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

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Waltham Forest findings ONLY
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Executive Summary

Background

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

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

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

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

Findings

This report only focuses on findings from Waltham Forest (WF). 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 (Integrated Care Teams – ICTs). 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 can be difficult to deliver in practice**. Co-location helps where there are shared professional and organisational vision and goals – and ideally one management line. Where this does not happen, people continue to work in their usual ways and they are not necessarily more collaborative or accountable to each other.

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

The role of agency staff both in health and social care is one aspect to consider carefully in the context of organisation change and continuous reconfigurations. 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, 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. As new services (i.e. 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 and strengthening dialogue across teams and organisations** in order to deliver better and more coordinated care. This work should be understood and supported better.

Key themes for each pathway

Admission Avoidance

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

- Limited resources, particularly within social care;
- Understaffed healthcare teams with high turnover and difficulties in recruiting and retaining staff, and particularly DNs;
- A task-orientated approach to care, often due to heavy patient caseloads;
- Broken communication between community teams, GPs, and social workers, whereby staff struggles to get hold of other professionals;
- Pressure on staff from increasing admin tasks and having to fill in different forms electronically and on paper (some felt there was often unnecessary duplication of information);
- No functional integration – i.e. access to other organisations data systems.

Rapid Response teams in the WEL area appear to have a positive impact and are making a substantive difference to patients’ care. WF’s RRT is a 24/7 service, unlike in other boroughs, although there is limited capacity at night. The service seems to be well recognised and used across the system. The team’s role has widened over time and it now also covers out of hours 111 calls.

RR service’s flexible inclusion criteria can at times generate confusion about the boundaries of the service and there can be some overlaps with DNs’ caseloads. Ongoing dialogue between ICTs and the RRT is helping to address and resolve these issues.

Overall, there is growing awareness that, if non-elective admissions are to be reduced, it is important to move away from a task-orientated approach and towards more holistic care.

Discharge from hospital

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

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, provided they enjoy adequate resources and recognition in the hospital.

The Discharge to Assess service (D2A), based at WXH, is becoming well embedded in the discharge pathway and is increasingly recognised and used by ward staff. D2A works closely with LBWF's Reablement team. There have been issues of limited access to each other's data system and caseloads; high turnover of staff in the Reablement team; and poor handover of D2A cases between senior reablement officers. These issues are being addressed through ongoing dialogue and mutual trust. As the service is starting to get referrals also from the community to prevent admissions, staff can feel overwhelmed, and the service might need to define more clearly inclusion criteria and/ or increase capacity.

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 WXH were rated as 'Inadequate' by the Care Quality Commission (CQC) in 2015. WF CCG has commissioned Social Finance to develop an End of Life Care model over the next two years, based on a 'hospice at home' approach.

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

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

Fieldwork has unveiled a number of issues across all three boroughs:

- **A task-orientated approach to care** affecting identification of end of life patients;
- **A lack of consistency of EOLC provision in the community;**
- **Filling in fast-track forms still seen as a challenge** that professionals would rather delegate to others;

- Limited awareness of need for and capacity of **therapies for EOLC patients** (specialist palliative OTs);
- **A lack of awareness of EOLC among GPs**;
- **In WF, communication issues between the CNS and DNs.** Some participants have suggested that the relationship might improve if the CNS team, currently under BHT, were part of NELFT. This is yet another example of the challenge of building effective collaboration across different Trusts on the ground.

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 the establishment of forums/ spaces/ peer-learning meetings** that can encourage dialogue and reflections among different roles/ teams involved in the same pathways.

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 (i.e. the relationship between healthcare professionals and the Reablement team for the D2A service could offer a good model);

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

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

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

Some of the most interesting examples of organisational development to improve coordination, dialogue and collaboration across WEL 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.

- **OT Collaborative in Newham** – senior OTs across organisations in the borough meet every three months to discuss borough-wide issues.
- **WF ICT and Rapid Response leads addressing communication issues** between the teams and confusion about referrals by organising meetings and developing an action plan that is proving to be very effective.

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.

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1. Background

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

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

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

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

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

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

In particular, following scoping work (May-August 2017), it was agreed the study would look at specific pathways to understand collaboration patterns within and across multidisciplinary teams from acute, community and social care. **Admission avoidance**, **discharge from hospital** and **end of life care** pathways were identified as high on partner organisations' agenda (also in light of current work at STP level) and selected as case studies to assess the level of horizontal (across different roles/ teams within either community or acute) and vertical (looking at the whole pathway and collaboration between acute and community) integration/ coordination.

This work addresses three interlinked research questions:

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

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

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

1.1 Waltham Forest

The initial Integrated Care System proposal in WF focused on three elements:

- The development of a strategic commissioning function bringing together the CCG and the local authority;
- The development of a clearly defined outcomes framework linked to population-based contracts;
- An integrated, place based service delivery model that provides gateways into re-designed services and pathways.

Partner organisations proposed to pilot the approach across four key areas:

- **System 1 – Community Care (Planned)**
  This builds on the existing Managed Network of Care and Support and aims to keep residents well at home, living as independently as possible.
- **System 2 – Integrated Urgent Care**
  This integrates service provision where an immediate response is required (i.e. urgent or crisis situations). The aim is to deliver highly coordinated services where professionals collaborate to determine the right pathways and outcomes for residents; it aims to deliver improvements across the system whilst taking out duplication of services.
- **System 3 – Leaving Hospital Pathways**
  The aim is to stream patients into the most appropriate pathway depending on their needs and potential for rehabilitation and reablement, reducing unnecessary long length of stay in hospital and ensuring people are not admitted because there is no other available pathway.
- **System 4 – End of Life Care**
  This model is based on a 'hospice at home' approach, integrating provision across professional boundaries. The ambition is to shift the focus away from 'treatment' towards the effective management of symptoms, providing compassionate care in a familiar and supportive setting.

The work to create these 4 systems is managed through the Better Care Together programme board. The CCG is working with the Local Authority to agree the scope and remit of an integrated strategic commissioning function (ISCF). The ISCF would bring together commissioning staff, budgets and contracts from across the Council and the CCG into a single integrated function; it would be accountable to the local authority cabinet and the CCG board and deliver its functions through a joint committee. At the time of writing, a work plan was in process to agree the scope of the pooled budget and the legal frameworks to be used.

2. Findings

This section explores findings that have emerged from participant observations and interviews with frontline professionals in Waltham Forest (23 one-to-one and group interviews with frontline professionals in different roles across 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 has unveiled organisational fragmentation, which inevitably affects collaboration and coordination, increasing risks of overlap and duplication. Staff have shared a number of recent cases from their professional experience, which reflects recent empirical literature, whereby patients are forced to navigate a myriad of health and social care teams, having to repeat their stories to many different health and social care professionals, and often experiencing long gaps between services without being given relevant information about next steps.

