

# Locality based approaches to integrated care in Tower Hamlets

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Interim Report – Phase 1

June 2018

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## Executive Summary

### Background

Tower Hamlets has an extensive history of partnership working which has been a key enabler in the development of an integrated care system. In 2015, a partnership of commissioner and provider health, social and voluntary organisations in Tower Hamlets was awarded Vanguard status and became known as Tower Hamlets Together. (Tower Hamlets Together 2018) In 2017, the procurement of Community Health Services (CHS) was finalised with mobilisation of a CHS Alliance contract with the THCCG, GPCG, ELFT and Barts Health. In March 2018, the Vanguard programme came to an end and steps are being taken to sustain the partnership to deliver a complex agenda.

The Vanguard programme has provided an opportunity to consider the way in which the system is organised and how services are delivered to meet the needs of the local population. Three workstreams have been developed to strengthen post-Vanguard collaboration across partners and promote local population health and wellbeing by delivering better integrated services around the following population groups; Children – Born Well and Growing Well, Healthy adults – Living Well, Complex adults – Supporting and Promoting Independence.

Tower Hamlets is split into four localities within which a Primary Care network model operates with eight GP networks each serving a population of around 30000-50000. Each locality has a multi-professional community care team known as an Extended Primary Care team (EPCT) (reconfigured from Community Health Teams) and a Locality Health and Wellbeing Committee (LHWC). Future plans for the locality model are centred on the locality becoming a fundamental component of a borough wide integrated health and social care system that aims to improve the health and wellbeing of the local population, focussed on prevention with consideration of the wider social determinants of health.

The report also draws on findings from a parallel evaluation (Bussu 2018) of the final phase of the Waltham Forest and East London Integrated Care programme undertaken between May 2017 and June 2018 - *'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.'* This evaluation sought to understand the delivery of integrated care on the ground, looking at specific pathways to assess collaboration patterns within and across multidisciplinary teams from acute, community and social care.

This report explores the effectiveness of the Vanguard and Community Health Services (CHS) model to enable **collaborative working** across the partnership at the strategic, operational and service delivery levels. The evaluation will understand the impact on staff and person outcomes at the locality level using the EPCTs and LWHCs as case studies for generalisable learning. The next phase of the evaluation will explore the implementation of the locality model focussing on the EPCTs and LWHCs as well as the extent of citizen engagement in health and social care service design in Tower Hamlets.

### Methods

This evaluation has used a model of participatory research in which the researcher has been embedded in the Vanguard programme. This interim report describes the findings from a formative

evaluation in which the researcher has observed locality level (EPCT/LHWC), operational and strategic level THT meetings and undertaken 20 interviews with individuals at these levels. Findings were organised using a framework proposed by *Cameron et al* (Cameron, Lart et al. 2014) that considers the key barriers and enablers for partnership working between health and social care organisations and professionals categorised as organisational, cultural/professional and contextual factors.

## Findings

The key themes from the evaluation are:

**1. The vanguard was perceived to be an effective enabler for greater collaboration between organisations.** Among all partner organisations and at all levels there was a shared vision in terms of improving the quality of service provision for Tower Hamlets residents. This was more than mere rhetoric and seemed to be espoused by all stakeholders which was reflected in a concerted effort to planning and implementing initiatives that would ultimately result in a better quality of health and social care for residents. Evaluation participants perceived the Vanguard programme as an enabler for the successful implementation of governance structures, managerial and administrative systems and a substantive organisational development programme that has built a foundation for the post Vanguard health and social care system. This includes the formation of a Joint Commissioning executive and a CHS partner Alliance board. Together this has provided the basis for greater collaboration at the strategic level between partner organisations. Furthermore, establishing certain key system enablers were seen as important in providing a platform for partnership working at all levels:

- a) **Adult Social Care (ASC) alignment with the CHS model:**
  - Combined front door/Single Point of Access
  - Integrated intermediate care (short-term rehab and reablement)
  - Long term care locality model
- b) **Formation of life course workstreams** that focus on a population health approach and use QI methodology to improve care systems for their population with a view to engaging the breadth and depth of services in Tower Hamlets so as to address the wider determinants of health.
- c) **Co-location of health staff** within the EPCTs with nurses, therapists, mental health practitioners, care navigators and in some case social workers was seen as the cornerstone of future effective partnership working and there is a small evidence base to support this notion. (Gibb, Morrow et al. 2002).

**2. In recent years there has been a shift in health professional mindsets to an ethos of promoting self-care and management.** In part, the Vanguard is perceived to have propagated a shift in the mindset of health professionals, acting as an enabler for partnership working; transitioning from a medical model of 'diagnose and treat' to a more social, holistic approach that focusses on prevention and involves a range of other professionals from health, social and voluntary care. In the community setting, this multi-disciplinary, person-centred approach has been most successful in managing patients and service users who have the most complex care needs. Indeed, there was a degree of mutual trust, respect and appreciation of profession specific skills and knowledge among some health and social care professionals especially GPs, care navigators and social workers.

Nonetheless, some of the key differences between the professional culture of health and social workers were evident. (Leutz 1999) For example, social workers viewed health colleagues as risk averse whereas district nurses suggested that they often had to meet the social needs for patients due to a lack of capacity of within social care which is a similar finding from the parallel evaluation mentioned above.

**3. There is need for more effective communication and information sharing with bottom up engagement.** Initial findings appear to suggest a gap in communication and information sharing between the strategic level (THT senior management) and some frontline staff with a lack of bottom-up engagement, a challenge noted in a previous evaluation of integrated care in the borough (Eyre, Farrelly et al. 2016) as well as the more recent evaluation of the final phase of WEL (Bussu 2018). Some frontline staff (inc. service managers) struggled to articulate the purpose of the Vanguard programme and in particular expressed some doubt as to whether change in the quality of care and in health service and patient outcomes was attributable to the Vanguard. Both health and social care professionals also expressed concern at a lack of involvement in service redesign consultations. Additionally, more regular senior presence at the LHWC meetings might contribute to improving communication, buy-in and commitment from committee members.

### Suggested actions

In light of these findings we make a series of suggestions for consideration to ensure the barriers to partnership working are addressed so as to facilitate the implementation of the locality model and the development of EPCTs and LHWCs. It is hoped that these suggestions will be further co-designed and developed with evaluation participants to ensure they are pertinent, tangible and feasible.

1. **Continue with activities that enhance partnership working between frontline professionals but make them more targeted.** Focussed OD work needs to be undertaken with EPCTs and LHWCs to enable their development. Professional identities have been suggested as a barrier to inter-professional working and cannot be overcome by ‘teaching or preaching’ but learning from practical experience. (Holloway 2001) Creating a partnership culture which fosters respect, trust, distributed leadership and mutual accountability will assist in the development of the post Vanguard system. Our research team at UCL is working with TH partners to design a maturity matrix that assesses the extent of partnership working in the LHWC and will act as an important tool in understanding the key barriers and enablers to collaboration at the locality level.

Suggestions to improve collaboration provided by interviewees included:

- Joint training and education sessions (between health and social care staff)
- Less structured meetings and more social gatherings over lunch or after work activities.
- Shadowing each other to develop a deeper understanding of roles and responsibilities.

*O’Daniel et al* (O’Daniel and Rosenstein 2008) suggest creating ‘partnership champions’ that are responsible for providing a platform to encourage different professionals to come together, facilitating collaboration through organising social and professional development events and arranging meetings that focus on troubleshooting specific inter-professional

issues through open dialogue, while ensuring principles of trust and respect are upheld in multi-professional teams.

