LONDON'S GLOBAL UNIVERSITY

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

---

Tower Hamlets findings ONLY
June 2018

Researcher in Residence: **Sonia Bussu (UCL)**

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

Executive Summary

Background

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

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

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

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

Findings

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

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

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

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

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

3. **Managing patients' expectations**

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

4. **Multidisciplinary ethos**

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

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

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

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

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

Key themes for each pathway

Admission Avoidance

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

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

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

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

Discharge from hospital

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

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

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

End of Life Care

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

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

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

- **A task-orientated approach to care** affecting identification of end of life patients;
- **A lack of consistency of EOLC provision in the community;**
- **Filling in fast-track forms still seen as a challenge** that professionals would rather delegate to others;
- Limited awareness of need for and capacity of **therapies for EOLC patients** (specialist palliative OTs).

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

Recommendations

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

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

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

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

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

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

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

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

- **Discharge Forum** – monthly meetings to discuss complex discharge cases across roles and organisations that take place at the Royal London and involve staff from the hospital, community services, GPs, social workers, and the voluntary sector (Age UK);

- **Palliative champions meetings** organised by lead nurses in different localities in Tower Hamlets to raise awareness about palliative care and end of life pathways and strengthen joined-up working, with designated palliative champions in each team taking responsibility over training colleagues.

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

Contents

Executive Summary 2

1. Background 10

1.1 The Tower Hamlets Together (THT) Vanguard 11

2. Findings 14

1. Barrier between acute and community 14

2. Cultural and organisational differences between health and social care professionals 14

5. Investing in permanent staff can help build mutual trust within and across teams 16

6. Frontline professionals' efforts to foster dialogue and create connections 16

2.1 Looking at pathways: Admission Avoidance 16

Map of Admission Avoidance Pathway in Tower Hamlets 19

Admission Avoidance in Tower Hamlets – Key findings 20

2.2 Looking at Pathways: Discharge from hospital 21

Map of Discharge Pathway in Tower Hamlets 24

Discharge Pathways in Tower Hamlets – Key findings 25

2.3 Looking at pathways: End of life care 26

End of Life Care – Key findings 28

Map of End of Life care in Tower Hamlets 29

3. Organisational development: what has been done and what is still needed 30

3.1 Tower Hamlet's OD programme 30

3.2 Insights from the frontline 32

3.3 What happens when frontline professionals take the initiative? 33

4. Conclusion 33

5. Recommendations to commissioners and providers' management 37

References 38

APPENDIX 40

Methods and participants 40

NOTES i

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 Tower Hamlets 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 The Tower Hamlets Together (THT) Vanguard

There have been a number of important strategic developments across the WEL area, with Tower Hamlets standing out in terms of governance-level progress, commitment to integrated care from all THT partners, and innovative approaches to drive and support organisation change. 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 WEL boroughs, which might indicate a difficulty in translating innovative visions into operational delivery.[3]

The early establishment of the Tower Hamlets Integrated Provider Partnership (THIPP) allowed for the creation of a provider partnership including partners across the health and care system. Following recognition as national MCP vanguard THIPP evolved to form Tower Hamlets Together (THT). The THT Board was established to take forward service design and secure operational arrangements for integrated health and Adult Social Care (ASC) services. This is a partnership arrangement made up of commissioners and providers of acute, community, mental health, social care and primary health services, represented by the following organisations:

The other organisations involved are:

- Local Borough of Tower Hamlets
- Tower Hamlets GP Care Group
- East London NHS Foundation Trust
- Barts Health NHS Trust
- Tower Hamlets Council for Voluntary Service

The THT Board provides a lead for strategic and operational decisions regarding health and social care integration and has set up sub-groups to deliver programmes. The THT Board does not have any formally delegated responsibilities from any of the respective partner organisational boards, however, representatives of each of the respective partner organisations, will represent the views of their organisation on relevant matters. In June 2017, a decision was taken that the THT Board would report to the Health and Well Being Board and the Joint Commissioning Executive (JCE).[4]

A Joint Commissioning Executive was established in June 2016 to provide leadership to deliver:

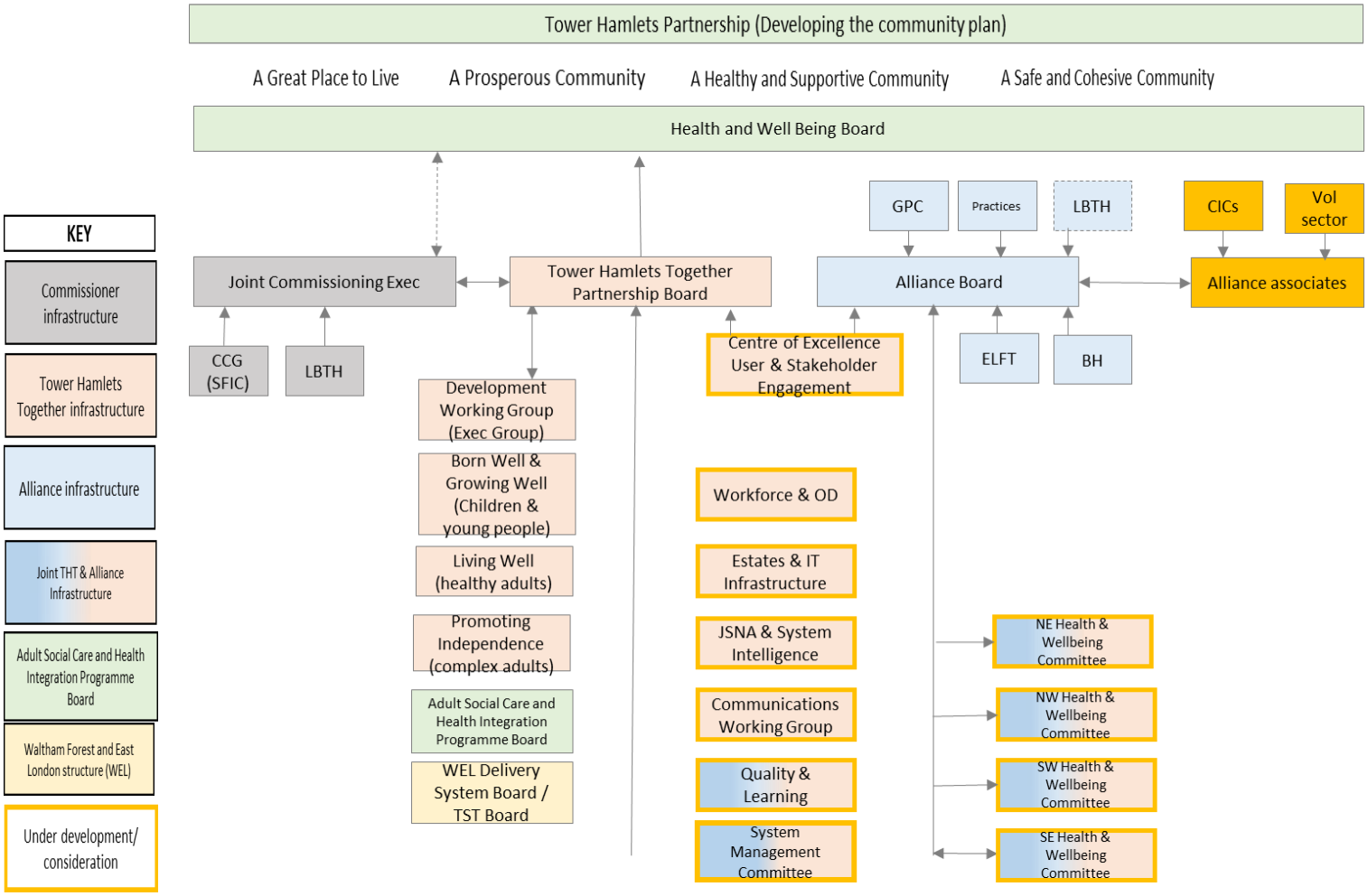
- better alignment of resources across Health, Adult Social Care, Children's Services and Public Health;
- increased joint working, the development of joint strategies, joint commissioning and system changes;
- investment plans, such as BCF (Better Care Fund) and IBCF (Improved Better Care Fund)
- effective oversight and management of market risk and market development;
- more integrated management arrangements headed up by a newly appointed joint Director of Integrated Commissioning.