Staff often mentioned delays in transfer of care due to finding places in care homes or putting together packages of home support, in a context where human and financial resources are stretched in all parts of the system, and particularly within social care. Across all three boroughs, the residential care market has been under pressure due to increasing regulation and the national living wage. A number of care homes closed down and providers are at times unable to hire appropriately trained staff. Similar pressures were reported in the homecare market.

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

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

1. **Barrier between acute and community**

   The **barrier between acute and community** continues to hinder coordination of care, with different organisations increasingly focusing on different parts of the health system, limiting opportunities for staff to rotate and understand the whole pathway and reinforcing silo-working. The lack of understanding of community provision among ward staff is one the issues interviewees often mention when discussing failed discharges. Examples of patients discharged without the required medication/ equipment were often cited, as well as cases of inappropriate or missed referrals to community teams. Intermediate care roles that might help bridge this gap (i.e. *in-reach nurses*, or nurses with a community background working in the hospital) need more resources and visibility in order to perform their role effectively.

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

   Health and social care staff have different professional and organisational cultures, as well as responding to different organisational pressures. The social workers we interviewed often perceived healthcare professionals as risk-averse, while they saw their own role as promoting independence. In contrast, healthcare professionals felt that social services' decisions were increasingly influenced by limited resources. Interviewees 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. 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.

Some interviewees felt that organisations often played a "blame game", rather than fostering a learning environment. The example of pressure ulcers was often mentioned, as illustrated by this interview excerpt with a District Nurse (DN) in the borough:

> DN: The only time they [the hospital] will get in touch with us [is] when there is a pressure ulcer on the sacrum and then the battles start…
> I: What do you mean?
> DN: the patient... It might be we have grading of pressure ulcers so the [2] is just a red area and slightly broken. [3] is a little bit different and [4] is very bad. So the first question you ask is: How long was the patient on that trolley, because when the patient left us this was what the grade was… […] Eight hours, four hours, five hours, within two hours the wound can deteriorate. So that is the first question we have to ask, in our defence...

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. This is true for health and social care staff co-located in a hospital (e.g. the Integrated Discharge team in Whipps Cross Hospital) or for locality-level

multiprofessional teams, where proximity of nurses and therapies (OTs and Physios) has helped staff have more direct communications (and faster internal referrals), but it is not always making their approach to care more holistic and integrated. For example joint assessments and visits of district nurses and therapists within the same locality team do not happen as often as some staff would like. This might be due to different professional cultures as much as to logistics, as DNs cannot plan visits in the same way as therapies do.[3] Therapies and Community Matrons appear to work really closely on ICP lists (2% of patients most at risk of admission).

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. Time-limited funding can continue beyond the piloting stage and some locums can be in the same role for some time. 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 might be 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 some time and they are very well integrated in the organisation, but mostly where there were high numbers of locums we also found higher turnover, which can affect relationships of trust 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 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 and strengthen dialogue** in order to deliver better and more coordinated care. This work should be understood and supported better.

In the rest of this section we first describe each pathway and then identify the teams involved, describing how they work together, 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 section 2). 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. It 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.

Rapid Response teams in the WEL area appear to have a positive impact and are making a substantive difference to patients' care (see table 2.1. for a comparative description of the RR service across the three sites). WF's RRT is a 24/7 service, unlike in other boroughs, although there is limited capacity at night. The service seems to be well recognised and used across the system. The team's role has widened over time and it now also covers out of hours 111 calls. The 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, however ongoing dialogue between community teams (Integrated Care Team – ICTs) and the RRT is helping to address and resolve these issues, showing a good example of **distributed leadership**.

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

- Limited resources, particularly within social care, following drastic cuts to local government;
- Understaffed healthcare teams with high turnover and difficulties in recruiting and retaining staff, and particularly DNs;
- A task-orientated approach to care, often due to heavy patient caseloads for DNs;
- Broken communication between 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);
- A lack of access to other organisations' data systems.

There are no care navigators in WF, unlike in Newham and Tower Hamlets.[4] Instead community matrons (CMs) manage ICP (Integrated Care Patients) lists working closely with therapies in the team (OTs and Physios). Waltham Forest's Integrated Care Teams (ICTs) have a stronger focus on Integrated Care Patients. ICP lists are allocated to Community Matrons, who work closely with therapies.

Overall these community teams tend to focus on housebound patients. At piloting stage, each team had had a dedicated social worker co-located with healthcare professionals. In some cases limited capacity among social workers meant this close relationship proved difficult to sustain in the long-term with social workers eventually only attending multi-disciplinary meetings (MDTs). Since fieldwork things have developed in a more positive direction. Two of the ICM bases have an allocated social worker (SW), with social services currently sourcing a third SW for ICT south. The SWs are now regularly attending all ICM meetings.

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

Admission Avoidance Pathway in Waltham Forest

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

Barts Health Trust
North East London Foundation Trust
GP
London Borough of Waltham Forest
Voluntary sector

UCL

Services and Teams

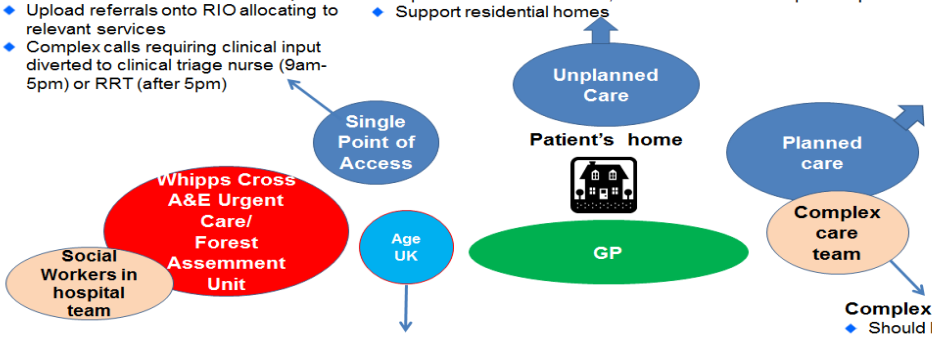
- Manage the referrals and enquiries for all planned and unplanned care services
- Patients and carers can self-refer
- Review the NHS.mail for referrals received and update onto RIO as per SOP
- Categorise referrals received to clusters and specialities and forward onto teams
- Liaise with clinical triage on referrals that have been screened & accepted
- Upload referrals onto RIO allocating to relevant services
- Complex calls requiring clinical input diverted to clinical triage nurse (9am-5pm) or RRT (after 5pm)

Rapid Response Team (RRT)

- Nurse-led 24 hours service, based at Woodbury Unit near Whipps Cross's Urgent Care
- Prescribers from different background (e.g. hospital; community)
- Provide a rapid assessment and immediate treatment for patients within their own homes (e.g. catheter management; chest infections, UTI, managing shortness of breath, heart failure, wound management)
- Clinical triage 20 minutes from receipt of referral
- Response within less than 2 hours for very urgent referrals/ 2-12 hours for less urgent ones
- Out of hours palliative care
- Support patient up to 3 days and then discharge to ongoing management pathway
- If patient known to service, undertake visit if care plan requires review
- Support residential homes