2. **Engage frontline staff in service development.** Ensuring frontline staff are members of key operational steering groups is one approach to increasing engagement. Yet, bottom-up engagement, involving staff in strategy through distributing leadership also warrants consideration. For example, some staff suggested Network Managers were better placed to lead the LWHCs than GPs given their intimate knowledge of the needs of the local population, awareness of community assets and relationships with voluntary care partners. Indeed, collegiality over consultation will facilitate engagement as well as mobilising pertinent knowledge and experience of frontline staff to assist in the development of service design strategy.
  
3. **Improve top down communication and acknowledge bottom up information.** In the LWHCs in which the assigned Alliance Board members regularly attended meetings and were actively involved in discussions about future planning and strategy, appeared 'further ahead' in their phase of development. This link to the senior level is crucial to maintaining engagement from LHC members. The board representative acts as a conduit for vertical top down and bottom up communication and information sharing. For example, in one of the LWHCs where Alliance Board representation was absent there were concerns that issues raised in meetings that required consideration by senior management would not be addressed causing frustration among the members, risking disengagement. The LHCs are thought to be an integral part of the future care system in Tower Hamlets and engagement from senior management while they are still evolving will support their development. Creating a formal mechanism for reporting and feedback where the Alliance Board representatives provide regular relevant updates (including those from THT) and addresses issues raised in previous meetings, are simple approaches to enabling engagement. Senior management support has previously been suggested as an important facilitator for effective partnership working. (Regen, Martin et al. 2008)

### Concluding remarks

The findings from this evaluation indicate that Tower Hamlets has successfully instituted a several system components that act as enablers for horizontal integration and effective partnership working which is apparent at the strategic level between organisations and senior managers. This, in part, has contributed to a cultural shift in the approach to patient care from health professionals recognising the holistic needs of a patient, the importance of promoting self-care and the need to address wider social determinants such as housing, domestic and welfare issues. This may explain the successful integration of social prescribers and care navigators into the health and social care system in Tower Hamlets. Yet, addressing some of the barriers presented above may further enable partnership working, reducing care fragmentation and duplication and improving the experience of patients and service users. In particular, involving frontline staff in service redesign and development would provide a better understanding of what change is needed, if at all. Moreover, co-location does not always foster inter-professional working but concerted efforts to provide a space for learning and sharing will develop relationships and overcome issues of professional identity that may hinder effective partnership working.

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## Introduction

Health and social care systems in the UK are facing unprecedented pressures to manage rising demand from an ageing population which is compounded by an increasingly demotivated and constrained workforce and the requirement to operate within tight financial parameters. (Ham, Dixon et al. 2011) Integrating health and social care systems has long been thought of as a means of streamlining and alleviating burden on services while maintaining the quality of care even as patients minimise their contact with a multitude of different services. (Humphries and Curry 2011) The term 'integration' is used interchangeably but represents a 'joining up' of traditional silos of care across (horizontal) and within (vertical) systems, organisations, services and service providers. (Shaw, Rosen et al. 2011) Additionally, integration has been used to describe the interface between different forms of care such as professionalised care and self-care. (National Voices 2013) Integrated care enables a focus on the relationships between those who promote and optimise health and pursues a holistic, person-centred approach seeing the person, not just the need, ensuring continuity and coordinated care that engages patients and their carers. (Brown, Stainer et al. 2008, Eyre, George et al. 2015)

There is a growing body of academic and policy literature for integrated care but as yet, not enough compelling empirical evidence for its impact on population level outcomes, mixed evidence for efficiency and some positive evidence for improved quality of care and patient satisfaction. (Goodwin and Smith 2011, Eyre, George et al. 2015) Perceived benefits of integrated care are described from findings in small scale case studies, or advocated by policy makers but seldom substantiated in large scale evaluations. (Roland, Lewis et al. 2012, Bardsley, Steventon et al. 2013). However, *Pitchforth et al* have suggested that the concept and assessment of integrated care requires a better understanding and that it should be seen as a strategy to innovate and implement long-lasting change in the way services in the health and social care sectors are delivered. (Nolte and Pitchforth 2014)

## New Models of Care

The NHSE (2015) Five Year Forward View, with its focus on new models of care, and the HM Treasury (2015) Spending Review and Autumn Statement, with its requirement on the NHS and Councils to "integrate care by 2020", provided a platform for local partnerships to improve delivery of care and enable support for it to be person-centred. (England 2014, Osborne 2015) Nevertheless, 'New Models of Care' are being developed against the backdrop of some of the most fragmented and complex organisational arrangements in the recent history of the NHS, involving several commissioners and quite often, a multitude of providers. (Collins 2016) Their successful implementation requires the overcoming of barriers presented by current health and social care legislation and policy. (Ham and Murray 2015) Indeed, a recent King's Fund publication has suggested that the New Models of Care require a focus on their relational and technical elements if they are to deliver on their early promise of allowing organisations to collaborate as effective learning systems. (Collins 2016)

## Multi-specialty Community Providers

Multi-specialty Community Providers (MCPs) were a new type of integrated provider and one of five New Care Models. In 2015 around 14 MCPs were awarded vanguard status across England. MCPs differed from other New Care Models as they provided a specific focus on primary care and community services, bringing care closer to the local population. The premise of an MCP was prevention and system redesign, around the person, to improve health and wellbeing, reduce avoidable hospital admissions and to establish more efficient delivery of care to the whole population. (Ham and Walsh 2013)

The existing boundaries between primary care, community, acute and social care services in terms of organisational structure, cultural differences and regulatory requirements make it more challenging to deliver coordinated care. The MCP model overcomes these boundaries, closing the gap between different components of the health and social care system, transcending existing organisational arrangements. MCPs reflect some of the principles of integrated care systems such as community and patient involvement, although they also extend to partnership working with voluntary sector groups. (Corrigan, Craig et al. 2013) Several commonalities in their models of service delivery exist across the vanguard MCP sites including: promoting prevention and self-care, especially amongst the highest risk groups; changing roles of health and social care professionals to maximise their effectiveness; moving services from hospitals to the community; and enabling more joined up working across health and social care services to avoid duplication, facilitate transition between services and to plan and build service capacity. (Collins 2016) However, just as there is no single model for integrated care, all MCPs also differ through the influence of local level factors; working relationships and partnerships, organisational culture and leadership. (Turner, Mulla et al. 2016)

## Background

The borough of Tower Hamlets has a population of around 280,000 with residents from across the UK and wider international communities. The population is mobile, relatively young and is expected to increase by around 20% over the next six years. A rapid increase in residents aged 35-64 bring new challenges as this is the age group in which chronic conditions first develop (at an earlier age in Tower Hamlets' population than most other places) which in turn increases demand for local health and social care services. (Tower Hamlets Together, 2017) The social and health determinants in Tower Hamlets provide unique challenges for the care system at a local level. For example, 39% of children live in poverty, the highest rate in the UK. Men in Tower Hamlets have the lowest healthy life expectancy in the country, at 53.6 years compared with 63.3 years nationally. Furthermore, Tower Hamlets has the fourth highest incidence of serious mental illness in London and 10% of people registered with a General Practitioner (GP) are observed as suffering from depression. (Tower Hamlets Together, 2017)

### Tower Hamlets Together

Tower Hamlets Together (THT) is a borough base integrated care partnership of local health and social care organisations which include:

- Barts Health NHS trust
- East London Foundation Trust
- London Borough of Tower Hamlets
- Tower Hamlets Clinical Commissioning Group
- Tower Hamlets Council for Voluntary Services
- Tower Hamlets GP Care Group

Recent years have witnessed Tower Hamlets form the building blocks of an integrated care system characterised by collaborative working between health and social care organisations and professionals. (Eyre, Farrelly et al. 2016) In 2013, Waltham Forest, Newham and Tower Hamlets came together as the Waltham Forest and East London (WEL) in the Integrated Care Pioneer Programme. This transformational change of local health and social care systems enabled the formation of the Tower Hamlets Together Provider Partnership (THIPP). In turn this partnership of providers acted as a vehicle for development of the Vanguard programme. In 2015, the partnership



became a new models of care MCP Vanguard site. In 2016, Tower Hamlets Clinical Commissioning Group (THCCG) announced that the partnership was to become the new provider of Community Health Services (CHS) in the borough enabling coordinated care to be provided to patients, outside of traditional hospital environments.