The JCE reports to the Health and Wellbeing Board and related Delivery Boards, as well as to relevant executive and governing bodies of the LBTH and CCG. It has a formal relationship with the Tower Hamlets Together Board; it oversees the Better Care Fund (BCF).

The current role of THT is set to be enhanced post-Vanguard. The CCG has transferred elements of its governance to allow THT to make system recommendations to the CCG and to ensure that the CCG has appropriate governance arrangements to meet its statutory duties while being a partner of the THT system. Following a procurement exercise of the Community Health Services (CHS), an Alliance contract was awarded in April 2017 to the GPCG, ELFT and Barts Health to deliver key outcomes under a central contract adopting a risk share approach. The scope of this contract is likely to increase over time as

organisations and alliance arrangements mature. The ambition is that the alliance will look to take on more services and might in the future include the Local Authority and Voluntary sector. Figure 3.1 represents the new operating framework in Tower Hamlets. As part of their development, the newly established Tower Hamlets Together lifecourse workstreams (Born Well and Growing Well; Living Well; Promoting Independence) will identify a core set of primary and secondary metrics as a foundation for tracking progress and identifying priorities for action.

Figure 3.1 *THT Operating Framework. October 2018-2019*



2. Findings

This section explores findings that have emerged from participant observations and interviews with frontline professionals in Tower Hamlets (36 one-to-one and group interviews with staff in different professional roles from acute, community, and social care). 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 on the frontline 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.

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, as Tower Hamlets recently moved towards means-tested access to social care. Interviewees 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 would visit immediately or that they would have immediate access to care, equipment and medication that could not be promptly provided outside hospitals. Other professionals, often in different care settings and organisations, were then left to manage their patients' frustration.

4. Multidisciplinary ethos

The **ethos of multidisciplinary work is embraced widely** at least in rhetoric, 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. As Tower Hamlets move towards Extended Primary care Teams (EPCTs), multiprofessional teams that include DNs, therapies (OTs and Physios), mental health nurses, and care navigators, staff can develop more direct communications (and faster internal referrals), but proximity might not always make their approach to care more holistic and integrated. In this respect, Newham's EPCTs might help develop learning for other boroughs. In Newham, EPCTs had different experience of joint working, but in many cases joint assessments and visits of DNs and therapists did not happen as often as staff would have liked. 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.[5] The role of **care**

navigators is seen by many participants as crucial to ensure greater coordination between health and social care as well as improving communication between community teams and GP practices.

5. **Investing in permanent staff can help build mutual trust within and across teams**
   The role of agency staff both in health and social care is one aspect to consider carefully in the context of organisation change and continuous reconfigurations. New services are often entirely staffed with locums because of time-limited funding (i.e. AADS). Time-limited funding can continue beyond the piloting stage and some locums can be in the same role for some time (i.e. Admission Avoidance Team). 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 have been in the same role for a few years and they are very well integrated in the organisation (e.g. Admission Avoidance Team), 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. New intermediate care services (i.e. Rapid Response; Discharge to Assess) 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, and some felt uncomfortable with what they perceived as "unclear criteria". By the same token, replacing locums with permanent staff might require upfront investment in induction and training and might affect short-term performance of the team, if newly recruited staff does not have the same level of experience.

6. **Frontline professionals' efforts to foster dialogue and create connections**
   There is much work, often on the initiative of frontline professionals, on **creating connections, multidisciplinary forums and collaboratives** in order to deliver better and more coordinated care. This work should be understood and supported better. Some permanent health practitioners also do "bank shifts" with others teams working in the same borough (e.g. locality team's physios also working with AADS in TH). 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 then identify the teams involved, describing how they work together and what is improving, and what the key challenges are. In Section 3 we report findings on the impact of current organisational development work on the teams involved in the three pathways. We identify staff's organisational development 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.

TH's Rapid Response team appears to be having a positive impact, often "picking up the pieces" from other parts of the system and making a substantive difference to patients' care. The RR team's flexible inclusion criteria, however, can at times generate confusion about the boundaries of the service and raise expectations from DNs in CHT/ EPCTS teams that RR would regularly respond to patients that should normally be on community teams' caseload (e.g. wound dressings; unscheduled DN visits). See Table 2.1 for a comparison of RR services across WEL.

Another central role is played by locality multiprofessional teams. At time of fieldwork, these locality teams were undergoing reconfiguration from Community Health Teams (CHT) to Extended Primary Care Teams (EPCTs). These locality teams include DNs and therapies (OT and physios), mental health nurses and Care navigators.[6] Care navigators 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.**

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[7];
- 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;
- Difficult communication between community teams, GPs, and social workers, whereby staff often 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).

One positive aspect that was often mentioned was the multidisciplinary approach of the locality teams, where therapies, nurses and care navigators are co-located. However, the shift from CHTs to EPCTs has just started and the learning process might well be long. Newham's experience should be tapped into to gain better understanding of what works and potential challenges. For instance, in Newham, 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. However, 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 Tower Hamlets

Admission Avoidance Pathway in Tower Hamlets

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 Tower Hamlets
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
- Clinical triage
- Response within 2 hours
- Usually 4 Nurses and a therapist on each weekday shift (including triage nurse)
- If required, patients will be referred on to other services after 3-5 days

Physician Response Unit (PRU)
- Partnership between London's Air Ambulance, LAS, Barts Health Trust and ELFT
- Emergency doctors + senior clinician
- 12 hours per day (8am-8pm), 7 days per week
- Treats 8 to 10 patients a day/ mostly complex adults/ frequent hospital attenders/ frail
- Keeps care in the community

- ❑ Rapid Response Team (RR)
- ❑ Admission Avoidance Team (AAT)
- ❑ Discharge to Assess (D2A)
- ❑ In-Reach nurses
- ❑ Seconded social workers

Admission Avoidance Team
- Based in Emergency Department RLH
- Multidisciplinary team (nurses and therapies)
- Operates 9am-7pm
- EPCTS staff can call AAT if patient on way to ED to hand over information
- Community follow up within 24 hours if required
- Out of borough patients assessed in ED