Integrated Care Teams (ICTs)

- All referrals for District Nursing, Community Matron/Case Management & Therapy, Palliative/End of Life care and Continence are sent to one of the three ICTs:
- North Integrated Community Team (Chingford)
- Central Integrated Community Team (Walthamstow)
- South Integrated Community Team (Leyton/Leytonstone)
- ICTs are multidisciplinary teams including:
  - ✓ District Nurses
  - ✓ Community Matrons (ICP patients)
  - ✓ Therapies (OTs and physios)



Provide support and a wide range of services for older people and their carers in WF

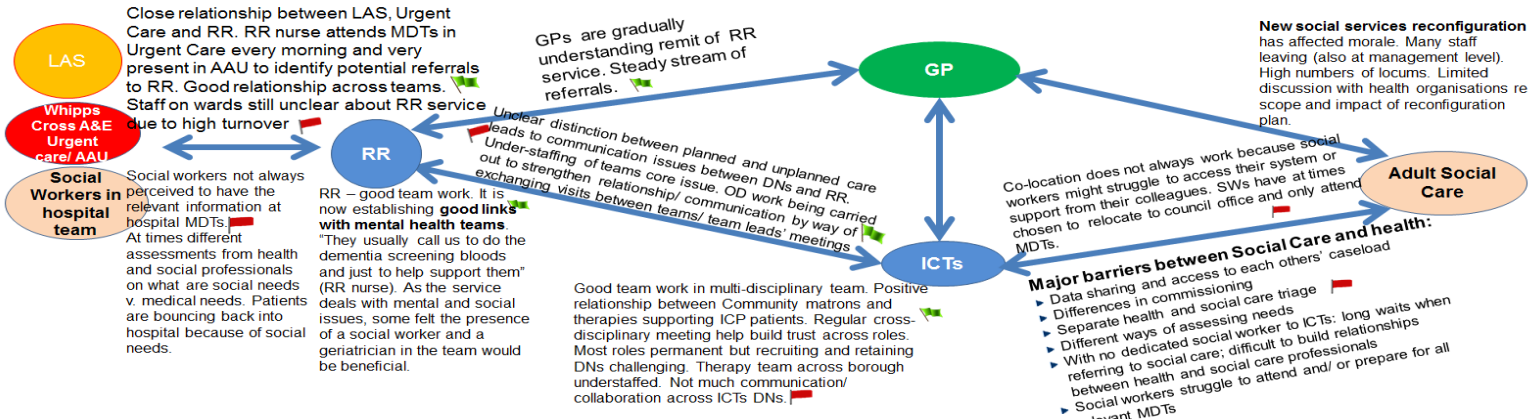
Adult Community Health Services have different functions that operate under planned care:

- District Nursing
- Therapy Rehabilitation Service
- Diabetes Education
- Community Respiratory Team
- Community Matrons/Case Management & Therapy
- Palliative/End Of Life care
- Tissue Viability Service
- Podiatry
- Continence Service
- Nutrition & Dietetics
- Specialist services – Parkinson's; Multiple Sclerosis & Haemoglobinopathy.

Complex care team

- Should be integrated with ICM/ICT
- Three social workers, each attached to one ICT (but also deal with other complex care cases because of a staff shortage)
- Referrals mainly from community matrons
- Weekly meetings with community matrons and GP
- Patients over 18 and on ICP list
- Communication with ICT via ICT email box

Admission avoidance referral pathways



Close relationship between LAS, Urgent Care and RR. RR nurse attends MDTs in Urgent Care every morning and very present in AAU to identify potential referrals to RR. Good relationship across teams. Staff on wards still unclear about RR service due to high turnover

Social workers not always perceived to have the relevant information at hospital MDTs. At times different assessments from health and social professionals on what are social needs v. medical needs. Patients are bouncing back into hospital because of social needs.

RR – good team work. It is now establishing **good links with mental health teams**. "They usually call us to do the dementia screening bloods and just to help support them" (RR nurse). As the service deals with mental and social issues, some felt the presence of a social worker and a geriatrician in the team would be beneficial.

GPs are gradually understanding remit of RR service. Steady stream of referrals.

Unclear distinction between planned and unplanned care leads to communication issues between DNs and RR. Under-staffing of teams core issue. OD work being carried out to strengthen relationship/ communication by way of exchanging visits between teams/ team leads' meetings

Good team work in multi-disciplinary team. Positive relationship between Community matrons and therapies supporting ICP patients. Regular cross-disciplinary meeting help build trust across roles. Most roles permanent but recruiting and retaining DNs challenging. Therapy team across borough understaffed. Not much communication/ collaboration across ICTs DNs.

New social services reconfiguration has affected morale. Many staff leaving (also at management level). High numbers of locums. Limited discussion with health organisations re scope and impact of reconfiguration plan.

Co-location does not always work because social workers might struggle to access their system or support from their colleagues. SWs have at times chosen to relocate to council office and only attend MDTs.

Major barriers between Social Care and health:

- Data sharing and access to each others' caseload
- Differences in commissioning
- Separate health and social care triage
- Different ways of assessing needs
- With no dedicated social worker to ICTs: long waits when referring to social care; difficult to build relationships between health and social care professionals
- Social workers struggle to attend and/ or prepare for all relevant MDTs

There is a fine line between what is *planned* and what is *unplanned* care

So a blocked catheter would be unplanned [care] *because it's blocked, it needs changing. But bypassing catheters that are leaking, that actually can wait for a few hours and becomes planned* [care] […] *But planned services will say it's not planned because 'I* [DN] *didn't have the visit in my diary for today', so it's not planned. But also Rapid Response will say actually, 'If you'd planned better and done better care for your patient, it should be a planned event to go in and change it'. So that's where we're struggling: it's about what is planned and what isn't… What's really easy is if the GP rings in and says, 'This patient has had a fall, they've got a new cut on their leg, can someone go and see it?' then it's obviously unplanned and Rapid Response will go. So those ones are easy. It's the fine line ones that we really struggle with. And the model was sold that actually the District Nurses would go out with their list of patients on a daily basis, those were the patients they were seeing, they wouldn't see anyone else, and the additional resources went into Rapid Response. But the demand far out-stripped the resources that were put in Rapid Response; so then we had to review that and look at how we could manage it better. And I think that's where the issues come from because the nurses felt it was a really good idea, 'I'm going out with my ten patients, this is all I'm going to see. I can plan my day around it,' but actually that's not a reality at all. […] And again, I think the other big issue for me is that Rapid Response take the [SPA] calls after 7 o'clock, so they are triaging them and they know what their workload is, and they know what's out there; but the nurses out there* [DNs] *don't want to hear it. It's like, 'You took the call, it's yours, sort it! […]* ***I think this model would work if you had enough resource to actually do your planned care better.*** (NELFT nurse)