#### Locality based approaches to integrated care

There are numerous examples of locality based approaches to integrating care within the other MCP sites in England as well as internationally where local system models are employed. (Ham , Karakusevic 2010, Alderwick, Ham et al. 2015) These systems design services and provision care to meet the needs of the local population, whilst, in some cases, actively engaging the community in service development. Indeed, the neighbourhood or locality model is often the building block of a wider integrated system. (Stockport Together, 2016) One such model being tested in various sites across the UK is Primary Care Home (Kumpunen, Rosen et al. 2017) which aims to improve the health and wellbeing of the population and provide high quality of care whilst effectively using available resources. Its core characteristics include integration of the community, acute and, social care workforce with aligned clinical financial drivers through a capitated budget with a provision of care to a population of between 30000-50000. Early findings indicate that the model acted as a strong catalyst for collaboration between health and social care organisations, redefined relationships across the primary and community care and created new multi-disciplinary teams, that were often co-located. The main concerns related to a need for organisation development within the local health economy and the development of integrated IT systems.

Within these locality models exist multi-professional teams ascribed as integrated teams comprising GPs, community and district nurses, allied health professionals, social workers and sometimes community and voluntary sector representatives. (Hamilton, Manthorpe et al. 2015, Roland, Barber et al. 2015) They primarily focus on the segment of the population with the most complex health and social care needs (the top 2-3%) and aspire to provide patient-centred care, reduce fragmentation of care delivery and promote self-care. A key feature of locality models is collaborative working between health and social care providers especially inter-professional working at the service delivery level. The extent and effectiveness of collaboration will determine the success of service delivery. There is a body of conceptual literature on inter-professional collaboration that will be further explored in later in this report in the context of this evaluation.

#### Locality level in Tower Hamlets

This evaluation will primarily focus on the locality level in Tower Hamlets which comprises four localities within which a Primary Care network model operates with eight GP networks each serving a population of around 30000-50000 (figure 1).



Figure 1: GP network model in Tower Hamlets

In the current model each locality has a multi-professional community care team known as an Extended Primary Care team (EPCT) and a Locality Health and Wellbeing Committee (LHWC). These are described in further detail below.

#### Locality health and wellbeing committees

Locality Health and Wellbeing Committees (LHWC) in Tower Hamlets represent a locality based approach to health and social care integration which provides the committees the ability to co-ordinate and improve local processes to ensure services are addressing local needs. The LHWCs are being developed out of the former Locality Integrated Care Boards (LICBs) and their transformation commenced in October 2017. The role of LICBs was to ensure services are integrated at a locality level and provide safe and effective care that improves the health and wellbeing of the community. The THT board view the newly created LHWCs as key enablers for the delivery of high quality, effective, integrated community services. Their aspiration is to increase the authority and responsibility of the LHWCs to ensure that decisions about services are made as close as possible to the front-line in order to be responsive to the needs of both local communities and the health and social care professionals that work in them. Most recently the commissioning and provider committees/boards at locality level have been merged and potential future developments include a proposal for a LHWC to report directly into the THT board whilst retaining a tactical commissioning role.

The current transitional status of the LHWCs provides an opportune time for this formative evaluation to enable the committee to achieve their objectives by generating and mobilising knowledge and learning (such as the sharing of good practice) across the localities as well as drawing on the evidence base from similar locality based models nationally. The main barriers and facilitators

to the development of the LWHC will be established to assess the extent to which the committee's overarching objectives are being met. A key objective of the LWHC is to improve the health and wellbeing of their local population with a focus on prevention that considers the wider social determinants of health. In this report we will focus on partnership working which will be integral to the success of the LWHC in the management of the health and wellbeing of their local population especially as it requires a traditionally health focussed model to transition to model a that also encompasses aspects of social and voluntary care.

#### Extended Primary Care Teams

Extended Primary Care Teams (EPCTs) provide community nursing and therapies for patients aged over 18 who are resident in Tower Hamlets, with the primary aim of providing person-centred coordinated care closer to home. The teams treat and support adults with complex needs as well as those who need specific time-limited interventions in order to enable them to recover from illness or injury. As part of the wider THT approach, the teams provide care coordination and case management for patients whose needs are most appropriately met by EPCT professionals comprising community nurses, occupational therapists, physiotherapists, mental health nurses, care navigators and individuals with clinical management and administration responsibility. There is also an ongoing commitment to integrating social care with Local Authority support. The four teams are linked into each of the four LWHCs in the borough, working closely with GP practices, community health service specialists, acute services, social care, the voluntary sector and with the wider THT provider partnership.

### **Aims and Objectives**

Assessing integrated care at the level of the locality in Tower Hamlets will provide a lens for understanding the effectiveness of CHS service delivery model. Hence, the evaluation aims to assess how the CHS model of joined up health and social care community based services can impact upon population health and wellbeing in Tower Hamlets.

The evaluation has three overarching objectives:

1. To explore the effectiveness of the CHS model to enable **collaborative working** across the partnership at the strategic, operational and service delivery levels and its perceived impact on staff and person outcomes.
2. To establish how the implementation of the Vanguard programme and CHS model has engaged front line practitioners and service users in terms of challenging their values and norms and changing their behaviours.
3. To assess the effectiveness of the Vanguard programme and CHS model in involving and engaging service users and citizens in programme activities and in their experience of using THT services.

This initial phase of evaluation has focussed primarily on **objective 1 – collaborative and partnership working in the context of LWHCs and EPCTs** which act as lenses for generalisable learning across the whole health and social care system at all levels. The final evaluation report due November 18 will provide more content and findings relating to objectives 2 and 3. This is mainly due to the LWHCs and EPCTs being in the early stages of transformation and development.

## Theoretical Framework

This evaluation builds in part on the findings of a previous evaluation of the Waltham Forest and East London Integrated Care Collaborative conducted by *Eyre et al* (Eyre, Farrelly et al. 2016). Several systems level findings emerged from the evaluation, some of which are particularly relevant to this evaluation. Broadly, the evaluation found that while the key building blocks for integrated care such as governance were in place, a gap between strategic and service delivery levels remained and there was considerable scope for cultural, professional and organisational development. Additionally, there was a need to ensure that a shared strategic vision was supported and owned by organisations. Furthermore, integration between health and social care professionals required further development. There was also a need to increase focus on empowering people and communities, involving them as collaborative partners. Overall, these findings provided useful insights for the organisations within WELC on several elements integral to the development of an integrated care system. This evaluation subsumes these findings into the overall objectives (partnership, implementation and service user engagement).

