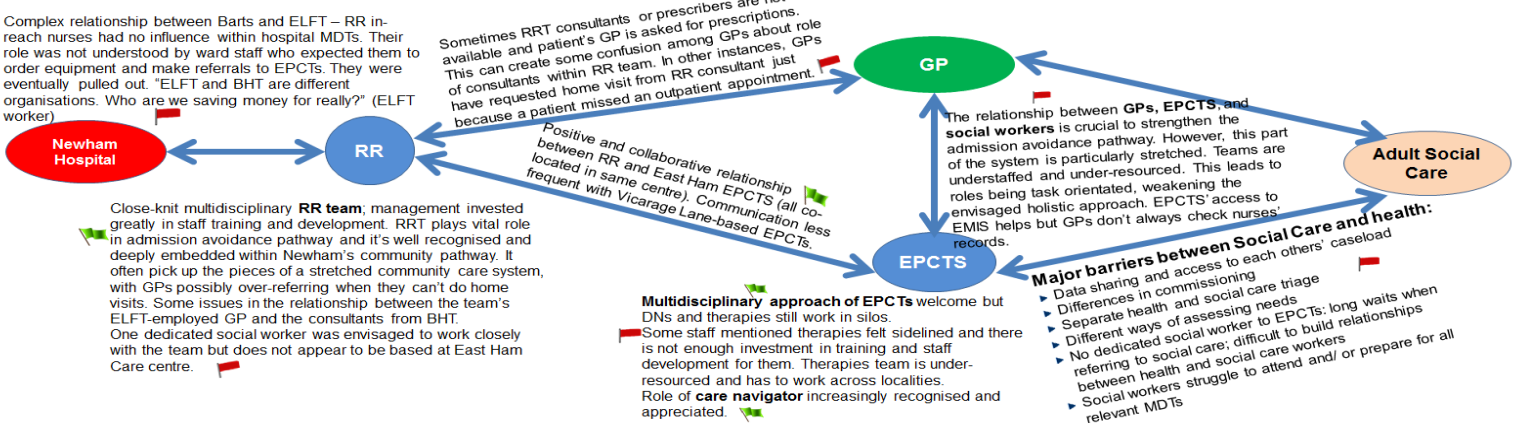
- Cover four localities incorporating eight General Practitioner clusters in Newham
- Each team led by a Clinical Team Leader (Band 8) and consists of lead nurse, lead OT and Physio (Band 7) and District Nurses, Community Health Care Assistants, Occupational Therapists, Physiotherapists, Rehabilitation Support Workers, Health and Care Navigators
- Work directly with and support local GP networks
- Initial assessment and day-to-day workings of community health/ supported by borough-wide specialisms
- Work in conjunction with St Joseph's Hospice Palliative Care Team to provide end of life care
- Treat and support adults with complex needs and those with specific time-limited interventions – housebound patients only
- Provide care coordination and case management
- Referrals from health and social care professionals, such as GP's, hospitals, care homes and social services

Enablement team

- Referrals from Access to Adult Social Care team
- Provide help with regaining independence or reducing /delaying care and support needs
- Split into statutory function/ care management that sits within hospital service (1 social worker, 1 OT, and social care officers) and a provider service
- Free service for up to six weeks (under Health fund)
- Restructured to remove the care management team and externalise provider service
- Plans to add one OT and one physio to current team

Admission avoidance referral pathways

All referrals to community services go through the **Single Point of Access** (SPA). One Rapid Response team nurse sits on triage Monday to Friday. Referrals are not always appropriate because of knowledge gap of available community provision, but having a dedicated clinician with in-depth knowledge of community services to assess and triage all referrals guarantees greater efficiency with no referral lost in the system.



A case of admission avoidance

Patient, 91 years was referred to RRT by GP to avoid possible hospital admission. Patient had had cold/cough SOB for 5 days and was on antibiotics, Holistic assessment was undertaken by RRT. The patient did not want to go into hospital and wanted to remain at home where possible. Urine analysis was positive for infection and the RR nurse suspected a UTI infection.. A sample was collected and sent to the lab along with the bloods for the GP to review. The COE consultant who supports RR recommended commencing a cephalosporin as patient was allergic to penicillin. Current antibiotic was not covering the UTI. The GP who referred the patient was also contacted and was told about the outcome of the visit and the need to change the current antibiotic to the new one. She prescribed the antibiotic and the patient was asked to commence the course on receiving the medication from the pharmacy.
The RR nurse reviewed the patient 72 hours post commencing the antibiotic, monitoring any further deterioration during the weekend. The patient was discussed in the MDT with the COE consultant who also reviewed her antihypertensives which was making the patient have a postural drop with her blood pressure readings. RRT was able to do a medication review and the consultant recommended the GP should prescribe some different medication. Good communication between the RR nurse, the consultant and the GP ensured the patient was treated appropriately in her own home.

Admission Avoidance in Newham – Key findings

- The Rapid Response Team (RRT) in Newham has developed as a multidisciplinary community health team, where patients can also self-refer. The team has access to the medical support of a GP that sits with the team and geriatricians from Barts Health Trust on a part-time/ ad hoc basis. Cultural and professional differences between the GP and the geriatricians have at times generated some tension.
- The RRT also manages the SPA with 2 RR nurses sharing a full time role triaging all referrals to community services. According to staff, having a clinician doing the triage centrally reduces the risk of referrals getting lost in the system.
- Co-location of RRT with the East Ham Care Centre's EPCTs ensures greater collaboration and understanding of each other's role; close proximity to EPCTs might also help explain how the RRT developed into a community-based role. The service is well recognised and the team has seen referrals increase by over 70% in the past year. The dialogue with the teams based in Vicarage Lane appears to be less seamless; this might be due to a lack of proximity compared to the East Ham Care Centre-based EPCTs. The RR service was initially implemented in these localities only and later rolled out to the rest of the borough, which might mean the other EPCTs will now need longer to understand and use the service adequately.
- There appears to be some degree of confusion among GPs about the role of consultants within the RRT and the service more generally, as they tend to over-rely on it and expect RRT's consultants to carry out GP visits and write prescriptions on their behalf.
- EPCTs expected to have social workers co-located with the team but this is not happening. However, conversations with management highlighted that the agreement to have co-located social workers only concerned the Virtual Ward pilot (led by community matrons), which was terminated following an audit highlighting overlap with the RRT. It was agreed that resources would be diverted to the RRT, including one dedicated social worker that would be based at the East Ham Care Centre where the RRT sits. During fieldwork it emerged that the social worker does no longer appear to be co-located; instead social services are trying to optimise their limited capacity by having social workers attend relevant MDTs only.
- EPCTs and RRT agree that having a dedicated social worker co-located in the team would be really beneficial, since communication with social services is currently difficult.
- Many among healthcare professionals mentioned difficulties in getting access to social workers in the community and highlighted how different approaches to assessing needs may also affect communication. DNs recalled several instances when they had referred patients to social services and, if the patient refused admitting a need with the social worker, this was too easily accepted by social services (with the initial assessment often done over the telephone only), even where the patient's needs were, in the nurse's opinion, self-evident. Participants in the study felt unaddressed social needs would more than occasionally lead to hospital admission.
- Here, as in Tower Hamlets, the role of care-navigator, albeit increasingly challenging due to patients' complexities, is recognised and appreciated.
- Some EPCT staff felt there was decreasing investment in staff development beyond compulsory/ internal training and that this was affecting staff's morale.