*So when it was historically **ICM,** it used to be the District Nurses and Integrated Case Management, which was the therapy and matrons. Now we're the ICT. When it was the ICM… […] each base used to have an allocated social worker and that's how Social Services were commissioned, so that each cluster got an allocated social worker. […] The ICM function is still there but we're known as **the Integrated Care Team.** So over, I'd say, the past four or five months the social care input has dwindled and dwindled and dwindled; **they no longer attend our MDT meetings.** We find that the Matron is dealing with multiple social workers; whereas before it would be one social worker that you dealt with* (ICT team member staff)

Admission Avoidance in Waltham Forest – Key findings

- NELFT carried out a restructuring of community health services based on the distinction between planned and unplanned care, but, as highlighted by the interview excerpt above, on the ground this distinction can be complicated leading to some confusion and overlap between some services – i.e. Integrated Care Teams (ICTs) and RRT. **Since fieldwork some of the planned/unplanned care issues have been resolved - the leads from ICTs and RRT met and a plan to improve communication and clarify inclusion criteria has been put in place.**
- The RRT, based at Woodbury Unit near Whipps Cross Hospital, works closely with hospital staff. A dedicated nurse attends morning huddles and other relevant MDTs and, when there is capacity, does case finding in AAU to identify patients that can be treated at home.
- WF's RRT is a 24/7 service, unlike in other boroughs, although there is limited capacity at night. The service seems to be well recognised and used across the system. The team's role has widened over time and it now also covers out of hours 111 calls.
- ICTs staff enjoy the multidisciplinary approach. There are no care navigators in WF. Instead community matrons (CMs) manage ICP (Integrated Care Patients) lists working closely with therapies in the team (OTs and Physios). WF staff still continue to use Health Analytics to update ICP lists, unlike the other two boroughs.
- Some staff have mentioned some degree of overlap between DNs and CMs, but being co-located helps staff clarify who has seen which patients and refer directly to other professionals within the team.
- There is a perception that the overall number of therapy roles in the community has decreased following the latest reconfiguration, moving to planned/unplanned care, within a context of already stretched resources. Other roles (team leads) were also deleted with the move from ICMs (Integrated care meetings involving CMs, Therapies, social workers and GP practice) to ICTs, which also include DNs.
- Therapists based in the ICTs are part of a duty rota to screen all community OT and PT referrals.
- While there is good dialogue between NELFT and Whipps Cross Hospital (although some staff mentioned this was still a very hospital-centric relationship), there are a number of issues between health staff (both acute and community) and social services. At the time of fieldwork healthcare professionals often complained that, particularly since summer 2017, access to social workers had become more difficult. Some participants mentioned that a dedicated social worker used to be co-located with each ICT - making it easier to refer and discuss patients. They also complained that social workers hardly ever attended MDTs and it was difficult to develop a relationship with them, as the staff turnover was very high. In A&E/AAU the relationship between health and social care staff also seemed to be fractured and the social worker would not always have or share the relevant information. At the time of fieldwork LBWF was planning a reconfiguration of social services and several interviewees felt there was a lack of clarity about the nature of this service re-organisation. This appeared to affect social services staff's morale and might have contributed to increased numbers of resignations (including at the management level). **Since fieldwork things have developed in a more positive direction. At meeting to discuss these findings in May 2018, ICT staff mentioned that issues with social services are now being addressed and resolved. Two of the ICM bases have an allocated SW, with social services currently sourcing a third SW for ICT south. The SWs are now regularly attending all ICM meetings.** It will be important for commissioners to monitor whether the new allocated resources are sustainable over time and work closely with frontline teams to ensure communication between health and social care staff continues to improve.
- All NELFT employees can access their data system (RIO) through mobile devices, which is helpful when visiting patients and attending MDTs. However, unlike Newham and Tower Hamlets, they have no access to EMIS.

2.2 Looking at Pathways: Discharge from hospital

The discharge pathways are particularly complex in all three boroughs. While there is much focus on Delayed Transfers of Care, with Barts Health Trust supporting consultant-led projects such as **Perform**[5] in all three main hospitals in the WEL area (i.e. Royal London, Newham Hospital, and Whipps Cross Hospital), the interviews highlighted concerns about patients being discharged too early or without the required medication, leading to hospital readmissions. Physios across the three boroughs have mentioned that increasingly patients are being discharged when "medically fit" but still needing high levels of reconditioning rehabilitation which community teams might be not able to deliver.

This is often seen as the result of broken communication between ward staff and community teams. There is limited understanding of community pathways and community provision among hospital staff, because community services are different from borough to borough and medical staff tend to rotate often, making in-depth inductions and training quite challenging. Increasingly separate acute/ community careers and limited opportunities for rotation further deepen the barrier between the hospital and community services. In-reach nurses – nurses with a community background working in the hospital in a community capacity – could act as a bridge between hospital wards and community services, provided they have adequate capacity and recognition within the hospital.

Co-location of health and social care staff at Whipps Cross Hospital (WXH), the Integrated Discharge Team, has not changed working practices; health social care professionals still work in silo and tend to respond to different organisational pressures and priorities. Many in the team believe that having different management lines and lacking genuinely shared vision and objectives has limited the impact of co-location.

Most recently all three WEL boroughs have introduced the Discharge to Assess service (D2A). A D2A team facilitates faster discharge of medically fit patients and provides therapy and social care assessment in the patient's home. The team provides ongoing support (up to 6 weeks) to increase level of function and independence (see Table 2.2 for a comparative description of D2A across WEL). The D2A service, based at WXH, is becoming well embedded in the discharge pathway and is increasingly recognised and used by ward staff. It has still limited capacity and issues with late evening discharges can undermine the effectiveness of the service. D2A works closely with the Reablement team. There have been issues of limited access to each other's data system and caseloads; high turnover of staff in Reablement; and poor handover of D2A cases between senior reablement officers working with the team. These have been addressed and mostly resolved through ongoing dialogue and mutual trust. Trusted Assessment is used effectively across health and reablement staff within D2A.

The effective embedment of new services within a complex and highly regulated system such as the NHS requires time and changes to services and pathways are not always adequately communicated and understood across the system and the pace of change is often perceived to be too fast. The issue of fast-paced change has emerged quite strongly and has unveiled a few paradoxes. For instance, in WF there is ongoing discussion about the need to merge the Rapid Response team and the D2A service into a wider intermediate care service, since there is a clear need for nursing skills within D2A. However, a similar service called INTER-CARE, including the Community Rehab team and the Rapid Response nurses, had

been dismantled only a few years ago. One NELFT employee commented, *"In the NHS, if you stand still long enough things will go round and you come back to the same spot"*.