Hospital Team
- 17 social workers, two first response officers, two senior practitioners, a reimbursement officer and a team manager
- Liaise closely with health and other social care services to assess need/ organise care packages

LAS
PRU
A&E
SW Hospital Team

Admission Avoidance and Discharge Services

Multidisciplinary team (nurses – including prescribers - OTs and physios rotate across RR, AAT and Discharge to Assess service; approx. 39 staff, mostly locums)

Geriatrician from BHT
Worked 1 day a week in the community – currently working on frailty clinic only

Community geriatrician

Patient's home

GP

36 practices working in 8 networks. Each localities includes **two GP networks** (four/ five GP practices in each network) and an assigned social worker

Locality Community Health Teams (reconfigured as EPCTS in 2018)

Social workers/ CHT

Community Health teams/ Extended Primary Care Teams (EPCTs)
- Four multidisciplinary locality teams (district nurses, mental health nurses, therapies, care navigators, and staff with clinical management and administration responsibility)
- Work directly with and support local GP networks
- Initial assessment and day- to-day workings of community health/ supported by borough-wide specialisms
- Treat and support adults with complex needs and those with specific time-limited interventions – patients mostly housebound
- Provide care coordination*

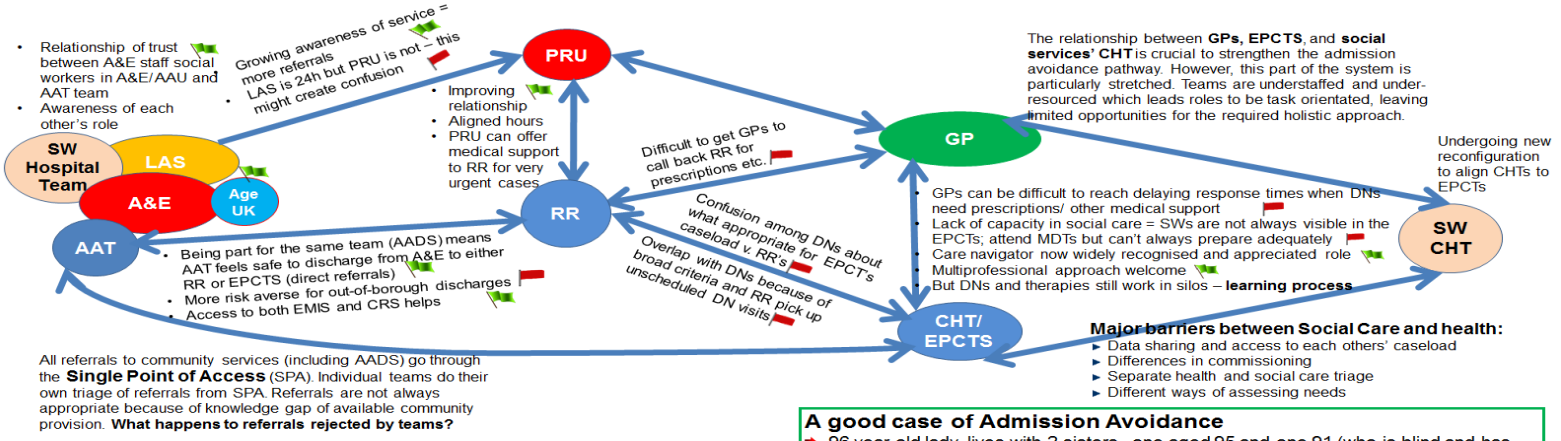
*used to provide case management but no longer capacity, according to staff

Hospital to Home programme
Hub in RL's ED to support admission avoidance of patients with social needs

Age UK

Community Health Team
- 14 SW; 2 senior practitioners; 1 hospital services; 1 team manager
- Act as a front door for complex cases on the ICP list
- Take direct referrals from health
- Should work closely with EPCTs

Admission avoidance referral pathways



Example of when broad inclusion criteria can compromise RR's effectiveness

So we had two [RR] nurses visiting and they already had a case-load of patients. We'd come to about four o'clock… three or four o'clock and then one nurse finishes at five, and then the last nurse is left to work until eight. So they've got their list and we had about fourteen calls that day. So a lot of them were catheter-related calls, blocked catheters, leaking catheters that traditionally would have gone to district nurses. So they're all going out doing their visits plus the calls and then we had one call from a GP […] maybe about four o'clock saying that they've got this patient who has got dementia, behaviour's getting worse, probably has a UTI but she has a catheter and she's always pulling the catheter out. […] So it's a call that we could have gone with our bladder scanner, scanned the retention, you know, done a full assessment rather than just dealing with a catheter problem. But we couldn't deal with it because the last nurse that was working was already going to do a simple blocked catheter.

A good case of Admission Avoidance
- 96 year old lady, lives with 2 sisters - one aged 95 and one 91 (who is blind and has QDS POC)
- Patient referred has no POC
- Referred by GP for acute onset confusion, not eating and drinking and reduced mobility – also had a fall
- Refused to go hospital. Her wishes before confusion were not to go hospital. GP expected death letter (and referral then went to NW DNs)
- Care navigator also involved and visited with social worker to set up POC, which started the next day
- RR nurse visited and liaised with PRU, ruled out infection blood showed ↑ K, ↑Cre, ↑Urea
- PRU gave IV fluids for dehydration
- RR nurse and therapist visited for three days to ensure hydration and safety
- Nursing: Holistic clinical review, encouraged fluid intake, follow up bloods, continence ax completed, pressure area care, wound care, – was then referred to DN for ongoing monitoring
- Therapy: Referred to ICT for on-going home exercise programme