2.2 Looking at Pathways: Discharge from hospital

The discharge pathways are particularly complex in all three boroughs. While there is much focus on Delayed Transfers of Care, with Barts Health Trust supporting consultant-led projects such as **Perform**[4] 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. Physios across the three boroughs have mentioned that increasingly patients are being discharged when "medically fit" but still needing high levels of reconditioning rehabilitation which community teams might be not able to deliver.

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. However, the Discharge Team at Newham Hospital, which deals with complex discharges, was praised by many participants. This team and the social workers' in-hospital team are co-located and have developed a good relationship which translates into efficient and timely complex discharges. An interesting QI project co-led by BHT and ELFT has started in Newham in early 2018.[5] EPCTs often raised complaints about poor discharges but Newham Hospital argued that its discharge process was very effective. The QI initiative involves EPCT staff keeping track of any discharges they would consider poor and discussing them in monthly meetings with Newham Hospital's Discharge Team.

Increasingly separate acute/ community careers and limited opportunities for rotation are deepening the barrier between the hospital and community services. 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 but, where this role exists, it often has limited capacity. In-reach nurses often do not have enough resources to appropriately cover all wards and attend all relevant MDTs. Furthermore, while in rhetoric their role is very much appreciated by hospital nurses in particular, in practice they seem to have limited visibility and influence in board rounds and often lack adequate work space. Limited influence of in-reach nurses in Newham hospital has led Newham's Rapid Response Team to redeploy their in-reach staff to a different project, training nursing and residential homes.

Community services undergo frequent reconfigurations and new services are introduced. Most recently Newham introduced the Hospital to Home (H2H) service (based on the Discharge to Assess (D2A) model - see Table 2.2 for a comparative description of D2A services across WEL).[6] These changes are not always adequately communicated and understood across the system and the pace of change is often perceived to be too fast. As one community nurse from Newham put it, "*It's like an oil-tanker that takes six miles to stop. That's how big the NHS is, so if you change something you've got to give it time to happen*". The perceived efficiency of the Discharge Team and the lack of clarity about the remit of H2H could help explain the scepticism that many participants expressed about the need of this new service in Newham. Unlike the other two WEL sites, H2H is led by LBN rather than the CCG, but some participants felt that closer collaboration between LBN and the CCG would ensure the team had a clearer understanding of patient cohorts and available funding. At the time of fieldwork this service was still at pilot stage. The effective embedment of these new services within a complex and highly regulated

system such as the NHS requires time and there is ongoing work to develop a dialogue between different acute and community actors working in the hospital. At Newham's hospital weekly evaluation meetings supported the development of the H2H service throughout the pilot stage, bringing together social, acute, community care staff and voluntary actors such as Age UK. It is too early to assess the effectiveness of these efforts at building and sustaining dialogue but they are a testament to the growing awareness that sustainable organisation change has to be owned and led by frontline professionals.

In Newham a collaborative of senior OTs (usually band 7 upwards) across acute, community and social services meet every three months to discuss any borough-wide issue and the minutes of the meetings are distributed to all OTs. Borough-wide PLOT (Peer Learning for OTs) meetings used to take place regularly, but, according to participants, there has not been one for the past year. These meetings were open to all OTs in Newham and were led by senior OTs in Social Services. Initiatives of bottom-up dialogic OD such as these are worth understanding better and supporting more, as they have the potential to be most effective at enabling staff to move towards more collaborative and coordinated work.

Table 2.2 – *Discharge to Assess (D2A) service across WEL*

D2A	Tower Hamlets	Newham	Waltham Forest
Hours	8am-6pm 7 days a week, including Bank Holidays Rapid Response and AADS therapies (Intermediate Care Team) work 8am-8pm so they would cover D2A patients if required	9am -5pm, with RRT completing welfare checks over the weekend for patients discharged on Friday	9am-5pm 5 days a week/ moved to 7 days with Winter money (but few referrals at the weekend)
Staffing	Social workers, nurses, OTs, physios, Reablement SWs (the AADS team as a whole has 39 staff, mainly locum)	✓ 1 social services OT, 2 social workers; ✓ Rapid Response provides nurses and physio Recently new roles were recruited (funded by social services): ✓ Band 7 agency nurse ✓ Band 3 Rehab Support Worker to support patients with Physio/rehab needs	✓ NELFT: 2 Band 6 OTs; and 2 Band 7 Physio (including 1 team lead); 3 Band 3 rehab assistants/ 7 days cover: 1 Band 6 OT and 1 Band 6 Physio ✓ LBWF: 1 social worker; 1 senior reablement officer; 1 OT; 1 rehab assistant
Service description	✓ Screeners take and triage referrals from	✓ Currently pilot under evaluation;	✓ Led by NELFT working closely with

	wards and in-reach nurses; ✓ Dedicated SW arrange same day care package; ✓ Reablement team provides majority of care packages; ✓ Patients on caseload for up to 6 weeks	✓ Also referred as Hospital to Home; ✓ Led by LBN; ✓ Dedicated SW arrange new care packages within 48 hours or double up care packages for significant change in patient's functions; ✓ RR nurse to visit patient at home 2/3 hours from discharge ✓ Enablement service provides majority of care packages; ✓ Patients on caseload for up to 6 weeks	Reablement – nurse support from Rapid Response; ✓ Reablement package starts on day of discharge ✓ Reablement team provides majority of care packages ✓ Patients on caseload for up to six weeks

Map of Discharge Pathway in Newham

Discharge pathways in Newham

What roles are involved and what do they do?
What works?
What can be improved?