Table 4.2 – *Discharge to Assess (D2A) service across WEL*

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

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

Barts Health Trust
North East London Foundation Trust
GP
London Borough of Waltham Forest

UCL

Services and Teams

Hospital Team

- 15.5 staff: 12.5 social workers; 2 senior practitioners; 1 manager
- Social workers allocated to different wards, based on skills and numbers of section 2s and 5s
- 2 designated workers in ED
- Six weeks reviews
- Out-of-hours discharges

Discharge Team

- 3 patient flow coordinators; 3 discharge coordinators; 1 clinical lead; 1 manager; 1.2 admin
- Complex discharges
- Input on continuing care assessment/ fast-track patients
- Single Point of contact for rehab services
- Attend board rounds
- When the hospital is in crisis involved in basic discharges (i.e. contacting nursing/ residential homes).

Ainslie Unit

- Community hospital
- Referrals mainly from acute (i.e. Whipps Cross hospital)
- Case finding function through therapist on hospital wards
- Provide rehab following falls, joint/ hip replacements, but also respiratory rehabilitation to patients over 18 and resident in WF
- 32 beds
- Over 50 nursing staff; therapists (including speech therapist); on site pharmacist; 1 social worker per ward (but **no longer co-located**); dietician (external)

SW Hospital Team
Discharge Team
Ainslie Unit
Integrated Discharge Team/ Whipps Cross
Health and social care staff colocated at Whipps Cross Hospital

Discharge to Assess (D2A)

- Pilot started in October 2016/ co-funded by LBWF and Health
- 5 days a week 9am-5pm service/ moved to 7 days with Winter money (but few referrals at the weekend)
- Led by NELFT working closely with Reablement – nurse support from Rapid Response
- Facilitate early discharge of medically optimised patients/ reablement package starts on day of discharge up to six weeks
- Maximise independence
- Provide timely therapy and social care assessment in the patient's home environment
- **Plan to expand to cover complex discharge pathway**
- Multidisciplinary team:
  - ✓ 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

Hospital to Home Pilot
Rapid Response
Reablement Team

Reablement

- Improve people's function in the community
- Facilitate discharges from hospital
- Patient on caseload for up to six weeks
- Referrals from acute, community, and social workers
- Three members of staff work on D2A service with NELFT therapies

Patient's home
GP

ICTs
Complex care team/ ICM

Integrated Care Teams (ICTs)

- Three teams (Chingford; Walthamstow; Leyton/ Leytonstone)
- ICTs are multidisciplinary teams including:
  - ✓ District Nurses
  - ✓ Community Matrons (ICP patients)
  - ✓ Therapies (OTs and physios)

Complex care team/ ICM

- Part of Complex Care which deals with legal cases/ safeguarding
- Should be integrated with ICM/ICT
- Three social workers and two assistants, each attached to one ICT (but also deal with other complex care cases because of a lack of staff)/ partly funded by CCG
- Referrals mainly from community matron
- Weekly meetings with community matron and GP
- Patients over 18 and on ICP list
- Communication with ICT via ICT email box
- Also includes dedicated social workers overseeing discharges from Ainslie Rehab Unit

D2A

- Positive patient experience data and ongoing dialogue between NELFT and reablement team to address issues
- **Trusted assessment across team**
- Capacity issues and reconfiguration of Reablement team has affected relationship and integration efforts and led to poor retention of staff (including management)
- High turnover of reablement staff working with D2A → poor handover and attendance at daily meeting
- Difficult to find SRO willing to relocate at Whipps Cross with D2A team
- Good relationship between D2A NELFT therapies and RR – referrals by direct calls for nursing support

Discharge referral pathways :

Despite co-location of health and social care staff in the Integrated Discharge team, each time works in silo and having different management lines complicates relationships of mutual trust. No regular communication between Adult social care senior management and IDT management (Barts health Trust).

SW Hospital Team
Discharge Team
Hospital wards

Ward staff more aware of D2A service
Discharges from WXH - often late in the day, and d/c dates changes at short notice

- Often no nurse handover when patient is discharged to ARU
- Patients often discharged without required medication
- ARU set up system of "discharge alert" to CCG to report inadequate discharge process

Staff in community services feel that patients are often discharged too early from hospital – leading to cases of failed discharges

RRT
Reablement
Hospital to Home Pilot

Most patients don't need further therapy input following D2A 6 weeks. When urgent input from GP or DNs is required it has been difficult to access RRT. (i.e. 3 days wait). GPs tend to refer to

Ainslie Rehab Unit (ARU)
Social workers from Complex care team working with ARU

- 2 SWs working with ARU (1 per ward) to set POCs for patients
- Attend MDTs but not based there
- ARU staff feel relationship would be stronger if SWs were based there
- SW said that when co-located at ARU they did not have access to their own data system and colleagues' support

- Good relationship between ARU and ICTs – close working with community matrons and DNs
- Easy to refer through SPA and follow up with ICTs

Issue with inappropriate/ incomplete referrals from WXH to ICTs/ referrals not always sent to DNS – i.e. referral for wound dressing without mentioning patient had cancer

GP
Complex care team/ ICM
ICTS

- Perception that social workers have been less present since summer 2017 – **things now improving**
- **Difficult for only three social workers** (some newly trained) to attend all relevant MDTs/ ICM in the postcode they're allocate to.
- High turnover of staff in Adult Social Care is an issue

I started in September and I already had two managers appointed to do this. I don't think it is a unique situation in Waltham Forest, I think it is everywhere. [...] In the last five years Social Care has shrunk at least in half in terms of staffing, there is no money to employ more staff, I'm fully aware of it. But we are turning into a bit of the delivery service [Social Worker]

It just seems that they are so desperate to get their estimated discharge date. Obviously the minute you are admitted they are already doing that, but I think because they've got that in mind they are almost forgetting that there's other stuff still going on with people [Community Nurse]

Why can't I set up a package of care? Because I've got enough experience and that... If someone needs someone to go in and look after them three times a day, why can't I as a nurse set that up? Why do we have to wait for social worker? So I find that that kind of boundary is still there, and I think that limits the success of having an integrated team, we are not working across [Ward Nurse].

All referrals to community services go through the Single Point of Access (SPA)

Out of hospital pathways

- **D2A/Reablement** – *Patient can benefit from OT/Physio assessment*
  - **Reablement**
    - Reablement POC required on discharge with OT/PT follow up within a few days
    - For other social services needs referrals to Integrated Discharge Team
  - **D2A**
    - OT/PT input required on day of discharge
- **Community rehabilitation** – *Existing package of care/ family OT/PT input to progress function*
  - **WFRS** intensive rehab for up to 6 weeks
  - **ICT therapy** Long-term condition management

In-patient rehab

- Rehab needs cannot be met at home
- Assessment carried out on ward
- Plan transfer to Ainslie Unit for up to six weeks

The **Waltham Forest Rehab Service** (WFRS)– based at WXH – triage all therapy referrals. ICT therapists also get direct referrals from CMs and DNs in their teams.