Admission Avoidance in Tower Hamlets – Key findings

- Two-fold role of AADS (Intermediate Care Team) in the admission avoidance pathway:
  1. The **Admission Avoidance team** is now well-embedded in the Royal London's A&E department. The service is recognised and used by the hospital staff and the team works well with A&E nurses and the social worker covering A&E and AAU, offering a good example of effective horizontal integration. These positive patterns of collaboration happen irrespective of the fact that the whole AAT and the social worker are locums. These professionals have been in post for some time and have developed a relationship of mutual trust.
  2. The **Rapid Response team** is also increasingly well-embedded in the system. It is developing good working relationships with other emergency services, such the Physician Response Unit and the London Ambulance Service. The fact that the RRT is not a 24/7 service might generate confusion among LAS staff on when it is appropriate to refer to the service. With different services and community pathways in different boroughs, it is challenging for hospital and LAS staff to fully understand community provision. As the RRT and other new services try to make a case for their role - often assessed in terms of numbers of referrals - they show a tendency to have flexible inclusion criteria. This has both a positive effect, in that they will help support other teams, and a negative one, as they might generate confusion about their criteria and when it is appropriate to refer to them, while raising expectations from other professionals that they will keep taking specific referrals (i.e. DNs' unscheduled visits), which might occasionally affect capacity to respond to other more urgent referrals (and more relevant to the specific service). Staff appear to be used to working based on clear inclusion/ exclusions criteria and at times some have felt uncomfortable with a more flexible approach.
- In Tower Hamlets at the time of fieldwork, locality teams including DNs, therapies (OTs and Physios) and care navigators were undergoing reconfiguration from Community Health Teams (CHT) to Extended Primary Care Teams (EPCTs). The multidisciplinary approach within these community service teams is welcome but therapies and nurses rarely have opportunities to work together as yet, i.e. carry out joint assessments/ visits (DNs cannot always plan their visits like OTs and Physios do). In some teams therapies did not appear to be co-located with nurses as yet.
- Care navigators' role is increasingly recognised and appreciated, as an effective bridge between different health and social care professionals and the patients.
- DNs are forced into a task-orientated approach to care, often because of the size of their caseloads; this weakens the effectiveness of the admission avoidance pathway.
- Dedicated community social workers (from the Community Health Team) were initially expected to be co-located with CHT/EPCTs, but according to staff this only happened for a short period (during the CHT pilot). Social workers try to attend MDTs, but limited capacity means they cannot attend all relevant meetings or prepare adequately when they do, gathering the information required by GPs and healthcare professionals. There is increasing commitment and ongoing work towards alignment of CHT/EPCTs and social services' Community Health Team, with future developments including a DN being co-located with LBTH staff. In light of these plans partner organisations might want to reflect on why initial co-location of a social worker with DNs and therapies (CHT pilot) did not prove sustainable in the long term.
- High turnover of social workers makes it difficult for healthcare professionals to develop a relationship of trust with them.
- There is ongoing work at a governance level to increase coordination between health and social care (i.e. **joint triage of health and social care through SPA led by a Band 7 nurse**) but major barriers remain: data sharing and access to each other's caseloads; different approaches to commissioning; different ways of/ standards for assessing needs.

2.2 Looking at Pathways: Discharge from hospital

While there is much focus on Delayed Transfers of Care, with Barts Health Trust supporting consultant-led projects such as **Perform**[8] in all three main hospitals in the WEL area (i.e. Royal London, Newham Hospital, and Whipps Cross Hospital), interviews highlighted concerns about patients being discharged too early or without the required medication, which can potentially lead 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 always be 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.

Community services undergo frequent reconfigurations and new services are introduced. These changes are not always adequately communicated and understood across the system and the pace of change is often perceived to be too fast. This is also the case for the Discharge to Assess (D2A) service (part of the AADS team). The service aims to 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 (see Table 2.2 for a comparative description of D2A across WEL). However, the service's criteria are still unclear among acute staff and locality teams, with some risks of overlap between teams.

Increasingly separate acute/ community careers and limited opportunities for rotation further deepen the barrier between acute 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 acute and community care but they often have limited capacity. 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 lack adequate work spaces.

This also applies to the **Screeners**, a relatively new role part of the AADS team. Screeners are based at the Royal London and take and triage direct referrals from wards and in-reach nurses. At the time of fieldwork they did not have a permanent office and, although they have now been allocated a small space, they continue to lack the required IT resources to perform their tasks effectively. Some have suggested that a lack of office space will require staff to increasingly hot-desk and be mobile, but recent literature has found that hot-desking can result in higher levels of distrust, fewer co-worker friendships and decreased perceptions of supervisory support.[9] Some of these issues emerged quite clearly from interviews and observations with these intermediate care roles.

Another aspect that might weaken the discharge pathway is the presence of several small teams whose functions are not always clear to all, with the risk of overlaps. The effective embedment of 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 the

Royal London, the **Discharge Planning - an Integrated Approach project**[10] aims to simplify and clarify the various discharge pathways.

One of the most interesting examples of frontline staff-led dialogic OD to improve dialogue and communication across organisations and roles is the **Discharge Forum**, a monthly meeting to discuss live complex discharge cases. This initiative was introduced following a Listening to Action project. The meetings take place at the Royal London and are organised by the AADS team's clinical lead. They involve staff from the hospital, community services, GPs, social services, and the voluntary sector (Age UK). Although there have been at times issues with low attendance, staff are very aware of the benefits of these meetings to build relationships across different organisations and roles, and they all continue to support the forum.

Initiatives of bottom-up dialogic OD such as this 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.

One recent example of ongoing efforts towards integrated care in the borough is the creation of a new role in May 2018 – the **Care Home Trusted Assessor**. This is a DN previously working with the AADS team, now based in the SW hospital team at the Royal London and employed by LBTH,[11] who assesses patients in the hospital on behalf of care homes in TH. It will be crucial to observe how this co-location works in the coming months and learn from previous experience of co-location in order to support the co-located staff and ensure sustainability.

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

D2A	Tower Hamlets	Newham (Hospital to Home)	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 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	✓ Currently pilot under evaluation; ✓ 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	✓ Led by NELFT working closely with 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

Discharge pathways in Tower Hamlets

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 Tower Hamlets
Voluntary sector

Services and Teams

Complex Discharge Team (CDT)
- 2 social workers, discharge coordinators attached to specific wards (i.e. "needy" wards such as 11th and 14th), one OT (recently left)
- Facilitates complex discharge (**delayed transfers of care**) from all wards
- Focus on out of borough discharges which tend to raise more challenges
- Weekly Get Me Home meetings to discuss Dtocs

What is a complex discharge?
"A range of things: from a restart to a family dispute, to people refusing to leave hospital, to safeguarding [...] disputes between local authorities, like in the care pathway, ordinary residents' issue [e.g. patient has not paid rent and can't go back home]. [...] Anything that comes to a dead-end comes to us."

CDT

Royal London 11 and 14 floor

SW Hospital Team

Hospital Team
- 17 social workers, two first response officers, two senior practitioners, a reimbursement officer and a team manager

- **11 floor**: acute admissions
- **14 floor**: care of the elderly

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

Age UK

Discharge to Assess (D2A)
- OT, nurses, social workers, physios, Reablement social workers
- Facilitate discharges of patients with rehab potential as soon as medically optimised
- **Screeners** (one nurse and two therapies/ team now expanding to include more therapies) take and triage direct referrals from wards and in-reach nurses.
- **Dedicated social workers arrange same day care package** (no need for section 2 and 5)
- For nursing can be expected to become stable in 1-2 days
- **Reablement** provides majority of care packages.
- Patients on caseload for up to 6 weeks
- Work closely with EPCTs and neuro team
- Funded until March 2019

What does a Screener do?
Screeners are based at RLH where they meet patients on ward following referral and let the referrer know if accepted. Screeners check EMIS records to establish if patient is active on EPCTs' caseload. If so, referrer advised to refer back to them.

- ❑ Discharge to Assess (D2A)
- ❑ In-Reach nurses
- ❑ Seconded social workers
- ❑ Rapid Response Team (RR)
- ❑ Admission Avoidance Team (AAT)

Admission Avoidance and Discharge Services

Reablement Team

Patient's home

GP

Each localities includes **two GP networks** (four/ five GP practices in each network) and an assigned social worker.