Different types of integration have been described in the literature and this evaluation will primarily focus on horizontal integration, between different parts of the health and social care system. While much of the basis of an integrated system is established at the strategic level between organisations through the pooling of budgets and the aligning of governance, managerial and administrative systems, it is at the service delivery level where multi-professional teams are formed and tasked with working in partnership to deliver care services on a day to day basis. The literature for partnership working more generally has tended to focus on organisational processes and studies on outcomes for patients. (Kaehne and Catherall 2012) Cameron et al, suggest that joint working can lead to improvements in population health and service/system outcomes. (Cameron, Lart et al. 2014)

However, there are several barriers (and enablers) that must be considered that are thought to hinder (or facilitate) partnership working which can be categorised as organisational, professional, cultural and contextual. (Cameron, Lart et al. 2014) For frontline professionals, issues such as professional identity, maintaining boundaries and organisational and professional culture have been suggested as potential barriers to inter-professional working. (Hudson 2002) Effective partnership working requires organisational (cultural) change, sharing of information (including data), trust and an understanding of mutual responsibility and accountability. (D'amour and Oandasari 2005) Paradoxically, organisational factors that are thought to enable integration may actually hamper collaboration (especially between professionals) when insufficient focus is given to their significance. (Cameron and Lart 2003)

The barriers outlined above are magnified when considered in light of the discernible differences between health and social care such as structural divides e.g. differing IT systems or incentive and performance frameworks and culture divides (organisational and professional) e.g. 'diagnose and treat' (health) versus 'assess and mitigate functional status and promote independence' (social). (Leutz 1999, Miller 2016, Stein 2016). Hence, senior management in organisations must consider these differences when planning integrated care initiatives to ensure that integration is successful. In particular, initiatives that facilitate partnership working at the service delivery level ought to be; i) relevant and specific to health and social service care provision, ii) take into account professional roles and responsibilities and iii) not in any way act as barriers to collaboration.

The report also draws on findings from the final phase of the Waltham Forest and East London Integrated Care programme - a parallel evaluation (Bussu 2018) undertaken between May 2017 and June 2018. *'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.'* This evaluation sought to understand the delivery of integrated care on the ground, looking at specific pathways to assess collaboration patterns within and across multidisciplinary teams from acute, community and social care.

## Evaluation design

### Evaluation setting and subjects

The evaluation commenced in June 2017 and will be completed in November 2018. The researcher has been embedded in the THT programme evaluating the LWHCs and EPCTs. The study has employed a case study approach and data has been generated using a variety of participatory and mainly qualitative methods at the four levels presented in the table below. Within these levels, participant groups have been categorised as in table 1 below and purposively selected from some of the partner organisations for THT as well as members of the LWHCs and EPCTs.

**Table 1: Evaluation participants categorised by level of organisation/service user**

<b>Level of organisation/service user</b>	<b>Participant group</b>	<b>Membership/team/group</b>
<b>Strategic</b>	Senior management	THT board members
<b>Operational</b>	Middle management	THT organisation representatives, LWHC leads and network managers
<b>Service delivery</b>	General practitioners Community and district nurses Social workers Care navigators Therapists Community/voluntary service organisations Service managers	Frontline professionals from selected localities  EPCT leads  EPCT team members
<b>Service user</b>	Service user/carer	THT user and stakeholder group

## Research Methodology

### *Researcher in Residence Model*

The Researcher-in-Residence (RiR) model is an emerging model of participatory research. In response to a recognised concern that 'established approaches to getting health services research into practice are not radically changing the extent to which management decisions are influenced by scientific evidence,' (Marshall, Pagel et al. 2014) the RiR model embraces the concept of 'co-creating' knowledge between researchers and practitioners, using a range of different participatory approaches. Practically the model places the researcher as a key member of the delivery team, as opposed to an external observer of change. With the RiR, research expertise is communicated to and negotiated with, rather than imposed on, the practitioners in the delivery team and other stakeholders. Essentially the researcher acts as an interface between the emerging evidence and its application to the service, co-creating knowledge through participation. The role of the RiR within this project was to undertake a participatory and formative local evaluation. The evaluation findings

will facilitate the mobilisation of existing and newly created evidence (generated by the research) across the localities that will hopefully optimise implementation of the LHWCs and EPCTs.

The evaluation can be considered as a series of iterative stages of participation; scoping, data generation and analysis, interpretation and dissemination of emerging findings with the application of evidence to influence the development of the LHWC and EPCTs. Each stage was negotiated with the ESG to enable the co-design process.

Data collection and analysis (phase 1)

The first phase of data collection and analysis has focussed on the locality level with a focus on the EPCTs and LHWCs. Data has been collected from observation of meetings, interviews and documentary review. Methods for data generation and analysis were determined through discussion with and agreement from the ESG. Health service evaluations using a participatory approach such as that of the RiR model have employed a range of methods and those utilised in this first phase of evaluation are outlined in table 2 below:

**Table 2: Proposed methods and participant groups for data generation**

<b>Method</b>	<b>Stakeholder/participant group</b>	<b>Description</b>	<b>Period</b>
<b>Participant observation (200 hours)</b>	Senior and middle management/frontline professionals	Observation of meetings/workshops: <ul style="list-style-type: none"> <li>• THT monthly board meetings</li> <li>• THT transformation steering group meetings</li> <li>• THT and life course workstream meetings and workshops</li> <li>• LWHC and EPCTs monthly meetings in each locality</li> <li>• Locality commissioning meetings</li> <li>• Adult social care and health integration meetings</li> </ul>	July 17 – May 18
<b>Semi structured interviews (n=20)</b>	Senior and middle management	Purposively selected participants including strategic and operational level stakeholders for LHWCs and EPCTs.  EPCT nursing leads and therapies leads.  Relevant stakeholders from Adult social care.	March 18- May 18
<b>Documentary review</b>	Relevant THT, LHWC and EPCT documentation		
<b>Informal discussions</b>	Senior/middle management and frontline professionals	Field notes of discussions have been kept and used as a source of data throughout the evaluation	July 17 – May 18

#### *Participant observation*

Green et al consider participant observation to require the researcher to live or work in the setting they are researching over a long period of time. (Green and Thorogood 2013) The researcher has undertaken a series of observations of the relevant THT, LHWC, and EPCT meetings totalling approximately 200 hours. This time was also spent on building rapport and trust with team members at the strategic and operational level initially, an important preliminary aspect of participant

observation. (Jorgensen 1989) Field notes at meetings and workshops were manually recorded throughout the study noting participant interactions, behaviours and conversations. Also, pertinent points arising from observations have been communicated to the boards/teams and committees to facilitate discussion at future meetings and to allow them to determine how best to use the findings.

#### *Interviews*

A series of semi-structured interviews (SSIs) (n=20) were held with key stakeholders at all levels. The SSIs enabled the researcher to pose pre-conceived questions on topics of relevance to the subject matter while providing a degree of flexibility to pursue emerging themes in an iterative manner.

The questions were formulated using the relevant themes from the literature on integrated care, and locality based approaches to partnership working and implementation. In addition, interview guides were informed by data from participant observation and documentary review. In line with participatory approaches the ESG were involved in co-designing the interview guides. An inductive approach was taken with emerging themes from initial interviews used as a basis for further iterations of the interview guide. Interview participants included:

- Senior manager in the GP Care Group
- Network managers (one per locality, n=4)
- LHWC chairs (one per locality, n=5)<sup>i</sup>
- EPCT lead nurse
- EPCT nursing leads (one per locality, n=4)
- Therapies lead for East of the borough
- Senior manager for adult social care
- Service manager for adult social care
- Senior social work practitioners (n=2)

The interviews covered broad topic areas such as those listed below:

- An understanding of the THT vanguard – its purpose and whether this purpose is perceived to have been fulfilled (or not).
- The locality model (implementation) – how the model has changed and perceived impacts so far on staff and service users and expectations (and hopes) on how the model will develop in the coming months to meet the needs of the local population.
- **Partnership working** and citizen engagement – facilitators and barriers to partnership working and the extent of involvement of staff and service users in service development.