Barts Health Trust
East London Foundation Trust
GP
London Borough of Newham
Voluntary sector

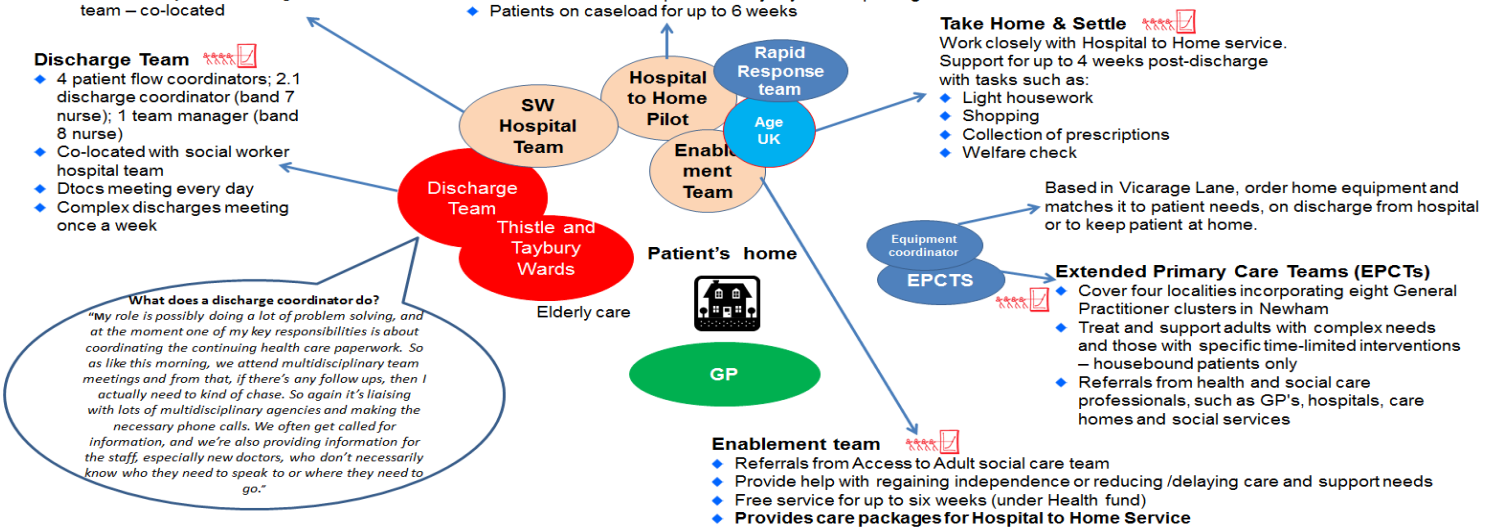
UCL

Services and Teams

Hospital to Home pilot (H2H)
- Facilitate discharges of patients with rehab potential as soon as medically optimised
- Led by social services/ focus on social care needs
- Team includes 1 social services OT, 2 social workers
- Recently recruited roles: Band 7 agency nurse; Band 3 Rehab Support Worker
- **Rapid response** team provides nurses and physio. RR nurse to visit patient at home 2/3 hours from discharge
- Dedicated social workers arrange new care package within 48 hours or double up care package for significant change of functions
- **Enablement service** provides majority of care packages
- Patients on caseload for up to 6 weeks

Hospital Team
- 14 social workers; 1 team manager
- Work closely with discharge team – co-located

Discharge Team
- 4 patient flow coordinators; 2.1 discharge coordinator (band 7 nurse); 1 team manager (band 8 nurse)
- Co-located with social worker hospital team
- Dtocs meeting every day
- Complex discharges meeting once a week



Take Home & Settle
Work closely with Hospital to Home service. Support for up to 4 weeks post-discharge with tasks such as:
- Light housework
- Shopping
- Collection of prescriptions
- Welfare check

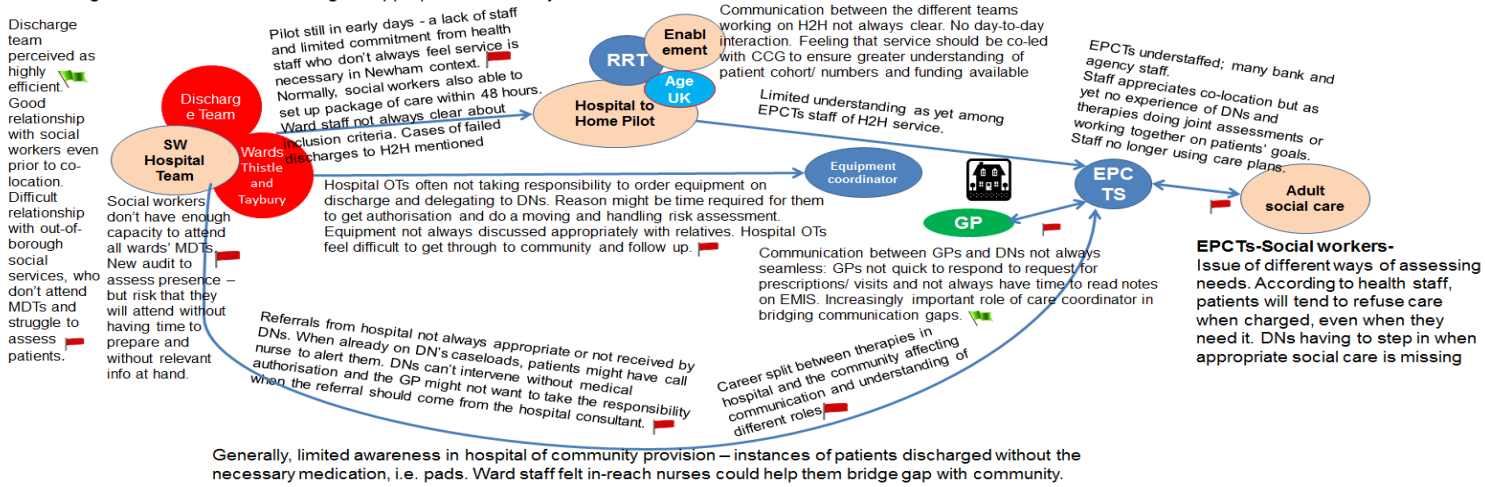
Based in Vicarage Lane, order home equipment and matches it to patient needs, on discharge from hospital or to keep patient at home.

Extended Primary Care Teams (EPCTs)
- Cover four localities incorporating eight General Practitioner clusters in Newham
- Treat and support adults with complex needs and those with specific time-limited interventions – housebound patients only
- Referrals from health and social care professionals, such as GP's, hospitals, care homes and social services

Enablement team
- Referrals from Access to Adult social care team
- Provide help with regaining independence or reducing /delaying care and support needs
- Free service for up to six weeks (under Health fund)
- **Provides care packages for Hospital to Home Service**

Discharge referral pathways

All referrals to community services go through the **Single Point of Access** (SPA). Rapid Response nurse triage all referrals and send through to appropriate community service.



EPCTs-Social workers- Issue of different ways of assessing needs. According to health staff, patients will tend to refuse care when charged, even when they need it. DNs having to step in when appropriate social care is missing

Generally, limited awareness in hospital of community provision – instances of patients discharged without the necessary medication, i.e. pads. Ward staff felt in-reach nurses could help them bridge gap with community.