Discharge Pathways in Waltham Forest – Key findings

- Like in Newham, Whipps Cross Hospital's (WXH) Discharge Team and the social worker in-hospital team are co-located and together they form the **Integrated Discharge Team.** However, co-location has not changed working practices; healthcare professionals and social workers still work in silo and tend to respond to different organisational pressures and priorities. Many in the team believe that integration has had limited impact on their day-to-day work and feel that only by having one team with one management line and genuinely shared vision and objectives it will be possible to drive meaningful integration.
- While there is close dialogue between the CCG, NELFT and WXH, LBWF is often missing from these conversations.
- **In the past year the gap in social care had increased dramatically**, because of reconfigurations, high turnover of staff (with difficulty in retaining management staff) and generally limited capacity in all parts of the system – acute and community. It was initially agreed there would be dedicated social workers attached to each ICT, and to ARU (Ainslie Rehab Unit). However, because of a lack of capacity in the Complex Care Team these social workers were relocated to the Complex social care team office. Some social workers mentioned that co-location with healthcare teams did not work for them, because they could not access their own data system or their colleagues' advice and support. As examined in the Admission Avoidance section, social workers have recently been allocated to ICM bases. These changes are undoubtedly a positive step forward. However, commissioners should pay close attention to the challenges experienced by social workers when co-located with health teams, in order to ensure recent changes are sustainable.
- As in the other two boroughs, there are a number of **communication issues between ward staff and community staff -** including intermediate clinics such as ARU - which affect discharges, with patients being discharged without the required medication; inappropriate referrals to community teams; DNs not receiving referrals although the patient had been promised a visit following the discharge, etc.
- The **D2A service**, based at WXH, is a supported home discharge pathway for those needing rehabilitation/reablement. It is becoming well embedded in the discharge pathway and is increasingly recognised and used by ward staff. It has still limited capacity and issues with late evening discharges can undermine the effectiveness of the service which at the time of fieldwork only functioned Mon-Fri, 9am-5pm. As the service is starting to get referrals also from the community to prevent admissions, staff can feel overwhelmed, and the service might need to define more clearly inclusion criteria and/ or increase capacity.
- D2A works closely and effectively with the **Reablement team**. There have been issues of inability to access each other's data system and caseloads; high turnover of staff in Reablement; and poor handover of D2A cases between senior reablement officers working with the team. These have been addressed and mostly resolved through ongoing dialogue and mutual trust. Trusted Assessment is used effectively across health and reablement staff within D2A.

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 4.3 – *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

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

In Waltham Forest there is a dedicated task and finish group co-led by the CCG and the Health and Wellbeing Board. WF CCG has commissioned the not for profit organisation Social Finance to develop an End of Life Care model over the next two years, based on a 'hospice at home' approach. This new model aims to increase capacity of the community nursing team based at the Margaret Centre (WXH); improve identification of palliative patients in the community; raise general awareness and education around end of life across health and social care professionals; and foster better integration across teams.

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

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

Below we summarise main findings:

- **Task-orientated approach to care** both in hospital and the community affects identification of end of life patients;
- **There is a lack of consistency of EOLC provision in the community;**
- Some interviewees mentioned that regular Gold Standard Framework[6] meetings should be essential for district nurses to attend;
- **Filling in fast-track forms can still be a challenge** for busy ward staff, as well as GPs, which might delay the process. Nurses and medical staff tend to rely on specialist teams in the hospital or community palliative care teams. However, the latter often have limited capacity and should be focusing on more complex issues and symptom control. Furthermore, they might not have the required knowledge of patient needs to fill in the form properly, as the professionals caring for them would. By the same token, some DNs in WF mentioned that what would work best from their perspective would be to have the professionals that first identify a patient as EOL taking ownership of the fast-track process and ordering equipment, rather than delegating to others, which inevitably requires further assessments and causes unnecessary delays;
- In Waltham Forest, **communication issues between the CNS and DNs** have emerged and some have suggested this relationship would work better if the CNS team, currently under BHT, were part of NELFT. There is a perception that this would ensure that the CNS team had more visibility in the community. This is yet another example of the challenge of building effective collaboration across different Trusts on the ground;
- There is still limited awareness of need for and capacity of **therapies for EOLC patients** (specialist palliative OTs);
- Generally, frontline professionals in the hospital and the community feel there is a lack of awareness of EOLC among GPs.

Map of End of Life care in Waltham Forest

End of Life Care pathway in Waltham Forest

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

UCL

Services and Teams

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

Rapid Response
- Based at Whipps Cross hospital
- Provides HCA (Healthcare assistant) for night sitting
- 24h nurse-led urgent care service

Rapid Response

Barts Health Trust Specialist Palliative Care team

Marie-Curie nurses
- Provide one-to-one nursing care and support (i.e. overnight) in the home, usually for eight or nine hours.
- Currently in WF, Marie Curie budget is sitting with Rapid Response

Marie Curie nursing service

St Joseph's Hospice Community Palliative Care Team :
- Provide clinical guidance and supportive care on social, emotional and spiritual matters
- Limited involvement in Waltham Forest – perceived as out of borough by residents who prefer Margaret Centre

St Joseph's Community Palliative Care Team

Community Palliative Care team
- Based in the Margaret Centre
- 6 CNSs and 1 part-time consultant
- Mon-Fri 9am-5pm service
- Visit patients in the community
- Cover all WF; each CNS has caseload
- Complete Fast track of identified EOLC patients
- Work with DNs and ICTs' therapies/ attend ICM meetings
- Funded by BHT but working under NELFT's umbrella – **policy and guidelines grey area**

Community palliative care team

Margaret Centre

The Margaret Centre
- 12 beds hospice based at Whipps Cross hospital
- Medical cover 9am-5pm (admitted to A&E)
- Provides specialist palliative care for people affected by life-limiting illnesses
- Provides advice and support in the hospital and the community

Patient's home

Provides packages of care for fast track

GP

ICTs

Adult social care

- GPs and district nurses in charge of non-complex palliative care in the home and take responsibility for prescriptions

EOLC in the community

- The community palliative care team is very stretched with only 6 CNS covering the whole borough
- Limited out of hour service - Rapid Response have an HCA overnight that can sit with patient but there is limited capacity
- There is no longer a community Palliative OT (locum has recently left, no plans for recruitment)
- There is no palliative social worker in the community
- The 6 CNS rely on ICTs' therapy and DNs but there is **limited collaboration**

Although we do work with the ICTs in the community, which obviously have access to occupational therapy, I think you'll find that when patients refer to palliative care they're almost passed on as if to say, 'Well you know your responsibility now'. […] So in terms of kind of integrated working there there's gaps really and it is disjointed.
[Specialist Nurse]

- Several great teams doing great work, but they work very much in isolation
- CNS organise monthly Gold Framework meetings at Margaret Centre but community staff (including GPs) do no attend – **barrier between BHT and community/ NELFT. CNS team caught in between as paid by Barts but working closely with community**
- Limited resources: CNS faxing to communicate with ICTs and GPs
- Confusion around referral form for DNs which include palliative care – incidents where GPs wanted to refer to specialist team but referred to DNs by mistake. DNs not always aware of when to escalate to CNS
- Difficult relationship between DNs and CNS – lack of clarity around roles
- A number of services were lost

We used to be able to ask 'Can this family have a little bit of respite?' [...[and they would take them in for a week or two. But now that has gone as well. (DN)

Years ago we had a man with a van, so if we had anyone coming in for respite and the odd symptom control admission would just be picked up and dropped off home. And we had a cat, we had a washing machine, we had a day centre.
(Palliative community nurse)

Fast Track: whose responsibility?