#### *Documentary review*

Documents pertaining to THT were collated through negotiation and collaboration with relevant stakeholders from the programmes. The documents provided contextual information and acted as a basis for the structuring of the interview guide(s).

#### *Informal discussions*

The RiR relies on the use of informal and unstructured approaches to generating data for nuanced and unique perspectives. Informal discussions in particular are a key feature of participatory models for research. (Baum, MacDougall et al. 2006) It is expected that these discussions will provide a rich and detailed source of data for the evaluation as means to confirm or reject theories developed through the course of the research.

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<sup>i</sup> Includes a temporary chair of one locality

### Data Analysis

The first level of analysis of the qualitative data was undertaken using a thematic framework approach. (Gale, Heath et al. 2013) This type of approach involves managing and organising qualitative data through a process of summarisation, resulting in a series of themed matrices. Despite its apparent structured format, framework analysis permits flexibility enabling interpretation through thematic analysis, typology and explanatory analysis. The framework was constantly changing in an iterative manner to capture the emerging themes from the data. This inductive approach enabled emerging themes to be explored in subsequent interviews. This report will be shared with the ESG and the findings will be co-interpreted and used to propagate learning, as well as acting as a basis for the next stage of research.

### Findings

The findings presented here are from participant observation of meetings, SSIs, documentary review and field notes from informal discussions with various key stakeholders. Using the theoretical framework described above the emerging themes were categorised as factors that promote and limit partnership working and grouped under three headings; organisational, cultural/professional and contextual. A brief description of each of these headings is provided in the table below:

<b>Organisational</b>	Which of the key building blocks of a local care system are in place (e.g. IT systems/co-location) and do they act as enablers or barriers to less measurable factors such as communication and information sharing?
<b>Cultural/Professional</b>	Which of the characteristics of partner organisations and professions play a key role in developing the culture of local partnership in terms of facilitating or hindering joint working? How do factors relating to individual professionals such as identity and understanding of roles affect partnership working?
<b>Contextual</b>	Which of the relevant aspects of current national and local policy context are particularly prominent at the locality level and how do they affect partnership working?

#### Organisational

##### *System aspects*

Several system aspects were perceived to be both barriers and enablers to effective partnership working between organisations and professionals.

**Access to patient/user data and records** - while primary and community care health professionals were able to view each other's patient notes (providing a sharing agreement had been signed), social workers had limited access to information due to different IT systems between health and social care and NHS information governance regulations. This was partially circumvented where social workers worked closely with the EPCT teams and in particular, individual professionals such as care navigators.

**Referral systems** - The single point of access – a referral system through which professionals from across health and social care could refer service users to different teams was seen as a positive development in recent years but was also thought by some health professionals to be unwieldy with some anecdotes of GPs in particular 'ticking multiple boxes on the referral form' to ensure the patient was definitely 'picked up' by one of the community teams/practitioners. Indeed, a couple of GPs remarked on how they wished that they could simply call a district nurse (as was the case



historically) for a referral and that the systems put in place removed the crucial 'face to face' element of inter-professional communication.

#### *Co-location*

At the strategic and operational level co-location of the EPCTs with nurses, therapists, mental health practitioners, care navigators and in some case social workers was seen as the cornerstone of effective partnership working and there is a small evidence base to support this notion. (Gibb, Morrow et al. 2002) Nevertheless, at the service delivery level, frontline professionals thought that that co-location had not as yet fostered effective inter-professional working although it had been relatively successful in developing relationships and communication between health professionals.

Under the current model for community adult social care, the local authority having assigned social workers to each locality to align with the EPCT teams. Embedding social workers was seen as slightly more challenging:

- Social workers were not always present at the EPCT offices
- Some EPCT teams claimed that they were fortunate to have a social worker present at least two days a week but others mentioned that they were not even aware of who their social worker was
- Social workers mentioned limited access to patient/user records, a lack of quality of space and cultural difference between themselves and health professionals as barriers to effective partnership working

Hence, co-location while viewed as a solution to partnership working may in fact be a limiting factor especially in instances where cultural barriers (discussed further below) have not been addressed. From a social work perspective, issues with recruitment and the use of agency staff has hindered partnership working and where health and social care professionals have formed effective working relationships it is because the social worker has been in post for an extended period of time.

#### *Management, support and engagement*

Overall, good management which includes professional and senior/middle management support has been suggested as an important facilitator for effective partnership working. (Regen, Martin et al. 2008) At the locality level, the management of social workers as part of an EPCT team was a key aspect that required further consideration and as well as focussed development. While social workers were not averse to the notion of being managed by a health professional they were concerned that the current arrangement of separate management structures working in parallel, was obfuscating and undermined partnership working and this was compounded by differences in organisation and professional culture.

*'...in speaking to some of the organisations there was still quite a degree of parallel working even when they were on paper quite integrated. You know like having an overall manager and then there were issues about them having to satisfy two bosses in effect.'* Middle manager

A key issue arising from general observations and interview data is the persisting gap between the strategic level and some frontline staff. This was identified by the previous WELC evaluation from 2016 as well as the parallel evaluation on the last phase of WEL (Eyre, Farrelly et al. 2016) Frontline professionals felt somewhat marginalised, citing that service redesign and reconfiguration took place in a vacuum without adequate involvement from staff and service users. For example, a recent consultation by East London Foundation Trust (ELFT) who hold the contract for EPCTs has recommended the disbanding of junior NHS band 4 care navigators. It has been suggested that the specific needs of service users that were previously addressed by care navigators will now be met by

voluntary services. GPs and social workers have described this decision as 'short sighted' and are concerned about the potential negative impact on patients/service users perpetuating pre-existing health and social problems as well as adding to the growing burden on the wider care system. They were particularly aggrieved about the lack of consultation on this proposed reconfiguration as most had learned of the planned changes through colleagues and informal networks.