CASE STUDY – helping patients regain independence. The patient had a fall and had lost confidence and was the first case to be referred through the H2H. She was deemed medically fit to go home, went home, all the services were put into place and Rapid Response went in. She left the ward with four calls initially double handed, and within the first three days she was reviewed to see how she was doing. It was felt that she could benefit from the enablement pathway. So she was referred to the Enablement team who [acting as a broker] provided the carers to carry out hands on care. The social work team wanted a review and felt she could benefit from enablement to help her regain independence. Following an assessment, it was agreed she only needed one carer. The four calls a day were reduced down to three. At first she was a bit anxious about going down to three calls. By week 2 of being with the enablement service she was already growing in confidence, so the service was reduced down to two calls and, following a new assessment, to 1 call. At the end of her six weeks intervention with the enablement team she has actually gone on with no support. [Enablement team]

Clash of professional cultures in the hospital

R1: Everyone needs to be mindful that the Care Act… you know, it's an Act, it's statutory, it states three days [for discharge]. As we know with statutory changes, it takes quite a while for any service to adjust themselves to that. I mean we do appreciate… A hospital environment is a very different environment to the community services for example, and having that three day period is challenging depending on what's going on in the hospital and the pressures they have to experience. I totally understand that, you know? And this is where it kind of goes out of our hands.

R2: See, with the section 2s before it used to be any person that comes onto the ward they'll do an automatic section 2. Now we're having problems trying to get a referral, because it's like chasing and chasing…

R3: I think they've got into the culture of, 'This person is going to probably need a care package, let's do a section 2,' because the section 5 they'll just do whenever. So they've got into their own culture and we're trying to feed into this culture that's already developed.

[*Group interview with social workers*]

Discharge Pathways in Newham – Key findings

- **The Discharge team at Newham Hospital and the social workers' in-hospital team** are co-located and have developed a good relationship (some mentioned this predated co-location) which translates into generally efficient and timely discharges.
- The efficiency of the Discharge Team might be the main reason behind the lack of enthusiasm from health staff in backing the new **Hospital to Home** (H2H) pilot (using the D2A model). Unlike the other two boroughs where the discharge to assess service is led by the CCG, in Newham LBN is piloting it. At the time of fieldwork, the team included social workers and one social services' OT, and it relied on the Rapid Response team for nursing and physio input. Since fieldwork, a Band 7 agency nurse was recruited (funded by LBN) to carry out visits Monday to Friday. The decision was taken by social care staff and was not supported by their healthcare colleagues who felt the RRT was able to provide the required support. This is an example of the difficulty in developing shared vision and understanding of needs across different organisations. LBN also recruited a Band 3 Rehab Support Worker to support patients with Physio/rehab needs. This decision was also perceived as questionable by healthcare professionals who felt that a very small number of patients being referred to H2H require a Physio assessment and many lack any rehab potential. There is a feeling among staff that the service should be co-led with the CCG to have a better understanding of patient cohorts and numbers. Weekly evaluation meetings at Newham Hospital bring together the H2H team; the RRT, including the geriatricians; the Enablement team providing reablement packages; the hospital's Discharge Team and social workers. However, attendance at the meetings is low, and this is symptomatic of a general perception that the service does not add value to what already provided in Newham. The H2H service takes about 48 hours to set up a care package (not necessarily faster than what already offered in the hospital) although the team feels that with increased capacity they could speed up the process. The service is in its early days but interviewees across the pathways mentioned cases of failed discharges, which show some degree of confusion about appropriate referrals to the service. Recent conversations with staff revealed that over time discharges through H2H have improved.
- Issue of **a lack of capacity of the SW in-hospital team**, who struggle to attend all the relevant board rounds. An audit was being carried out at the time of fieldwork to assess SWs' presence at MDTs. However, attendance might not help if SWs do not have the time to prepare beforehand.
- Similarly to the other two boroughs there are **communication issues between acute and community**, causing missed referrals to DNs; patients discharged without the required medication (e.g. pads are often cited by interviewees with DNs) etc.
- One example of the persisting barrier between acute and community is the case of in-reach nurses in Newham Hospital, who were unable to embed and have any influence on the ward. The RRT therefore made a decision to redeploy them as part of a new training project targeting six nursing and residential homes to increase awareness in caring for complex adults and improving understanding and usage of services such as RR and LAS. The project has proved successful in providing an increased level of support to Nursing Homes and their residents, as well as levering increased support from other health and care professionals such as therapists, pharmacists and geriatricians.
- Because of a lack of therapies' capacity in the hospital, **few ward OTs carry out home assessments** and tend to delegate equipment orders to community teams who might not know the patient and will need to undertake further assessments. One of the reasons might be the time required for hospital OTs to get authorisation and carry out a moving and handling risk assessment.
- There exists an **OT collaborative** in the borough that could help strengthen understanding of community pathways/ provision and different roles. Staff have suggested that similar collaboratives could also be set up for other roles, such as physios, who, since the end of rotations across acute and community are experiencing increasingly separate careers.

2.3 Looking at pathways: End of life care

EOLC covers patients who are expected to die, including those with advanced incurable conditions; those with general frailty and co-existing conditions; those with existing conditions who are at risk from dying due to a sudden crisis in their condition; and life threatening acute conditions caused by sudden events such as accident or stroke (NHS Choices 2013). However, there is great variation not only in practice but also in the literature in terms of definitions, particularly in relation to time. Quality of EOLC clearly depends on cooperation across different services and organisations, across and health and social care, but there appears to be a gap in the literature on integrated care for dying patients and their families. A model of integrated care may benefit from elements present in successful care pathways: the inclusion of educational components; the presence of a coordinator; and the support of senior staff and management.

Recently the variation in quality of care at the end of life has become a point of national debate and in 2015 the National Palliative and End of Life Care Partnership published a national framework for local action that puts forward six main ambitions for 2015-2020 (see figure on the right). The three WEL boroughs are all strengthening collaborations across stakeholders to work on these six ambitions. 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.

When fieldwork began there was cross-borough work on EOLC under the TST programme. This work has now being subsumed under the East London Health and Care Partnership (ELHCP), within an EOLC OD programme dedicated to developing an EOLC strategy. Participant observations at meetings and informal conversations with some of the actors involved highlighted some concerns about the risk of

diluting the work carried out under TST and weakening commitment to working closely across the three WEL boroughs. The ELHCP OD programme involves 7 different boroughs and a wide range of stakeholders, making agreement on targeted actions more challenging.

Table 2.3 – *Key issues of EOLC pathway in the WEL area*

KEY ISSUES ACROSS WEL

- 4000 deaths per year across WEL
- Bottom 3 out of 211 CCGs
- Inequity in service provision and patient outcomes
- Gaps in access to community specialist palliative care and district nursing services across the CCGs
- Limited access to end of life care medication out of hours.
- New BHT's strategy to deliver safe and compassionate care

In Newham an EOLC steering group was co-led by LBN and the CCG and the first meeting took place in September 2017. However, meetings stopped in February 2018 and it is unclear whether they will continue.