- Specialist teams often picking up the pieces and completing/ submitting forms

It distracts us from doing core business which is symptom control for patients. And then we have to go and meet the patient when teams already know them. District nurses obviously know the family really well, know what their care needs are...
(Consultant)

EOLC in the hospital

- BHT hospital palliative care team, the Margaret Centre and the community palliative care team should work as an integrated service but the hospital team works in isolation (i.e. psychological support for patients)
- The Margaret Centre is registered as a hospice for palliative care but when there are empty beds, the in-patient unit is expected to take acute admissions with other care needs from other areas of the hospital. Not all nurses are trained to treat acute patients placed at the Margaret Centre
- Gaps in transition from acute to community – staff mentioned need for one transferrable document (i.e. Respect)
- Lack of financial governance – i.e. monthly activity reports against contract

What is happening to address these gaps?

- Programme of palliative champions has been agreed
- Investment in EOLC (although not as much as initially planned)
- Transformation board Task and Finish Group on developing EOLC as accountable care system (**but BHT community team not invited**?)
- Coordinate my Care pilot in Chingford (some staff pessimistic about it taking on because GPs might not have capacity)
- Work led by Social Finance

I hope we get the model right. And then it doesn't become political battle ground around who is going to run what. Because I think that, in a way that's a shame... […] Because if everyone wants to lead... unless one partner is willing to follow how are you ever going to be working to the same thing? And I guess that's where they sort of see the provider, the Accountable Care system comes into play because it puts all the money in one organisation's pocket and then you can sub-contract out to other organisations. But I think there will be some power struggles with that..
[Specialist Palliative Care]

What other solutions do staff envisage?

- Targeted training for DNs (i.e. Band 5) for them to take ownership. Not all palliative patients need referring to specialist team
- Joined up services: Margaret Centre-CNS-Hospital specialist team-DNs-GP-Rapid Response to have a **Hospice at Home** or 24 hour access to palliative advice. Currently too many services with little clarity on who takes responsibility over what.

So we'd say give us the Fast Track money, we will set up a Hospice at Home service; or we will commission a **Hospice at Home service**, for which we will have absolute responsibility. And we will be responsible for the training of those carers, the outcomes, for the documentation, for the governance, and if it starts to go belly up you can come to us, we can use the Margaret Centre as that hub.
(Consultant)

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

3.1 Current OD work

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

More recently the ELHCP has invested in two pilot OD programmes focusing on specific workstreams, including End of Life Care. The ELHCP's OD work has only recently started and is beyond the scope of this evaluation.[7] Instead, here we look at programmes that were implemented at borough-level based on partnerships between health Trusts and local authorities, with the aim to support integration and coordination across health and social care. Our focus is on the impact of these programmes on frontline staff involved in the three pathways under study.

In Waltham Forest, the Better Care Together Fund has been used as the driver of a wide-ranging transformation initiative that brings together WFCCG; LBWF; NELFT; BHT and the voluntary and community sector. Although this work is not labelled as OD, the intent is to drive transformation, strengthen integrated care and support plans for all service users. The programme is divided into 3 work streams: Wellbeing; Coordinated pathways; and Strategic enablers.

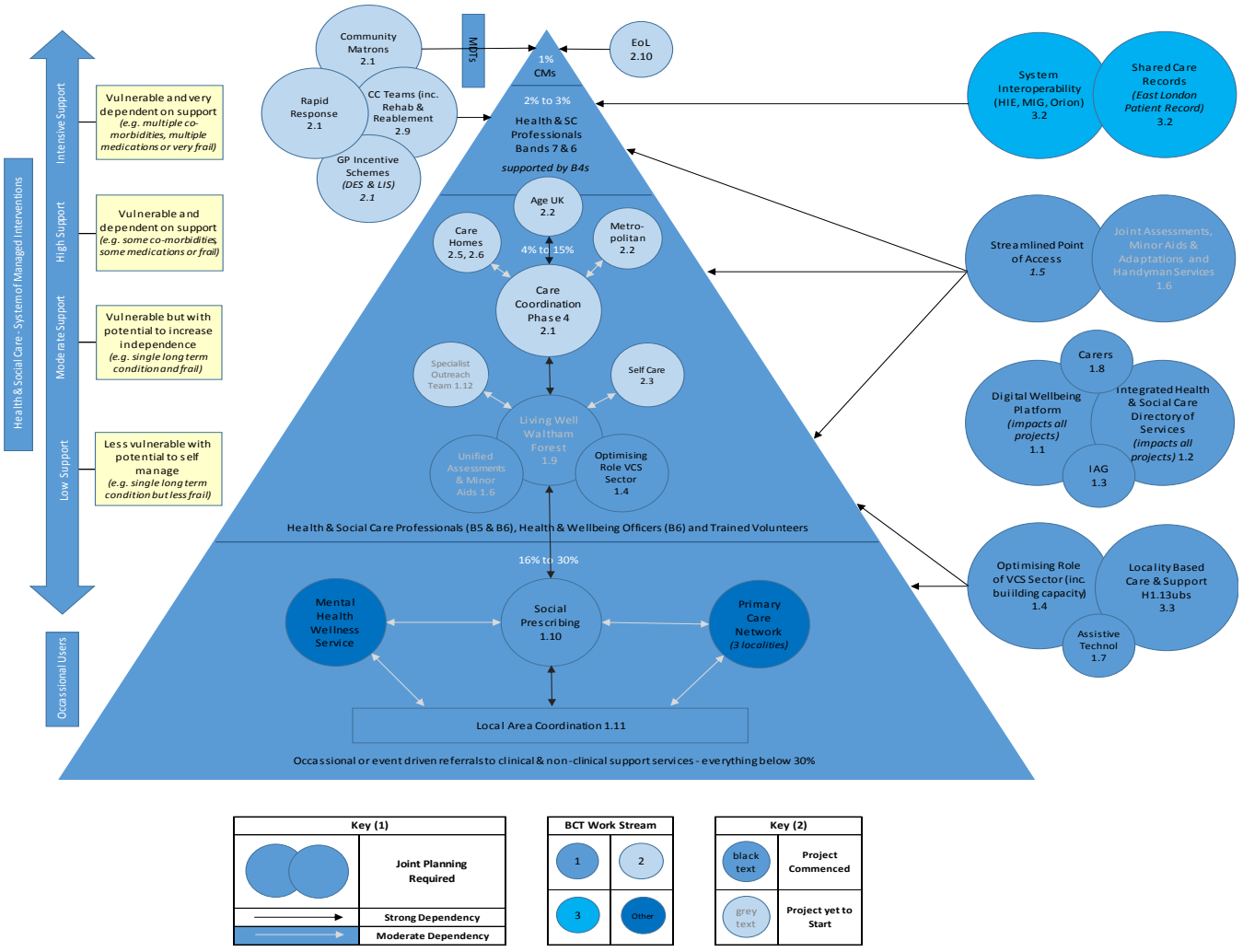
WF developed a new 'system model' known as the Managed Network of Care & Support (see Figure 3.1). The aim of this model is precisely to improve connections between services so that transfers of care are managed in a more 'seamless' way. WF's plans for 2017/18 include a number of developments that focus on joint assessments and integrated care planning, having recently set up a multi-stakeholder planning forum that also includes partners from the voluntary sector.