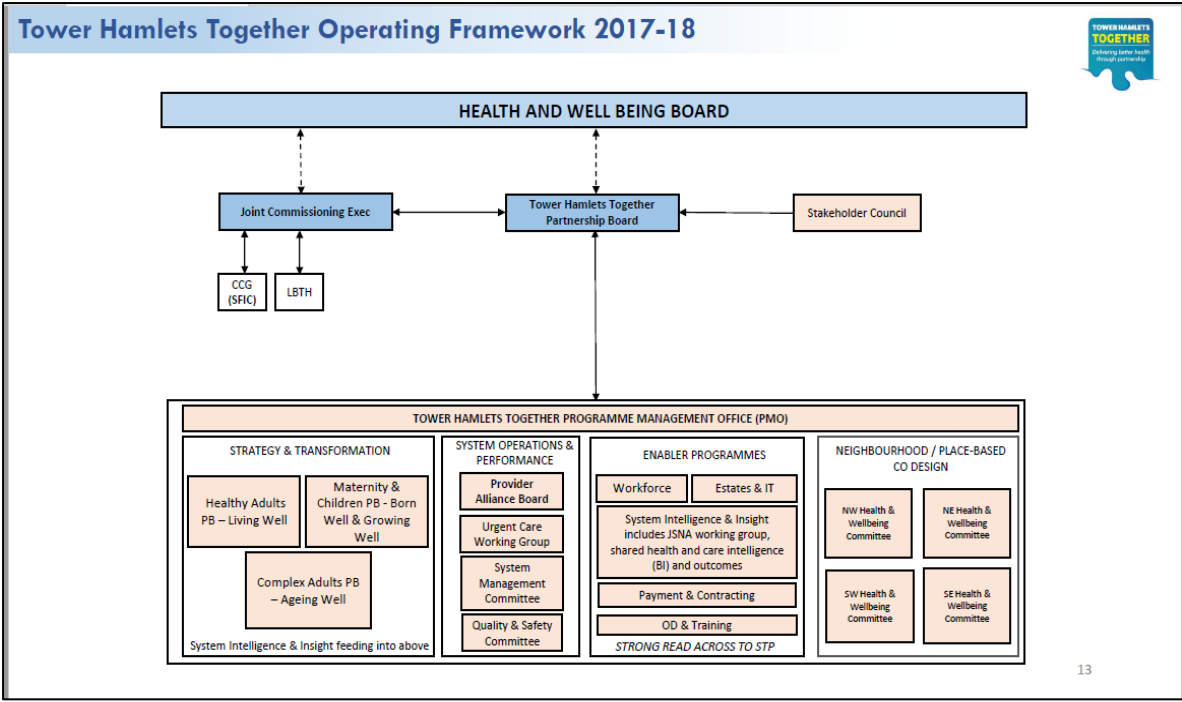
*'Care navigators are incredibly skilled in what they do, so to lose them will have an adverse effect on patient care, but it will have an adverse on practitioner health and wellbeing as well; because we will all have to do that ourselves, and we won't do it as well. We will get frustrated by it and it will be all for the sake of a very small amount of resource.'* General practitioner

This absence of bottom up engagement was also reported by *Bussu et al* (Bussu 2018) in the aforementioned parallel evaluation, where frontline professionals expressed a desire to be involved in decisions on service changes. Nonetheless, a positive recent development has seen EFLT involving care navigators in discussions to provide an appropriate solution to the proposed restructure.

#### *Organisational vision*

Among all partner organisations and at all levels there was a shared vision in terms of improving the quality of service provision for Tower Hamlets residents. This was more than mere rhetoric and seemed to be espoused by all stakeholders which was reflected in a concerted effort to planning and implementing initiatives that would ultimately result in a better quality of health and social care for residents. Senior and middle managers believed that the Vanguard had been crucial in acting as a vehicle for positive change especially at the strategic level. At this level, funding from the Vanguard and CHS contract had provided the much needed resources to enable effective collaboration.

The focus on establishing a care system post-Vanguard and undertaking the necessary governance arrangements and organisational development needed to facilitate this change was a key objective of the final year of the Vanguard. As figure 2 shows, through the course of the Vanguard the CCG and Local Authority have formed a Joint Commissioning Executive and under the CHS contract the provider partners have formed an Alliance board of which the Local Authority representatives also attend meetings given its dual role as commissioner and provider.



**Figure 2: THT operating framework**

Crucially the THT partnership board has remained and will oversee the transformation from a system focussed on integrating care and addressing the needs of the top 2-3% of the population that extoll the greatest burden on health and social care, to a system that works to prevent, not just treat, managing population health and wellbeing. Post-Vanguard THT has driven organisational development and established three life-course workstreams: Born Well, Living Well and Promoting Independence (focusing on Complex Adults). Each workstream involves a mix of stakeholders from health and social care organisations, but attendance from frontline professionals has been observed as being quite low thus far. These workstreams exemplify a key success of the Vanguard; partnership working at the strategic level and engaging all actors which is best exemplified by the Local Authority chairing all three life-course workstreams.

However, the vision of integration at the strategic level is somewhat less recognisable at the service delivery level. Indeed, many of the frontline service delivery interviewees were unclear about the purpose of the Vanguard, regarding it as significant because of the resources it had provided enabling them to work more collaboratively to some extent, but unsure as to whether it had impacted on the quality of care to patients and service users.

*Communication and information flow*

Several studies have cited effective communication and information flow as enhancing partnership working at the service delivery level as well as improving the provision of care through more timely assessments and better case prioritisation. (Gibb, Morrow et al. 2002, Brown, Tucker et al. 2003, Clarkson, Brand et al. 2011) Overall, at the strategic level, communication across all partners was very effective with regular meetings and workshops especially more recently, through the THT OD workshops which surfaced important issues both within partner organisations and between organisations that were discussed and addressed swiftly. At the service delivery level, communication and information sharing between frontline health professionals was thought to have improved as a result of co-location and at the GP practice level, MDT meetings had succeeded in

bringing together health and social care partners to discuss complex patients/service users. Nonetheless, the quality of MDT meetings was thought to differ across the borough as a result of:

- Lack of continuity of personnel (different district nurses or social workers attending)
- Variation in the quality of leadership from GPs
- Degree of engagement from all stakeholders

Through observations and interviews it is apparent that pre-established relationships between key actors from different organisations and professions was key to partnership working. This is a similar finding from the previous evaluation in the borough that highlighted that personalities and relationships between professionals were key to integration of services. (Eyre, Farrelly et al. 2016)

However, as mentioned in the previous section the gap in between the strategic level and some frontline staff is quite prominent in terms of communication and information sharing and is exemplified by perceptions of several interviewees who felt that top down communication was lacking especially with regards to major policy initiatives such as the Vanguard. Some operational level individuals recognised that THT had endeavoured to cascade information on the Vanguard through various channels of communication yet, there was a general perception of a lack of ownership of the Vanguard among frontline professionals.

*'Whether it was mailshots, whether it was badges, whatever it was, none of the modes of communication really worked exclusively, effectively.'* Middle manager

Staff engagement events through the course of the Vanguard were useful in bringing together staff from across the spectrum of health, social and voluntary care to disseminate Vanguard related information as well as, to some extent, creating a collective Tower Hamlets identity. Yet, the breadth and depth of their impact is difficult to assess, as many of the interviewed frontline professionals (including service managers) struggled to articulate the purpose and more importantly the impact of the Vanguard.

## Cultural/professional factors

### *Differing professional culture*

In the earlier part of this report we illustrated some key differences between health and social care. The difference in professional culture as a potential barrier to partnership working is quite prominent elsewhere and is somewhat apparent here. (Kharicha, Iliffe et al. 2005) Despite some of the organisational enablers for partnership working being established by THT such as co-location, there remained some work to be done in terms of addressing organisational and professional cultural issues. This was also a key finding of the parallel WEL evaluation (Bussu 2018) which suggested that multidisciplinary approaches while welcomed by all professionals, were often difficult to deliver in practice due to differing organisational and professional goals.

Broadly, social workers viewed health colleagues as risk averse which resulted in differing perspectives of how best to meet some patient/user needs. For example, often a health professional would recommend a specific package of care for a patient and pressure the social worker to implement that package, even though from a social care perspective it was deemed that the service needs could be met by the user themselves, family members or a somewhat smaller care provision. This led to some difficult discussions with health colleagues, as in the vast majority of cases social workers trusted in their own assessment and adhered to Local Authority processes. Social workers also emphasised how their approach to assessment centred on evaluating the holistic needs of a

user, promoting independence and encouraging self-management where possible, although, they mentioned that these principles were also gradually being adopted by health professionals.