Barts Health Trust has recently signed off an EOLC strategy to set up a dedicated Trust board and steering group. There is therefore a lot of work happening, although different organisations/ boroughs often continue to work in a disjointed way.

Overall, many interviewees agreed that some important conversations need to happen about:

- Linking up Integrated Care and EOLC programmes, which have surprisingly been kept separate;
- Rethinking the concept of EOLC where "uncertain recovery" might prove more helpful, in light of growing numbers of elderly frail people, whereby an EOL stage is more challenging to identify compared to terminal conditions such as cancer;
- Who should take responsibility for patients' End of Life Care (i.e. having clear conversations about options to help patients make viable and informed choices etc.)? Many agrees it should be GPs, but most often this is not happening;
- 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;
- Developing the concept of Hospice at Home to help shape better integration of services and guarantee 24/7 access to care and advice.

Below we summarise the main findings.

- **Task-orientated approach to care** both in hospital and the community affects identification of end of life patients;
- **There is a lack of consistency of EOLC provision in the community**. One interviewee in Newham commented:

[Y]ou will have a District Nurse in one area who knows a palliative patient is coming out and will put in care and support. Yet in another area you get them saying 'No - it is Social Care'. So Social Care go in, and until that patient needs a syringe driver or something needs that intervention...only at that point will they put a District Nurse in.

- Some interviewees mentioned that regular Gold Standard Framework[7] meetings should be essential for district nurses to attend;
- **Filling in fast-track forms can still be a challenge** for busy ward staff, as well as GPs, which might delay the process. Nurses and medical staff tend to rely on specialist teams in the hospital or community palliative care teams. However, the latter often have limited capacity and should be focusing on more complex issues and symptom control. Furthermore, they might not have the required knowledge of patient needs to fill in the form properly, as the professionals caring for them would. By the same token, some DNs mentioned that what would work best from their perspective would be to have the professionals that first identify a patient as EOL taking ownership of the fast-track process and ordering equipment, rather than delegating to others, which inevitably requires further assessments causing unnecessary delays;
- There is concern about a loss of community beds and access to respite centres, e.g. in Newham Fothergill Ward (EOLC) and Cazaubon Unit (intermediate care rehab) have been recently merged;
- There is still limited awareness of need for and capacity of **therapies for EOLC patients** (specialist palliative OTs);
- Generally, frontline professionals in the hospital and the community feel there is a lack of awareness of EOLC among GPs;
- There are some efforts to improve awareness and more coordinated delivery of care. For instance, DNs in Newham and Tower Hamlets have **weekly palliative meetings** with St Joseph's specialist nurses to discuss patients.

Map of End of Life care in Newham

End of Life Care pathway in Newham

Barts Health Trust
East London Foundation Trust
GP
London Borough of Newham
Voluntary/ Charity sector

Services and Teams

BHT Specialist Palliative Care team
- Multi-professional team: 2 part-time consultants, 2 specialist nurses (Band 7), 1 team leader (Band 8) 1 palliative social worker; 1 psychologist; chaplaincy; **1 EOLC facilitator** to support and train staff (recently appointed)
- Work across the whole of Bart's Health, four acute hospitals and the community team in Waltham Forest
- Gives specialist advice about symptom control and psychological and social support to patients, families, carers and staff
- Expert support in bereavement for families and carers

Marie-Curie nurses
Provide one-to-one nursing care and support (i.e. overnight) in the home, usually for eight or nine hours.

Barts Health Trust Specialist Palliative Care team

Palliative social worker

Marie Curie nursing service

St Joseph's Hospice Community Palliative Care Team :
Provide clinical guidance and supportive care on social, emotional and spiritual matters:
- clinical nurse specialists (CNS)
- occupational therapists
- physiotherapists
- social workers
- specialist doctors
- counsellors/chaplains

The hospice also offers:
- In-patient wards (34 beds for short stay – i.e. two weeks)
- Respite
- Day hospice
- 24/7 support line

Works closely with Fothergill providing medical advice and regular visits from CNs

St Joseph's Community Palliative Care Team

There's always an illusion that conversations have been had
The patient is always in assumption you are seeing me because you know what my GP has already done for me. So that illusion of conversation and communication has been received, but yet... (Specialist nurse)

Fothergill Ward

- Based at East Ham Care Centre
- Provide continuing and respite care to Newham residents age 65
- Fast-track discharges from Newham hospital
- Referrals from EPCTs
- Merged with Cazaubon Unit offering intermediate care/ rehab/ loss of beds

Patient's home

GP

EPCTS

Adult social care

- GPs and district nurses in charge of care at home and take responsibility for prescriptions
- Working closely with St Joseph community palliative care team
- Some practices run Gold Standard Framework monthly meetings but DNs not able to attend regularly

End of life action plan to be delivered with CCG:
- Set up EOLC steering group
- Identify and train palliative champions
- Establish champion network
- Provide training to social care workers and domiciliary care managers

End of Life Care Pathways

Fast-Track process in Newham hospital

➡ **Discharge to Fothergill Ward -** After confirmation of eligibility, the EOLC Co-ordinator Continuing Healthcare Team - Community Health Newham passes the forms to the Continuing Care Team / East Ham Care Centre who liaise directly with the family and the ward

1. Fast Track forms completed by the medical team with support from Palliative Social Worker (SW)
2. SW completes section with specifics of proposed care package following discussions with patient (i.e. if they have capacity), significant others (family / friends) and at MDT
3. SW submits forms to EOLC Co-ordinator Continuing Healthcare Team - Community Health Newham to confirm eligibility
4. SW contacts care agencies to identify a provider who has capacity for proposed care package
5. SW completes form to request care package providing details of the input required, costings and provider. This is submitted to the Continuing Health Care Manager for approval
6. Once the care package is approved, the SW liaises with the ward, patient, care agency, family members, friends and other professionals to facilitate the discharge and commence the package of care
7. A risk assessment is required by EOLC Co-ordinator Continuing Healthcare Team - Community Health Newham within 2 weeks of discharge
8. Changes to the care package (increases etc.) are the responsibility of the SW for 6 weeks post discharge as long as the patient remains at home
9. The case is handed over to EOLC Co-ordinator Continuing Healthcare Team - Community Health Newham 6 weeks post discharge

➡ The process for **Out of Borough** discharges is as above except the forms are submitted to the appropriate team in the relevant borough.