In-reach nurses
- Attend hospital MDTs and board rounds to identify patients for discharge to D2A and EPCTs
- OPAT (Outpatient Parenteral Antimicrobial Therapy)
- Order nursing equipment for discharge
- End of life care/Fast Tracks, close working with Continuing Health Care (CHC)
- Mainly cover 10th,11th, 13th and 14th floor

Community Health Teams (CHT)/ Extended Primary Care Teams (EPCTs)
- Four multidisciplinary locality teams (district nurses, mental health nurses, therapies, care navigators, and staff with clinical management and administration responsibility)

CHT/ EPCTS

Long-term needs team
- OT Teams – 13 staff trained to do adaptations in homes and work across health and social care on a rotation framework
- East and West social work teams (CHC patients mainly)
- **CHT (ICP patients only)**

Longer term support

Reablement Team
- 66 staff
- Short-term interventions (up to 6 weeks)
- Provides reablement care packages for D2A/ joint intermediate care service
- **Ambition** to use trusted assessors and remove clinical gatekeeping to services

Discharge referral pathways

All referrals to community services go through the **Single Point of Access** (SPA). Individual teams do their own triage of referrals from SPA. Direct referrals from wards to In-reach nurses and screeners for D2A. Plans for integrated SPA and triage process for health and social care.

CDT

Out of borough

Age UK

RL Ward 11 and 14

In-reach

SW Hospital Team

SW Seconded to AADS

SW- AADS: Some divergence on needs assessment but overall positive relationship.

D2A

Reablement

Long-term needs

Adaptation team

SW CHT

CHT/ EPCTS

GP

D2A-CDT:
- Lack of clarity around roles and responsibilities
- Lack of understanding of each other's role along pathway
- Lack of trust (including on data recording)
- Ongoing dialogue between teams to address issues

Ward staff – D2A: Confusion around appropriate referrals due to flexible D2A criteria

In-reach- screeners: Perception that D2A's screeners overlap/ duplicate some in-reach functions – some lack of clarity over roles.

Discharge to EPCTS: Late discharges (often due to transport)

Referral to DNs not always issued

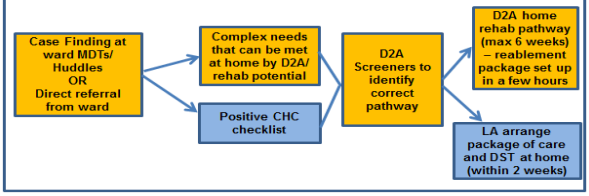
Patients discharged without required medicines/ equipment

Patients discharged with unrealistic expectations (i.e. pads). Hospital staff can raise unrealistic expectations from patients about community provision.

D2A – CHT/EPCTs Lack of consistency in referring patients to one or other team. Perception of some overlap among therapies

Community services roles in the hospital
- ☑ **In-reach nurses** highly valued by ward staff, as vital bridge between hospital and community
- ☑ A lack of capacity means in-reach nurses can only cover a limited number of wards and their role is not widely understood.
- ☑ In-reach nurses struggle with working conditions – really small office outside hospital. This affects their sense of worth – they carry their own bag and coats as they work on the wards and often have to explain who they are/ what they do. This also applies to **screeners**.

D2A and Continuing Healthcare pathways



Because there is no clear criteria in terms of what type of patients do we accept, what type of patients do we reject, how long we should keep those patients. I know that we have to keep the patients for six weeks but there are people who are keeping the patients longer than six weeks sometimes, more than eight months on their caseloads. So... (AADS worker).

AADS integrated working with Reablement

Perception from reablement team that AADS therapies are not always able to visit patients on the day after discharge. This was not confirmed by AADS and this perception might be due to poor dialogue between the two teams.

Reablement staff not always clear about value added of D2A pathway v. traditional reablement pathway: *Hospital SW ⟶ Reablement OTs and ROs*

The Reablement team appears to struggle to work effectively with AADS – no direct and ongoing communication with ADDS therapies affects ROs' work.

Weekly meetings including AADS and Reablement help improve relationships.
Because of the high number of patients discussed, limited information can be shared and some felt the format of these meetings should change to make better use of the available time.

Patient discharged from hospital with reablement package ⟶ Allocated to Key AADS worker (PT/OT/nurse) on morning after discharge ⟶ SW to inform reablement officer via email ⟶ First visit – Therapist agrees goals and leaves doc for RO ⟶ Discussion of patients at Tuesday meeting

Issue of trust between the two teams on how data is recorded.

There can be very unrealistic referrals [from the hospital]. *So three times a day dressing changes. Things like that, that could be facilitated on a ward, but not facilitated here.* (CHT/EPCT DN).

Discharge Pathways in Tower Hamlets – Key findings

- Within the hospital (Royal London) there were several communication-related issues between different actors that were expected to work closely together but did not seem to understand each other's role clearly, leading to a lack of trust:
  - **The Complex Discharge Team (CDT) and the D2A service** (see map above for a description of teams and roles) – Both teams seemed quite protective of each other's roles and boundaries and this affected collaboration. As the CDT manager left in late 2017 and a new one has only been recently recruited (spring 2018), some interviewees felt the team's focus had been affected.
  - **In-reach nurses and screeners** – the role of the screener is relatively new and is not always clear to other professionals, including within parts of the AADS team. Some felt there was some duplication with other roles (i.e. in-reach nurses). However, based on observations of both roles, it seemed clear that they are complementary, with in-reach nurses attending board rounds and MDTs and case-finding appropriate referrals for both DNs in the localities and D2A, and screeners triaging all other direct referrals from wards. A lack of capacity and support for role development (particularly with the regard to screeners) as well as changes that are not communicated clearly across the system might be placing some pressure on staff that do not have the time and space to develop collaborative working practices with others.
  - **Ward staff and D2A service** – at the time of fieldwork there was still a lack of clarity about appropriate referrals for D2A, due to the service's flexible criteria.
- Questions focusing on discharges from hospital to the community highlighted a few issues between:
  - **Ward nurses and DNs** – DNs are not always notified when a patient requiring their care is discharged. A number of instances were recalled by interviewees where patients were promised by hospital staff that that the DN would see them the following day, raising expectations that could not be met and generating frustration among both patients and DNs. There is a lack of trust on both sides.
  - **Ward OTs and community OTs** – interviewees mentioned that OTs in the hospital have limited understanding of the role of OTs in the community. Many felt that a collaborative for all OTs in acute, community and social care across the borough could improve communication and understanding of different roles.
  - **D2A – CHT/ EPCTs** - there was limited understanding of D2A in the community. DNs and therapies in the localities felt there had not been enough communication and they were unclear about criteria. There is some overlap between D2A therapies and CHT/EPCT therapies and at times there is still uncertainty over which team a referral should go to.
- The **social workers in-hospital team** is well embedded but has limited capacity. Social workers mentioned that healthcare staff often struggle to understand their financial pressures and approach to needs assessment. Generally there is good and ongoing dialogue among health and social care staff in the hospital and "Get me home" meetings led by the CDT bring together health staff and social workers twice a week to discuss DTOCs.
- The **Reablement team** (LBTH) provides reablement packages to D2A patients, but there are overlaps between the "traditional" reablement pathway and the D2A pathway. Although the Reablement team lead regularly attends AADS' weekly meetings, the dialogue between the two teams is difficult and the relationship between AADS therapies and the reablement officers needs improving to ensure the expected high standards of care are met (see map).
- **There is not always agreement on assessment of needs** between health and social care staff in community care, with social workers feeling health staff tend to overprescribe intense packages of care (24 h), which will often have to be reduced shortly after they start. This can be demanding for SWs who might need to negotiate patients' expectations and at times complaints that care (e.g. often night care) is being taken away from them.
- Some interviewees have expressed anxiety about **funding of packages of care under D2A**. At the time of fieldwork the local authority was providing a number of 24 hour care packages as part of the service and social services' staff were unsure about contributions from the CCG (in TH D2A is a health-led pathway). This might further exacerbate a lack of trust between organisations. Some interviewee raised concerns that initial estimates of the cost of the service were too low.
- **The closure of the Jubilee Ward raised some concern among frontline staff**, who felt that D2A cannot always provide the intense level of rehab offered by a hospital ward, which might be required in some cases.