*A GP might think that it's the day centre that the person needs, we might go out and the person might say 'No', and actually, 'When I was much able, I used to go to the theatre. So I would rather have the equivalent of what you would pay for me to go to the day centre to go to the theatre.' So you see the GP's have already assumed that is what will solve the problem, but when we talk to the person, it's not the case. Social worker*

#### *Challenging established mindsets*

Of interest, health professionals were keen on evolving their approach to patient care, transitioning from a traditional biomedical model to a psycho-social model whereby they promote independence, and encourage patients to better manage their own care which reflects some of the key Vanguard principles. They acknowledged that 'diagnose' and 'treat' was no longer a valid approach given an ever-reducing financial envelope which had an impact on the resources available to their service. There is evidence for health professionals struggling to adapt their working practices to suit the health and social needs of their patients, being rooted in a medical model, although this is much less apparent in Tower Hamlets (Havelka, Despot Lučanin et al. 2009). In this evaluation, health professionals appeared to have embraced a holistic approach to the management of patients which is demonstrated by the extent to which social prescribers and care navigators have embedded into the system. This is an undoubted success of the Vanguard and has resulted in GPs in particular, highly valuing new or extended professional roles including pharmacist and nurse prescribers, care navigators and social prescribers. Moreover, GPs and social workers described their working relationship as 'progressive' and 'productive' and based on mutual respect and trust.

#### *Roles and responsibilities*

Horizontal integration which involves different professionals working as part of multi-professional team requires the dissolving of boundaries between health professionals and health and social care more broadly. Yet, in this evaluation it was clear that professionals had both a strong professional identity and a reluctance to either work outside of the parameters of their role, or in a few cases, to relinquish their responsibilities to other professionals. In part, the maintaining of boundaries was as a result of health professionals (mainly district nurses) not understanding the roles and responsibilities of a social worker and in particular, a lack of appreciation of the administrative and organisational pressures in creating a care package and minimal understanding of the Care Act (2014). A simple solution offered by social care staff was for health colleagues to spend a few days shadowing or working alongside them so they could better understand the nuances of the social care system.

#### *New or extended roles*

The report has already reflected on the importance of new professional roles within Tower Hamlets. The care navigator, is a new role that has embedded itself into the care system, filling an important gap and addressing the needs of individuals that cannot be met by either health or social care services. The patients/service users that were normally referred to care navigators often had a multitude of complex care needs. Care navigators worked within a loose professional framework and their general local health and social care service and wider system knowledge was highly valued by GPs and social workers, in particular. Indeed, social workers describe them as 'a bridge to health', acting as conduit or interface with other health colleagues. Care navigators and social workers often conducted joint visits to service users and the role in itself was an enabler for partnership working.

### *Addressing user culture 'wants' versus 'needs'*

An interesting emerging theme was a perception among health professionals that transitioning to a model of care that promotes self-management and independence among patients/service users was challenging in Tower Hamlets. There was a perceived notion of greater entitlement among Tower Hamlets residents and all professionals stressed the importance of encouraging patients to take greater responsibility for their own care especially where there was a support network such as family members or friends that could provide assistance. This was a key concern for district nurses who felt the service was already compromised as a result of dwindling resources and staff shortages and the requirement to meet patient 'wants' was adding further pressure. Administering insulin and eye drops were provided as examples as tasks that could be taken on by other stakeholders including family members, carers and the patient themselves.

### Contextual factors

#### *National and local context*

**National level** - ever decreasing financial provision, problems with workforce retention and staff shortages have had a significant impact at a local level on health and social care service provision in Tower Hamlets and a reductive effect on partnership working resulting in professionals working within their role parameters and frameworks at a time when as many interviewees suggested, 'we all need to work above and beyond our job role to deliver a seamless service.' These are ubiquitous issues and at a local level it is the responsibility of THT to attempt to circumvent them.

**Local context** - initiatives such as the Vanguard are perceived to have catalysed change with financial support creating a basis for effective partnership working. This is in spite of a very challenging local context in Tower Hamlets which has some of the lowest measures for health and social outcomes in England. Interviewees suggested that a mobile population with significant socio-economic inequality and a large migrant population, many of whom do not speak English as their first language provided a series of unique and unprecedented challenges for the health and social care system locally. Nonetheless, a vibrant community and voluntary sector has somewhat helped to ease the burden on statutory services yet they also operate in an unpredictable financial environment.

#### *History of partnership working*

At the local level many interviewees perceived a history of partnership working as a precursor to the Vanguard. THIPP preceded the Vanguard and coupled with the GP federation was seen as the key contributory factor in being awarded Vanguard status. Indeed, GPs in Tower Hamlets view the GP network model as fundamental framework around which an integrated care system can be built. The ethos of partnership working has hence, long been established in Tower Hamlets, although as one middle manager suggested 'putting in place the building blocks for integrated care is hard, but has been achieved in Tower Hamlets....actually achieving a fully integrated, all singing and dancing system is nirvana.'

From these findings we present three overarching themes from the evaluation thus far:

The key themes from the evaluation are:

**1. The vanguard was perceived to be an effective enabler for greater collaboration between organisations.** Among all partner organisations and at all levels there was a shared vision in terms of improving the quality of service provision for Tower Hamlets residents. This was more than mere rhetoric and seemed to be espoused by all stakeholders which was reflected in a concerted effort to

planning and implementing initiatives that would ultimately result in a better quality of health and social care for residents. Evaluation participants perceived the Vanguard programme as an enabler for the successful implementation of governance structures, managerial and administrative systems and a substantive organisational development programme that has built a foundation for the post Vanguard health and social care system. This includes the formation of a Joint Commissioning executive and a CHS partner Alliance board. Together this has provided the basis for greater collaboration at the strategic level between partner organisations. Furthermore, establishing certain key system enablers were seen as important in providing a platform for partnership working:

- a) **Adult Social Care (ASC) alignment with the CHS model:**
  - Combined front Door/single Point of Access
  - Integrated intermediate care (short-term rehab and reablement)
  - Long term care locality model
- b) **Formation of life course workstreams** that focus on a population health approach and use QI methodology to improve care systems for their population with a view to engaging the breadth and depth of services in Tower Hamlets so as to address the wider determinants of health.
- c) **Co-location of health staff** within the EPCTs with nurses, therapists, mental health practitioners, care navigators and in some case social workers is a key step in building a foundation for effective partnership working

**2. In recent years there has been a shift in health professional mindsets to an ethos of promoting self-care and management.** In part, the vanguard is perceived to have propagated a shift in the mindset of health professionals, acting as an enabler for partnership working; transitioning from a medical model of 'diagnose and treat' to a more social, holistic approach that focusses on prevention and involves a range of other professionals from health, social and voluntary care. In the community setting, this multi-disciplinary, person-centred approach has been most successful in managing patients and service users who have the most complex care needs. Indeed, there was a degree of mutual trust, respect and appreciation of profession specific skills and knowledge among some health and social care professionals especially GPs, care navigators and social workers.

Nonetheless, some of the key differences between the professional culture of health and social workers were evident. (Leutz 1999) For example, social workers viewed health colleagues as risk averse whereas district nurses suggested that they often had to meet the social needs for patients due to a lack of capacity of within social care which is a similar finding from the parallel evaluation mentioned above.