Communication issues between the hospital palliative specialists and the community

I would say I... we do get more response from St Joseph's instantly, we don't get a response or confirmation from the District Nurses. Sometimes we do, sometimes we don't. GPs we hardly ever hear anything back from them saying 'Oh I went to visit a patient as per your request." (Specialist nurse 1)

There is no handover from the community back into the acute Trust.[…] The whole emphasis is to make sure that we hand that over going that way, but actually if somebody is coming back in then there is problems; you have no communication […] I mean in an ideal world you would all have the same access to the same database and the same records. But I guess the frustration is there is so much emphasis on our documentation out, but nobody ever mentions that handover back in. So almost you need a patient held passport, that the patient keeps. (Specialist nurse 2)

So you send someone home, they've just come from hospital, […] you know they're end of life but you send them home with no end of life care drugs. Now there in the community it will now take me up to two days to get the drugs. The drugs need to be ordered […] we only recently in the last four years or so have a chemist that has end of life care drugs, and they open up until midnight. In Newham we didn't have any place that had end of life care drugs. And as a professional if you go in and this patient has no drugs, you have to find the drugs, you've got to get the drugs for them. That then takes more of your time because you can't leave them now. (Community palliative care team)

Night sitting

This last week I did a fast track… up to four times a day you can get visits to see someone, but you need night sitters. […] I requested night sitters and the continuing care nurse then said to me, 'Well you know, it's difficult. Maybe you should offer them a nursing home?' She doesn't want to go to a nursing home. They said, 'Yeah, but the commissioners probably won't agree with the night sitters.' I said, 'Well she can't stay at home if she doesn't have night sitters. […] She has capacity; she doesn't want to go to a nursing home.' What do you do? So in fact you don't have a choice because the services are not set up for that, and then you've got your Marie Curie sitters. You would only get two weeks of Marie Curie sitters, and you request a Marie Curie nurse… with all the good will in the world they try, but you request a Marie Curie nurse and they'll say to you, 'No, I don't have anybody for the next three nights. The next person I have is Tuesday night,' but that doesn't help me. If I request for you tonight and you tell me you only have somebody for Monday night, how does that help me between now and Monday? (Community palliative care team nurse)

End of life care in the community: who takes responsibility?

So my reason that I cc in the District Nurse and the GP is to inform them that this patient will be followed up and it will be reviewed by the Palliative Care team in the community for specific reasons, symptom control, psychological and psycho-social issues, so we are only letting them know. But it is not for them to assume that the palliative care nurse is fully responsible, and solely responsible for that patient and that... (Specialist nurse1)

At the minute you've got GPs who believe that we do all the care. So when you call a GP and say, 'Can you go and please visit Mrs Smith?' 'No, I'm not going.' End of conversation. 'Because she's under palliative care.' "Yes she is, we complement the care, but we don't take over the care you're still responsible for Mrs Smith.' (Community palliative care team nurse)

I think in a way it should be the GP [to take responsibility] because they are the constant aren't they, everybody... 99.9% people have got a named GP. […] Yet a lot of complaints that we get will be from GPs that say they have not been kept up to date. They get very upset when they don't know what is going on with their patients. But with that information comes a level of responsibility, and I think we get that wrong. We don't sort of force the issue that actually the GP is the accountable person. Well actually the patient is the accountable person if they have got capacity; and they [should] work in partnership with their GP (Specialist nurse 2)

End of life care in the community: a lack of consistency

I do feel that the understanding of who cares for people at End of Life is so variable across different nursing practices because you will have a District Nurse in one area who knows a palliative patient is coming out and will put in care and support. Yet in another area you get them saying 'No - it is Social Care'. So Social Care go in, and until that patient needs a syringe driver or something needs that intervention...only at that point will they put a District Nurse in. So that compounds that [EOLC] being task orientated. And I have... When I worked in the community I used to hear people all the time from the acute trust saying 'Put a syringe driver up, because at least if we put a syringe driver up that will make the District Nurse go in". (Specialist nurse 2)

3. Organisational development: what has been done and what is still needed

There has been some investment in OD programmes to support organisation change across WEL. TST funded an OD programme in 2016 to support culture shift, but this was quickly closed down, possibly because of a lack of commitment to cross-borough collaboration among commissioners and providers.

More recently the East London Health and Care Partnership (ELHCP) has invested in two pilot OD programmes focusing on specific workstreams, including End of Life Care. The ELHCP's OD work has only recently started and is beyond the scope of this evaluation.[8] Instead, here we look at programmes that were implemented at borough-level based on partnerships between health Trusts and local authorities, with the aim to support integration and coordination across health and social care. Our focus is on the impact of these programmes on frontline staff involved in the three pathways under study. While transformation boards with dedicated task and finish groups involving cross-organisational partnerships have been set up in all three boroughs to work on specific aspects of care delivery, most of this work focuses on the governance/ strategic level. OD work targeting frontline staff generally consists of staff engagement events and away days, with most organisation change at this level based on project management and QI initiatives. Although feedback on these events was always positive, interviewees identified a number of issues:

- **Limited bottom up involvement of frontline staff in shaping the focus and the agenda of the events**, while often a large chunk of time was allocated for senior management's contributions;
- **Consultation fatigue**, with too many meetings, workshops with unclear goals and outcomes; not always relevant to frontline's staff day-to-day challenges;
- **A feeling of frustration** after attending several workshops and consultations and offering input on similar issues each time, without seeing any concrete developments or follow-up on their suggestions.

Some participants felt that **more investment in staff development**, beyond compulsory and internal training, would be welcome.

3.1 Insights from the frontline

As current OD work is not effectively supporting staff to move towards more integrated care, interviews elicited insights from frontline professionals on what would help them.

Participants felt they needed more targeted training and embedded and ongoing support to develop more collaborative working practices. For instance, **coaching sessions** targeted at frontline staff could involve whole teams over longer periods, as training only a few individuals for half a day, in a context of high staff turnover and high numbers of locum staff, weakens the impact and sustainability of any OD activities. Given the impracticality of having whole teams attending structured coaching sessions at the same time, coaching programmes could be developed with frontline staff and tailored to their needs and working routines.

From all parts of the system and across all three boroughs, several interviewees mentioned:

- **A knowledge gap** about community provision and community pathways which affect referral pathways, potentially leading to duplication, overlaps and patients falling through the cracks.

Many called for

- **More targeted communication** about changes to services, perhaps with teams organising visits to talk about new roles and functions, and by establishing **more direct channels of communication** between teams working regularly together on the same pathways (i.e. not just through SPA);
- **Rotations** or spending time with different teams to help bridge the gap between different roles across acute and community, although many raised the **issue of limited capacity to release staff for OD activities**;
- Developing and/ or strengthening (where existing) **collaboratives** for roles that exist across acute, community and, in some cases, social care (e.g. OTs), but work in silos. Collaboratives can help staff address the challenge of separate acute/ community careers which are exacerbating fragmentation. For instance, borough-wide PLOT (Peer Learning for OTs) meetings, which used to take place regularly, could be revived. These meetings were open to all OTs in Newham and were led by senior OTs in Social Services. Staff have suggested that similar collaboratives could also be set up for other roles, such as physios.
- Enabling joint **assessments and visits** of DNs and therapies, or health and social care practitioners could help develop mutual understanding (and mutual trust) of each other's pressure and priorities and encourage **trusted assessment** across different roles and teams. This might also help staff to have a more holistic approach to patient care;
- Several interviewees suggested fun activities to build team spirit and mutual trust - see interview excerpt below.