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 Tower Hamlets the "Last years of Life" group, led by the CCG, meets monthly and has been pivotal in bringing together a number of different stakeholders from acute, community, social care and the voluntary sector, including nurses, social workers and other roles working on the frontline, and encouraging collaborative work on a number of different project ideas, such as training and supporting palliative champions within community health and social care teams.[12] There are regular meetings at the Royal London led by the hospital palliative care team, but community staff have found it difficult to gain access to these meetings, while Barts' staff have not always attended the CCG-led steering group. There is growing awareness across both sides about the need for the hospital and the community to work in more collaborative and coordinated ways.

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.

End of Life Care – Key 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;**
- **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;
- There is still limited awareness of need for and capacity of **therapies for EOLC patients** (specialist palliative OTs);
- While there is much enthusiasm from CCGs about rolling out Coordinate My Care there is some scepticism about introducing yet another platform among some frontline professionals;[13]
- Generally, frontline professionals in the hospital and the community feel there is a lack of awareness of EOLC among GPs;
- There are many efforts to improve awareness and more coordinated delivery of care:
    - ✓ **In TH palliative champions meetings are** organised by lead nurses in different localities to raise awareness about palliative care and end of life pathways and to strengthen joined-up working. Designated palliative champions in each team take responsibility over training colleagues. LBTH Community Health Team also has a palliative champions programme.
    - ✓ DNs in Tower Hamlets have **weekly palliative meetings** with St Joseph's specialist nurses to discuss patients.

End of Life Care pathway in Tower Hamlets

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 Tower Hamlets
Voluntary/ Charity sector

UCL

Services and Teams

Hospital

BHT Specialist Palliative Care team
- Multi-professional team: consultants, specialist nurses, palliative social worker
- 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

Barts Health Trust Specialist Palliative Care team
Palliative social worker

In-reach nurses

In-reach nurses
- District nurses in the hospital (part of AADS)
- Support Fast Tracks, close working with Continuing Health Care (CHC) and EPCTs
- Mainly cover 10th,11th, 13th and 14th floor

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

Marie Curie nurses

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

St Joseph's Community Palliative Care Team

Community

Patient's home

Age UK

Last years of life
- Provide practical and emotional support to adults 18+ with palliative care needs
- Personal Care Support Escorting to GP and hospital appointments
- Domestic Help
- Shopping
- Planning for the future
- Works closely with St Joseph

GP
CHT/ EPCTS

- GPs and district nurses in charge of care at home and take responsibility for prescriptions
- EPCTs' DN palliative champions raise awareness across team

Longer term support/ CHT

- ICP patients
- Palliative champions scheme just started

STP Vision
Our vision is to work and learn from each other with our communities to achieve person centred care. We will have shared outcomes and priorities and aim to do things differently

End of Life Care Pathways

Continuing Healthcare eligibility criteria based purely on care needs and NOT on a person's income. **Fast track funding** is available for elderly people with significant health needs, not just those at the end of their life. A special process for **immediate provision** is used in emergency situations when a person is in a period of rapid deterioration and may be entering a terminal phase.

Patient with rapidly deteriorating needs identified by registered medical practitioner

Issues:
- ✕ Task orientated approach to care can affect early identification of end of life stage
- ✕ Eternalism-nihilism dichotomy - medical culture is to keep treating
- ✕ 'Specialist palliative care', 'palliative care', 'end of life care' often used interchangeably, and people have different definitions
- ✕ Integrated care and end of life kept as separate programmes but clearly closely interlinked
- ✕ For elderly frail people idea of **uncertain recovery** more useful than EOL

Fast-track forms to be completed by medical practitioner

Issues:
- ✕ GP/ ward consultant/ nurse can experience difficulties in filling out form for lack of knowledge of patient's care needs or required phrasing
- ✕ Ward nurses often very busy and form may get delayed
- ✕ Specialist teams in hospital and community struggle to offer support with form filling for lack of resources

Patient moved to his/her preferred place of care - CHC DST should not delay process

Issues:
- ✕ Nursing home of choice might not have beds available
- ✕ Instances where patient was directed to less costly nursing/ care home against patient's relatives choice
- ✕ Rhetoric around patient's choice: at times patient's choice is not viable because of relatives/ carers' situation or complexity of symptoms.
- ✕ No 24 hour service package in the community. In order for people to die well in the community, relatives have to be involved.
- ✕ Need for honest conversations with patients about effective provision and support to help them make informed decision. **Who should be in charge of having these conversations with patients?**

CASE STUDY - 95 year old patient with end stage dementia and registered blind. Fast track completed and care plan due to start on discharge. Discharged late on a Friday evening and readmitted at 23:05 on Saturday night. No district nurse referral made on discharge from the ward. Agency care workers concerned he was not eating or drinking. LAS said he should not have been discharged as he was in last stage of dementia and was unable to eat and drink. Family raised concern with site practitioner.
Site practitioner emailed complex discharge team that he was readmitted.
The patient was discharged again after 9 days with referral to St Joseph and call to GP but no DN referral. The care agency contacted EPCT to say they were unable to give medication. DN said no referral had been received and the patient was not open to them. CHC advised to refer via SPA.
GP prescribed EOL injections to be given subcutaneously. Expected death letter was completed, but there was still no DN referral. DN finally visited 20 days post discharge.

Where are the gaps and what are staff doing about it?

Well-integrated care, with continuity of provision is key for patients and their family (Parker JPSM 2007, Belanger Pall Med 2011).