Most OD work targeting frontline staff across WEL consists of staff engagement events and away days, with most organisation change at this level based on project management and QI initiatives.

Staff engagement events, workshops, and away days are popular, although mainly at organisational level (i.e. NELFT's engagement event for their own staff). 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 which might have 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.

Figure 3.1 Managed Network of Care & Support



3.2 Insights from the frontline

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

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

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

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

Many called for

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

Staffing pressures inevitably weaken sustainable organisation change and represent a barrier to some of the suggestions above. Recruitment and retention of staff remain huge challenges across all care settings. This means that organisations are more cautious about releasing staff to support service improvements and organisational development activities. Stakeholder organisations in Waltham Forest are considering creating a range of new roles to help ease staffing pressures (e.g. Physician Associates, Self-Care Pharmacists, Health and Wellbeing Officers, Local Area Coordinators and Social Prescribers). The success of Care Navigators in Tower Hamlets and Newham suggests these roles might prove helpful; by the same token new roles take time to embed in a complex and highly regulated system and might further fragment delivery of care**.**

4.4.3 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. Two good cases were identified in WF.

- WF ICT and Rapid Response leads addressing communication issues between the teams and confusion about referrals by organising meetings and developing an action plan;
- D2A health professionals and reablement team strengthening a relationship of trust and enabling trusted assessment through ongoing dialogue.

These are good examples 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.

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

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	○ Strong national rhetoric in support of coordinated care and accountable care systems (i.e. urgent care; EOLC)
Enablers: Horizontal integration/ health-social care	○ Efforts to align frontline delivery (i.e. SWs allocated to ICM bases); encourage trusted assessment (D2A in WF)	○ Work on developing/ strengthening **distributed leadership**, often on the initiative of frontline staff	○ Strong national rhetoric supporting integrated care
Barriers: Vertical integration/ acute-community care	○ Fragmented system with different trusts increasingly focusing on different parts of	○ Increasingly separate careers between acute and community ○ Knowledge gap in acute sector of community provision/	○ All parts of the system understaffed/ stretched ○ Difficulty in recruiting and retaining healthcare professionals ○ High turnover of staff

	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 in the hospital)	roles	○ Complex and ever changing community pathways: new services take time to embed within complex, highly fragmented and regulated system
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

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 –** the initial issues experience by staff following the planned/ unplanned care reconfiguration of community services might be an example. This contributes to exacerbating the gap between strategic vision and operational delivery. 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 in the locality 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. WF's leads of D2A and Reablement working toward better integration between the two teams) or raise awareness among colleagues about specific aspects of care. 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**
   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.[8]

5. **Create collaborative interpersonal relationships**
   There has been some work on promoting collaboration and raising awareness of organisational and inter-organisational functional interdependencies. 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.[9]

6. **Continuously assess and learn from cultural change**
   Health and social care organisations in WEL as elsewhere invest in research on many levels, from audits to quantitative and qualitative evaluations of various interventions. The culture of evaluation is often driven by a focus on meeting targets and demonstrating outcomes and accountability, rather than building learning. More resources could be invested in cultural assessments and fostering environments that support learning. For instance, processes to

engage staff in collecting and sharing data across teams and organisations, in an open manner, might help foster ownership of the data and reinforce a learning environment based on mutual trust.

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

6. 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.
- Some staff in Waltham Forest mentioned that there can be considerable time gaps between assessments from healthcare professionals and social care assessments. This can be problematic as unaddressed social needs might then deteriorate into medical needs.
- Participants mentioned the issue of fewer carers on the ground as demand continues to rise.
- Different organisations appear to have different guidelines and this might have serious repercussions on care delivery. One example mentioned by staff was that WF CCG and NELFT have different guidelines on GP visits for EOL patients. While NELFT would expect GP visits every two weeks for these patients, GPs often disagree.

- Rigid role boundaries can hinder holistic care. In particular, healthcare professionals in the community felt GPs should take more ownership of EOLC patients. Across all boroughs both DNs and specialist nurses often mentioned a lack of the required awareness and knowledge of EOLC among GPs.
- Generally, staff across all part of the care system felt people should take more ownership and not delegate to other roles as much as it currently happens.

Based on these reflections and the findings presented in the report, we list two main sets of recommendations that address issues of both vertical and horizontal integration.

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

a) **Well-resourced and visible in-reach nurses** (nurses with a community background working in the hospital and attending board rounds to identify patients for discharge to community teams) could help bridge the communication gap;
b) **Regular meetings between DNs and discharge teams** in the hospital could ensure hospital staff are familiar and up-to-date with community pathways and provision;
c) **Compulsory training for junior doctors** (not just junior GPs) with community teams would ensure medical staff can gain an understanding of different roles in the community;
d) Organisations should consider reinstating **rotations across acute and community**, also as part of staff early training, particularly for roles such as OTs and Physios. Rotations can help staff gain a better understanding of the whole pathway and address the issue of silo-working;
e) **Collaboratives** for similar roles across acute, community and social care could help staff gain a better understanding of different roles and whole care pathways;
f) Providers and commissioners should **support the establishment of forums/ spaces/ peer-learning meetings** that can encourage dialogue and reflections among different roles/ teams involved in the same pathways.

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

a) Work with frontline staff to find ways to enable and support **trusted assessment** across health and social care professionals, by aligning organisational guidelines and priorities and embracing a culture of learning;
b) Support staff to plan **joint visits** and **assessments** (e.g. DNs and therapies; healthcare professionals and social workers) to help them develop a more holistic approach to care and build mutual trust;
c) Enable and support **distributed leadership** that can be instrumental in embedding new practices and raising awareness, though peer-support and training;

d) When co-locating social workers in a healthcare team or vice-versa, make sure you learn from previous failed experience of co-location, in order to support staff and ensure sustainability. Previous efforts 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.

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APPENDIX

Methods and participants

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

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

NOTES

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

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

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

[4] These are non clinicians supporting complex adults and helping them navigate the health and social care system, ensuring they get the required support to attend hospital appointments and have access to the benefits and care they are entitled to.

[5] 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.

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

[7] 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.

[8] 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.

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