Staffing pressures inevitably weaken sustainable organisation change and represent a barrier to some of the suggestions above. Recruitment and retention of staff remain huge challenges across all care settings. This means that organisations are more cautious about releasing staff to support service improvements and organisational development activities.

3.2 What happens when frontline professionals take the initiative?

Some of the most interesting examples of organisational development to improve coordination, dialogue and collaboration were led by frontline staff. These initiatives are often a good example of diagnostic and dialogic OD (see literature review in the full report for a definition), where staff recognise a clear problem to be addressed and try to change both behaviours and thinking through cross-disciplinary and ongoing dialogue:

- **OT Collaborative** – senior OTs across organisations in the borough meet every three months to discuss borough-wide issues;

- **Rapid Response team** addressing the issue of in-reach nurses unable to perform their role in the hospital by redeploying them to care homes to train carers and help reduce hospital admissions;
- QI initiative led by BHT and ELFT's EPCTs to flag and discuss failed discharges.

4. Conclusion

We refer to the categories developed by Cameron et al. (2013) (see also Cameron and Lart, 2003) - **organisational, cultural and professional, and contextual** – to summarise the findings described above. We use these categories to identify barriers and enablers on the two levels of integration we examined: vertical (acute-community), and horizontal (multiprofessional teams/ health-social care). Table 4 summarises key enablers and barriers.

Table 4 – Enablers and barriers of vertical and horizontal integrated care

Integrated Care: Enablers and Barriers	**Organisational**	**Cultural and professional**	**Contextual**
Enablers: Vertical integration/ acute-community care	○ Continuous efforts to build collaboration/ shared visions across organisations at governance level	○ Quality Improvement initiative to strengthen dialogue between acute and community staff (current QI on failed discharges from Newham Hospital)	○ Strong national rhetoric in support of coordinated care and accountable care systems (i.e. urgent care; EOLC)
Enablers: Horizontal integration/ health-social care	○ Efforts to align commissioning and frontline delivery ○ Co-location of CCG and Local Authority in Stratford	○ Work on developing/ strengthening **distributed leadership**, often on the initiative of frontline staff ○ Increasingly recognised and valued role of **care navigators**	○ Strong national rhetoric supporting integrated care and integrated care systems
Barriers: Vertical integration/ acute-community care	○ Fragmented system with different trusts increasingly focusing on different parts of the system (i.e. either acute or community) and having different priorities and pressures (i.e. "your saving, my loss" mind-set)	○ Increasingly separate careers between acute and community (affecting therapies in particular) ○ Knowledge gap in acute sector of community provision/ roles	○ All parts of the system understaffed/ stretched ○ Difficulty in recruiting and retaining healthcare professionals ○ High turnover of staff ○ Complex and ever changing community pathways: new services take time to embed within complex, highly fragmented and regulated system

	○ A lack of facilities – offices and working computers (i.e. to accommodate community staff such as in-reach nurses in the hospital)		
Barriers: Horizontal integration/ health-social care	○ No functional integration (IT)	Co-location is not integration/ hampered by: ○ Different management lines ○ Different organisational pressures ○ Different cultures	○ Cuts to social care ○ High turnover of staff weakens efforts at building relationship of mutual trust

The literature on organisation change identifies six guiding principles to support implementation (Willis et al 2016 - see section 2). Here we attempt to summarise how Newham have been using these strategies.

1. **Align vision and action**
   While there is much work (with varying degrees of success) on aligning vision across organisations and developing implementation plans, **communication to frontline professionals has been piecemeal, with limited understanding among frontline staff of planned changes and reconfigurations.** This contributes to exacerbating the gap between strategic vision and action. Frontline staff could be best placed to help commissioners understand potential unintended consequences or existing barriers that can jeopardise the implementation process.
   OD work could include activities and coaching targeted at frontline professionals in ways that are sensitive to existing contextual values and beliefs, with the aim to foster a sense of legitimacy and ownership of the change ahead. One example would be giving multiprofessional teams the formal authority to make changes, the ability to allocate resources, expertise needed to channel both the process and content of change. Empowering staff to embrace risk in a culture of learning rather than blaming may well prove crucial to building mutual trust and encouraging people to move beyond narrow role boundaries. Risk aversion appears to be a challenge to culture change as the need to get 'permission' from someone in authority can be a barrier to progress.

2. **Make incremental changes within a broader transformation strategy**
   Investing in incremental change can ensures that the range of activities needed to generate system-wide cultural transformation reflect the actual capacity of the organizations and systems.

3. **Foster distributed leadership**
   Distributed leadership has emerged at times among professionals on the ground that have taken the lead to help strengthen dialogue between teams across different organisations working on the same pathways. Giving frontline professionals with complementary skills the resources, space and authority (and targeted coaching where needed) to take the initiative is a key ingredient towards implementation of change in a way that is sustainable. Frontline professional are best placed to understand the day-to-day challenges of working collaboratively and with the right support and resources they can drive actions that help them address these challenges.

4. **Promote staff engagement**
   Across all three boroughs, there has been limited staff engagement to date. Staff often do not feel listened to and do not feel they have much influence on the change process, such as in the case of service (re)design. Future work on OD should focus on involving frontline staff in a more active way. Some suggestions were highlighted in the previous section.[9]

5. **Create collaborative interpersonal relationships**
   There has been some work on promoting collaboration and raising awareness of organisational and inter-organisational functional interdependencies (i.e. through collaboratives and QI initiatives). This work should be supported and further strengthened. The issue of high numbers of locums emerged as a problematic one, and participants recognised both positive and negative impacts. Overall, where there are high numbers of locums there is higher staff turnover, which can weaken the process of building sustainable relationships of trust.

6. **Continuously assess and learn from cultural change**
   Health and social care organisations in Newham are investing in research on many levels, from audits to quantitative and qualitative evaluations of various interventions, demonstrating growing awareness of the benefits of formative evaluations and embedded research. The culture of evaluation is often driven by a focus on meeting targets and demonstrating outcomes and accountability, rather than building learning. More resources could be invested in cultural assessments and fostering environments that support learning. For instance, processes to engage staff in collecting and sharing data across teams and organisations, in an open manner, might help foster ownership of the data and reinforce a learning environment based on mutual trust.

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. 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 staff 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.

The six principles discussed above should underpin any new change programme. As recognised in the literature, a bottom up approach takes longer and might be more complex but it increases the chance of sound and sustainable implementation.