- Barrier between acute and community/ primary care –DNs in EPCTs do not always receives referrals from ward when patients are discharged
- Ward discharge checklists do not take account of what available in the community (e.g. prescriptions for injectable medications)
- When BHT Specialist Team is involved referrals are made to St Joseph's community team but GPs and DNs are not always informed
- Community palliative care in TH heavily relies on St Joseph's team's input, also on advanced care planning discussion, but many feel GPs should have a more central role – need to raise awareness
- *"Specialist palliative care teams spend too much time doing tasks that you don't need specialist knowledge for"* (Specialist Nurse)
- Knowledge and practice gap around role of therapies for palliative and EOL patients
- Some services under used – e.g. Marie Curie's night sitting
- DNs' task-orientated approach

Improving coordinated work
- **EOLC steering group monthly meetings** have been instrumental in connecting different actors in TH and co-creating joint narratives/ visions/ goals. Currently attempting to bridge gap between hospital and community.
- EPCTs DNs have **weekly palliative meetings** with CNS from St Joseph to discuss their palliative patients.
- **Palliative champions meetings** are organised by lead nurses and social workers in different localities to raise awareness about palliative care and end of life pathways and strengthen joined-up working – designated palliative champions in each team take responsibility over training colleagues

Good model - renal palliative care MDM led by a group of specialists keen to work with St Joseph's team to address EOL needs for people with advanced kidney disease.
- Started in 2016
- Use a screening tool on whole cohort of dialysis patients to identify those at risk of dying in the next 12 months
- Patients on register get discussed at renal palliative care MDT meeting

My experience would tell me, clinically, that a lot of people want to be at home until it gets really difficult, until maybe they're being doubly incontinent or until they're frightened of being on their own, and then they want to be anywhere but home […] So we encourage ladies for a birth plan, but we say to ladies when we're writing the birth plan, 'Look, this might not happen. Lots of things might change that. You might need intervention, you might need medicines, you might need this you might need that […] I don't know why we approach death and birth in a different way. […] I think we have to educate patients about if you want to die at home this is what it might mean for you; is that really what you want? And therefore make it a… It's the only time I think in healthcare we don't give information.
[Nurse]

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

3.1 Tower Hamlet's OD programme

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. [14]

More recently ELHCP has invested in two pilot OD programmes focusing on specific workstreams, including End of Life Care. ELHCP OD work has only recently started and is beyond the scope of this evaluation.[15] Our focus is on the impact of THT's OD programme on frontline staff involved in the three pathways under study. Out of the three WEL boroughs, Tower Hamlets Together (THT) is only site to have invested in a dedicated OD programme to promote culture change and partnership working.

THT's OD plan was delivered to the Board in May 2017 and is informed by the Burke-Litwin's model of organisational change and performance[16] and Barry Oshri's system thinking, which underpinned workshops for system leadership development.[17] The plan covers culture change (i.e. THT Board Development; Locality Health and Wellbeing Boards' (LHWB) development), systems learning and development and service transformation (i.e. to bring the changes following the CHS contract in line with the transformation set out in the contract) through a range of *ad hoc* workshops and development sessions, away days and staff engagement events, starting in autumn 2017, and mainly taking place between June 2017 and March 2018.[18] A Workforce OD Workstream was set up to deliver the plan but has recently been dissolved. At the senior level the THT Board has driven developments on OD work through three life-course workstreams: Born Well; Growing Well; and Promoting Independence (focusing on Complex Adults). Each workstream involves a mix of actors from different organisations, but attendance from clinicians and frontline professionals is low.

THT's OD programme contains elements of both diagnostic and dialogic OD (see literature review in the full report for a definition). Although the change strategies are grounded in an understanding of systems thinking, they continue to seek transitional change (see literature review in full report), which might clash with the complex reality of health and social care organisations. Here change often happens in an emergent rather than linear way and tends to be developmental, often focusing on the improvement of a process. Changing a particular set of behaviours or part of a system will often have unexpected and unintended implications on other parts and sustainable implementation may require wholesale change of the system itself. The literature shows how most change programmes fail at the implementation stage because these implications are not adequately considered and discussed with - and embraced by - professionals working on operational delivery. Often OD work and communication of change strategies are focused on the governance level and this change does not trickle down to the operational level as it might have been envisaged.

The THT OD plan includes work targeted at frontline professionals, but this appears to have had limited impact to date, i.e. a two-day coaching skill programme for frontline staff from multidisciplinary teams with the aim to develop a coaching culture – e.g. enabling partnership and collaborative working to co-

design services, and training to upskill non mental health staff with mental health and dementia awareness and assessment /intervention skills. According to the plan, both these interventions are aimed primarily at CHT/EPCTs and SPA staff, but to date we are unware whether this development work has actually taken place. No substantive impact was unveiled on the frontline teams involved in this study.

The national programme MECC (Making Every Contact Count) was also rolled out in TH and an evaluation was published in December 2017.[19] This half day training delivered by an external trainer is based on the recognition of the potential of the wider workforce in promoting health and wellbeing and is focused on how to approach conversations with patients and service users. Staff from 90 different organisations (including several voluntary sector organisations) took this training, with the vast majority (43%) from LBTH and 28% from the NHS.[20]

Figure 3.1 – The Wheel of Partnership

Tower Hamlets has also partnered with Bournemouth University to develop a Wheel of Partnership based on available literature on the skills, knowledge and behaviours required to deliver person-centred care. A team of facilitators involved 400 staff across THT to hear from them about their experience of what is successful person-centred care. The analysis of these stories highlighted similar competencies and behaviours as those identified by Bournemouth University's literature review as key drivers of success: creativity and innovation; resilience, can-do (pro-active) attitude; positive risk taking. At the time of writing, The Wheel of Partnership was about to be rolled out in the borough to support partnership working among frontline professionals.

In TH, the staff engagement events format often aimed at increasing knowledge about, and understanding of, different services in the borough (i.e. using market stalls); in some cases, action research approaches such as storytelling were used to help increase awareness of different roles and experiences of the health and social care systems.

This work has clear dialogic elements and participants shared positive feedback. However, they also identified a number of issues with relying mainly on this type of *ad hoc* approach to OD, based on short-term training programmes and events:

- **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, which do not always equip staff to address their 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 there was a need for more investment in staff development, beyond compulsory and internal training.

3.2 Insights from the frontline

As current OD work is not always supporting staff to move towards more integrated care in an effective and sustainable way, 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;
- 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.

> "But [name of trust] was very good because there was a lady called [name] […] she always used to email encouraging like football tournaments, getting together outside of just work. Whereas it does feel at the moment you'll get those emails but it will just be about maybe training. It wouldn't really be about anything non-work related, just to try and kind of help staff. I think some of that does help. We used to go to the theatre and things like that, and we'd go as a team." [TH EPCT physio]

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.

3.3 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, where staff recognise a clear problem to be addressed and try to change both behaviours and thinking through cross-disciplinary and ongoing dialogue. We mentioned above two cases in Tower Hamlets where forums championed by frontline staff are helping to build relationships and clarify and develop care pathways:

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

These are good cases of distributed leadership, where professionals on the ground are successfully addressing, on their own initiative, tangible needs, through developing dialogue across teams and roles.

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	○ OD and project management work to enable staff to understand roles and responsibilities across acute and community and develop clearer pathways (i.e. Discharge Forum; RL's work on "planning discharges")	○ Strong national rhetoric in support of coordinated care and integrated care systems (i.e. urgent care; EOLC)
Enablers: Horizontal integration/ health-social care	○ Efforts to align frontline delivery (CHTs and SPA in TH)	○ Work on developing/ strengthening **distributed leadership**, often on the initiative of frontline staff (i.e. palliative champions) ○ Increasingly recognised and valued role of **care navigators**	○ Strong national rhetoric supporting integrated care
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" mentality) ○ A lack of facilities – offices and working computers (i.e. to accommodate community staff such as in-reach nurses or	○ Increasingly separate careers between acute and community ○ 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

	screeners 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: fewer social workers in hospital and particularly in the community ○ 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). Here we attempt to summarise how Tower Hamlets has been using these strategies.