5. Recommendations to commissioners and providers' management

Discussions of these findings with some of the frontline teams involved in the study generated several of important insights from frontline professionals as they reflected on what can help them deliver more integrated care:

- Without more staff and resources it is a challenge to commit to genuine and sustainable organisation change, as understaffed teams just about manage to "firefight". Cutting resources in a context of increasing demand is the big elephant in the room: is it time to be resistant to cuts rather than resilient?
- Functional integration (sharing data systems across acute, community and social care) is crucial to improve communication and deliver more integrated care.
- Health and social care integration requires joint commissioning and pooled budget; current progress towards co-location will not be sufficient and might be difficult to sustain in the long-term, without one management line and strong alignment, in terms of financial priorities as well as visions and goals. At the moment universal access to healthcare vis-à-vis means-tested social care is a barrier to attempts to joint needs assessments. Different organisational priorities, guidelines, and pressures can also exacerbate difficulties.
- Participants mentioned the issue of fewer carers on the ground as demand continues to rise.
- Rigid role boundaries can hinder holistic care. In particular, healthcare professionals in the community felt GPs should take more ownership of EOLC patients. Across all boroughs both DNs and specialist nurses often mentioned a lack of the required awareness and knowledge of EOLC among GPs.
- Generally, staff across all part of the care system felt people should take more ownership and not delegate to other roles as much as it currently happens.

Based on these reflections and the findings presented in the report, we list two main sets of recommendations that address 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;

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 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;
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. PLOT meetings for OTs) 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;
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 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
    - co-located staff were not able to access their own data system or support and advice from their colleagues, which meant that 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, often continued to work in silos.

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APPENDIX

Methods and participants

Method	Stakeholder/ participant group	Description	Sample size	Period	Recruitment
Documentary analysis	n/a	Relevant policy documents (i.e. urgent care; end of life care)	n/a	May 2017-March 2018	n/a
Participant Observation at relevant meetings	Senior and middle management and frontline professionals	Observation of relevant meetings/ workshops/ training events/ evaluation meetings. Field notes of discussions were used as a source of data throughout the evaluation	n/a	May 2017-February 2018	Key meetings were identified with the help of CCGs and provider organisations. The researcher had an agreement with stakeholders to be invited to all new/ ad hoc workshops/ events, as part of her Researcher-in-Residence role.
Participant observations of frontline staff's organisational routines	Frontline professionals from acute, community and social care; voluntary sector	The researcher spent between 1 and 4 full days with each team to understand their service and patterns of collaboration within the team and across teams involved in the same pathway.	**TH:** • AADS; • 2 CHT (Community Health teams) currently being reconfigured as EPCTs (Extended Primary Care teams); • Adult social care CHT; • Reablement team; • Social workers in-hospital team; • Royal London's nurses/ consultants • RL's Complex Discharge Team • St Joseph's community palliative care team **Newham:** • Rapid Response team • 2 EPCTS • Home 2 Hospital team • Newham Hospital's Discharge team • Social workers in-hospital team • Enablement team **WF:** • Rapid Response team • 1 ICT (Integrated Care Team)	October 2017-January 2018	Teams willing to take part in the study were identified during the scoping phase.

			• Whipps Cross Hospital's Integrated Discharge Team (including social workers in the hospital team) • Reablement team • Complex social care team Other teams/ professionals were also included in the study, by way of semi structured interviews: • Barts Health's palliative care team (1 consultant; 3 nurses; 1 social worker) • Margaret Centre, Whipps Cross • Age UK		
Semi-structured interviews	Frontline professionals; voluntary sector	Interviews elicited in-depth understanding of working routines; patterns of collaboration within and across teams; organisational development needs.	**82** frontline staff, ensuring a mix of roles from all the teams/ organisations mentioned above	October 2017-January 2018	Potential interviewees were approached before and during fieldwork with teams.

NOTES

[1] The new partnership covers 7 boroughs: Barking, Havering & Redbridge, City of London & Hackney, Newham, Tower Hamlets, Waltham Forest.

[2] Although its development seems to date unclear, in autumn 2017, partners proposed an over-arching framework for the 'WEL Delivery System' in the context of developments at both borough and STP level, which were perceived as an opportunity to refresh the purpose of collaboration at WEL level and assess benefits and opportunities. WEL DS would build on existing shared strategies and work programmes, including: shared analysis of future demand and demographic pressures and a system-wide response through better management of demand, prevention and more efficient use of resources; the TST programme, which has agreed consistent strategic interventions that are being implemented across WEL, including redesign of outpatients, urgent care pathways, end of life care, maternity services, and diagnostic services; WEL-wide enabling work on information technology and interoperability, estates and workforce. Waltham Forest, Newham and Tower Hamlets are working collaboratively to deliver the ambitions set out in the *Digital Road Map*. The three boroughs appear to be 'on track' to link up their main operating systems by 2019. The East London patient record (eLPR) already exists and will be continuously developed over the next 18 months to support the sharing of resident-centric information across the health and care economy.

[3] Each team naturally has several nurses vis-à-vis a small number of OTs and physios, who can at times feel side-lined when strategic decisions are made.

[4] This is a PWC-led project to address Delayed Transfer of Care (DTOC) or bed-blocking by changing the approach to board rounds in the hospital and using whiteboards as a way to communicate more clearly across staff and keep track of patients to be discharged, to identify and address potential causes for delays. I carried out my fieldwork at the Royal London about two months after the end the six weeks training. Some of the wards included in the study, such as the 14th floor (Elderly care) were included in the project. During the six weeks implementation, as staff were closely followed by PWC trainers who facilitated the board rounds, progress was being made, but based on informal conversations with staff and observations at board rounds several weeks after the end of the project, it appeared that staff were no longer, or not consistently, using the tools learnt during the project. Staff seemed to point to "firefighting-like" working conditions as well as staff turnover as the main reasons behind the failure to new working practice taking hold.

[5] This initiative was not covered by fieldwork for this study, which had already been completed when the QI project started.

[6] A D2A team facilitates faster discharge of medically fit patients and provides therapy and social care assessment in the patient's home. The team provides ongoing support (up to 6 weeks) to increase level of function and independence.

[7] The Gold Standards Framework (GSF) is a model that enables good EOL care practice. It is not a prescriptive model but a framework that can be adapted to local needs and resources. It enables teams to build existing good practice and strengthen coordinated care with a more patient-centred focus.

[8] The OD programme on End of Life Care is led by Staff College, an independent charity dedicated to developing health and social care leaders. The aim of their work is to support the East London Health and Care Partnership, (ELHCP) in developing key priorities and strategies to meet those priorities. The focus is on building relationships, team cohesion and leadership capability. Interventions follow two formats: 1. Intensive one day team development programmes for the work-stream teams to understand the stakeholders involved and some of the key challenges and areas of development; 2. a series of half-day development sessions to be held every two months for a year. Each session has a central development theme, identified by the participants and facilitators, with some theory and models used to support the team's understanding. An example of a theme could be 'trust:' how organisations can build trust between their members; how they can break trust; and the impact of doing/not doing this has on teams.

[9] Patient engagement is beyond the scope of this work, but that is definitely a gap that needs addressing in the context of the patient-centred care rhetoric.