1. **Align vision and action**
   While there is much work 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 particularly, whereby the need to get 'permission' from someone in authority can be a barrier to progress.

2. **Make incremental changes within a broader transformation strategy**
   In some cases the pace of change has been too ambitious for staff to develop the capacity to implement it adequately (i.e. a range of new services in intermediate care); while in other cases change that had been talked about and planned for a long time (functional integration of IT systems) has not yet materialised fully. Investing in incremental change can ensure 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 (i.e. TH's AADS lead driving the Discharge

forum) or raise awareness among colleagues about specific aspects of care (i.e. one of the CHT/EPCT's lead in TH and the LBTH CHT's lead driving the work on palliative champions). 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.[21]

5. **Create collaborative interpersonal relationships**
   There has been some important work on promoting collaboration and raising awareness of organisational and inter-organisational functional interdependencies on the ground. 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 make building relationships of trust more challenging. Furthermore, new services that might have a different approach to delivery of care (i.e. RRT or D2A's flexible inclusion criteria) might benefit from investing in permanent teams that fully embrace the new work ethos.[22]

6. **Continuously assess and learn from cultural change**
   The culture of evaluation is often driven by a focus on meeting targets and demonstrating outcomes and accountability, rather than building learning. Tower Hamlets has shown increasing awareness of, and experimentation with, QI initiatives and action research; 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".
- 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.
- Rigid role boundaries can hinder holistic care. In particular, healthcare professionals in the community felt GPs should take more ownership in the case 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. Discharge Forum; Renal Palliative Care MDM) 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, as demonstrated by the growing success of the palliative champion schemes, can be instrumental in embedding new practices and raising awareness, though peer-support and training;
d) When co-locating social workers in a healthcare team or vice-versa, make sure you learn from previous failed experience of co-location, in order to support staff and ensure sustainability. Previous efforts 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, continued to work in silos.

References

Cameron, A., Lart, R., Bostock, L. and Coomber, C., 2013. Factors that promote and hinder joint and integrated working between health and social care services: A review of research literature. *Health and Social Care in the Community*, 22, pp.225–233.

Cameron, A. and Lart, R., 2003. Factors promoting and obstacles hindering joint working: a systematic review of the research evidence. *Journal of Integrated Care*, 11(2), pp.9–17.

Eyre L and Marshall M (2016) *Qualitative Evaluation of the Waltham Forest and East London (WEL) Integrated Care Pioneer Programme*. UCL.

Leutz, W.N., 1999. Five laws for integrating medical and social services: lessons from the United States and the United Kingdom. *The Milbank quarterly*, [online] 77(1), pp.77–110.

Marshall, M., Pagel, C., French, C., Utley, M., Allwood, D., Fulop, N., Pope, C., Banks, V. and Goldmann, A., 2014. Moving improvement research closer to practice: the Researcher-in-Residence model. *BMJ quality & safety*, [online] 23(10), pp.801–5. Available at: <http://qualitysafety.bmj.com/content/early/2014/06/03/bmjqs-2013-002779.full>.

Willis, C.D, Saul, J., Bevan, H, Scheirer M.A., Best, A., Greenhalgh, T. Mannion, R., Cornelissen, E., Howland, D., Jenkins, E., Bitz, J. 2016. Sustaining organizational culture change in health systems. *Journal of Health Organization and Management*, Vol. 30 Issue: 1:2-30

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) • Whipps Cross Hospital's Integrated Discharge Team	October 2017- January 2018	Teams willing to take part in the study were identified during the scoping phase.

			(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] The literature review of organisation change management in the full report might offer insights on the implementation gap that characterise many change programmes.

[4] New governance arrangements for the THT Board include the Board providing support to the Health and Wellbeing Board to discharge its duty under section 195 of the Health & Social Care Act 2012 to encourage health and social care services to work in an integrated manner.

[5] 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.

[6] In Tower Hamlets, the role of care navigator has in fact existed for several years, although under different names (i.e. care coordinator). The role has however developed over time and gained increasing visibility and recognition.

[7] According to participants, in Tower Hamlets funding from the Improved Better Care Fund (IBCF) has been principally used to inject resources into social care.

[8] 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.

[9] See https://theconversation.com/the-research-on-hot-desking-and-activity-based-work-isnt-so-positive-75612

[10] The project - led by Barts Health Trust with EICP's support - aims to reduce unnecessary waiting time for patients; reduce duplication for staff and patients; provide clarity of accountability and responsibility for patient discharge. It involves regular **Integrated Discharge Meetings** at the Royal London which together all the actors from acute, community and social care involved in discharges.

[11] The Care Home Trusted Assessor Post has been created due to Care Homes representatives not being able to get to the hospital within a reasonable time frame to assess patients who are medically fit for discharge. The post is funded through pooled budget from health and social care.

[12] Recently the group has agreed actions and continuing commitment to work towards key priorities:

- Person centred integrated care, which includes carers and families;
- Being able to express preferences about care and place of death;
- Identifying and meeting palliative needs early;
- Improving the experience of hospital care in last years of life;

- Access to Specialist Palliative Care;
- Training and education for health and social care staff;
- Reducing inequalities in access and experience;
- Community approaches to Last Years of Life and "healthy dying"

[13] One interviewee commented: "Well, Coordinate My Care is an IT platform. It's not a programme, it's just an IT platform of sharing of information; the problem is at the moment it's duplication of work. IT sharing platforms are not brilliant, so for example, the London Ambulance Service can't see things […] We don't even know if Bart's Health will log into to Coordinate My Care, because it's a separate log in, it's a separate IT platform. So what's the point of GPs doing care plans on there, on top of our medical records which is EMIS? Because that is legally where everything needs to be. And then we have to go into a different IT system to enter it all so that our other partners can look at it; but do we even know if the other partners are even going to bother to log in to have a look."

[14] Overall, significant investment has been made in staff development and infrastructure to support integrated working – e.g. £1.2 million on CHS IT Transformation; £105k on MECC staff training; £150k on Whole Systems Data project.

[15] 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.

[16] According to this model, environmental factors are the most important driver for change. Change can often be traced back to external drivers. Key elements, such as mission and strategy, leadership and organisational culture, are often impacted by changes that originate outside the organisation (Burke and Litwin 1992).

[17] Oshry's work is based around recognising four roles/ conditions: Top, Middle, Bottom, and Customer. Oshry argues that we are constantly moving in and out of these four conditions. His simulation workshops are about illuminating the pitfalls and behaviours in each of them, which can result in dysfunctional systems. Advocates of this approach claim that it can provide the framework and tools for accelerating the impact of an organization's initiatives.

[18] The person delivering the OD plan left at the end of 2017 and this has affected progress.

[19] The aim of MECC is to use contacts with a person as an opportunity to encourage behaviour change through:

- Initiating a conversation
- Offering brief tailored advice/guidance
- Signposting people to support services

[20] Overall 773 staff were trained between January 2015 and July 2017. An evaluation has been published recently March 2018: Ferguson, K. *Making Every Contact Count: Evaluation Survey for CHS staff 2017/18.*

[21] 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.

[22] By the same token, permanent staff might require greater investment in training and induction, since locums are often expected to be highly experienced.