**3. There is need for more effective communication and information sharing with bottom up engagement.** Initial findings appear to suggest a gap in communication and information sharing between the strategic level (THT senior management) and some frontline staff with a lack of bottom-up engagement, a challenge noted in a previous evaluation of integrated care in the borough (Eyre, Farrelly et al. 2016) as well as in the more recent evaluation of the final phase of WEL (Bussu 2018) Some frontline staff (inc. service managers) struggled to articulate the purpose of the Vanguard programme and in particular expressed some doubt as to whether change in the quality of care and in health service and patient outcomes was attributable to the Vanguard. Both health and social care professionals also expressed concern at a lack of involvement in service redesign consultations. For example, GPs and social workers were concerned that their voice was absent in a recent consultation on the disbanding of NHS Band 4 care navigators as part of the restructuring of community health services in the borough. Care navigators were thought to play a crucial role; bridging the gap between health and social care as well as addressing the unmet need of patients

with complex care problems. Additionally, more regular senior presence at the LHWC meetings might contribute to improving communication to and buy-in and commitment from committee members.

Summarising the enablers and barriers

The key barriers and enablers to partnership working are summarised in the table 3 below:

**Table 3: Key barriers and enablers for partnership working**

Category	Barrier	Enabler
Organisational	<ul style="list-style-type: none"> <li>• Differing systems for patient/user records (health and social care)</li> <li>• Management lines especially for social workers who have in effect two managers</li> <li>• Perceived lack of senior management support at locality level</li> <li>• THT vision not understood at service delivery level perpetuates the gap between levels</li> <li>• Top down communication exists but not effective enough</li> </ul>	<ul style="list-style-type: none"> <li>• Co-location (from health perspective)</li> <li>• Shared vision and collaboration at strategic level</li> <li>• Relationships between individuals improves communication</li> </ul>
Cultural/Professional	<ul style="list-style-type: none"> <li>• Elements of the differing professional culture between health and social care</li> <li>• Health professionals not understanding role of social care</li> <li>• Restructure of EPCT model – loss of some care navigators</li> </ul>	<ul style="list-style-type: none"> <li>• Effective transition from medical to psycho-social model</li> <li>• Recognition of new or extended roles e.g. care navigators</li> </ul>
Contextual	<ul style="list-style-type: none"> <li>• Demography related challenges</li> </ul>	<ul style="list-style-type: none"> <li>• History of partnership working with established infrastructure that acts as a facilitator e.g. GP network model</li> <li>• Vibrant voluntary sector</li> </ul>

## Suggested Actions

In light of these findings we make a series of suggestions for consideration to ensure the barriers to partnership working above are addressed so as to facilitate the implementation of the locality model and the development of EPCTs and LHWCs. It is hoped that these suggestions will be further co-designed and developed with evaluation participants to ensure they are pertinent, tangible and feasible.

**1. Continue with activities that enhance partnership working between frontline professionals but make them more targeted.** Focussed OD work needs to be undertaken with EPCTs and LHWCs to enable their development. Professional identities have been suggested as a barrier to inter-professional working and cannot be overcome by ‘teaching or preaching’ but learning from practical experience. (Holloway 2001). Creating a partnership culture which fosters respect, trust, distributed leadership and mutual accountability will assist in the development of the post Vanguard system. Our research team at UCL is working with TH partners to design a maturity matrix that assess the extent of partnership working in the LHWC and will act as an important tool in understanding the key barriers and enablers to collaboration at the locality level.

Suggestions to improve collaboration provided by interviewees included:



- Joint training and education sessions (between health and social care staff)
- Less structured meetings and more social gatherings over lunch or after work activities.
- Shadowing each other to develop a deeper understanding of roles and responsibilities.

*O'Daniel et al* (O'Daniel and Rosenstein 2008) suggest creating partnership 'champions' that are responsible for providing a platform to encourage different professionals to come together, facilitating collaboration through organising social and professional development events and arranging meetings that focus on problem solving specific inter-professional issues through open dialogue, while ensuring principles of trust and respect are upheld in multi-professional teams.

**2. Engage frontline staff in service development.** Ensuring frontline staff are members of key operational steering groups is one approach to increasing engagement. Yet, bottom-up engagement - involving staff in strategy through distributing leadership also warrants consideration. For example, some staff suggested Network Managers were better placed to lead the LWHCs than GPs given their intimate knowledge of the needs of the local population, awareness of community assets and relationships with voluntary care partners. Indeed, collegiality over consultation – asking 'how' and 'why' will facilitate engagement as well as mobilising pertinent knowledge and experience of frontline staff to assist in the development of service design strategy.

**3. Improve top down communication and acknowledge bottom up information.** In the LWHCs in which the assigned Alliance Board members regularly attended meetings and were actively involved in discussions about future planning and strategy, appeared 'further ahead' in their phase of development. This link to the senior level is crucial to maintaining engagement from LHC members. The board representative acts as a conduit for vertical top down and bottom up communication and information sharing. For example, in one of the LWHCs where Alliance Board representation was absent there were concerns that issues raised in meetings that required consideration by senior management could not be addressed causing frustration among the members, risking disengagement. The LWHCs are thought to be an integral part of the future care system in Tower Hamlets and engagement from senior management while they are still evolving will support their development. Creating a formal mechanism for reporting and feedback where the Alliance Board representatives provides regular relevant updates (including those from THT) and addresses issues raised in previous meetings, are simple approaches to enabling engagement. Senior management support has previously been suggested as an important facilitator for effective partnership working. (Regen, Martin et al. 2008)

## Conclusions

The findings from this evaluation indicate that Tower Hamlets has successfully instituted a number of system components that act as enablers for horizontal integration and effective partnership working which is apparent at the strategic level between organisations and senior managers. This in part has contributed to a cultural shift in the approach to patient care from health professionals recognising the holistic needs of a patient, the importance of promoting self-care and the need to address wider social determinants such as housing, domestic and welfare issues. This may explain the successful integration of social prescribers and care navigators into the health and social care system in Tower Hamlets. Yet, addressing some of the barriers presented above may further enable partnership working reducing care fragmentation and duplication and improving the experience of patients and service users. In particular, involving frontline staff in service redesign and development would provide a better understanding of what change is needed, if at all. Moreover, co-location does not always foster inter-professional working but concerted efforts to provide a space for learning

and sharing will develop relationships and overcome issues of professional identity that may hinder effective partnership working.

### **Next steps for the evaluation**

The next phase of the evaluation will largely centre on objectives 2 and 3, namely the implementation of the LWHCs and EPCTs and the involvement and engagement of service users and citizens in Vanguard and CHS programme activities and in their experience of using THT services with a focus on EPCTs. These two objectives will be explored through three further parallel phases of the evaluation:

#### **1. Evaluating the experience of service users on the EPCT caseload**

Service users/carers will be purposively selected for participation. A sample of around 30 service users/carers will be identified from the patient list of the EPCT teams across the selected localities and approached for interview. The interviews will be undertaken by a service user partner who has been recruited to the evaluation team.

#### **2. Evaluating the key successes and challenges of the wider THT vanguard programme**

Interviews (n=20) with senior stakeholders and middle managers from across THT partner organisations will be undertaken between July-September 2018 to gather the general perceptions of the key successes and challenges of the Vanguard programme. We will also explore some of the findings from phase 1 and consider the extent of citizen involvement in the previous, current and future service development and design. These interviews will address some of the key barriers and facilitators to partnership working, implementation and citizen engagement through the course of the vanguard.

The findings from these interviews and those undertaken in phase 1 will then be used to form the basis of 2-3 facilitated workshops with frontline health, social and voluntary care professionals and representatives from housing, police, education and other relevant system representatives from Tower Hamlets, as well as selected service users. The purpose of this approach is to understand if the perceived successes and challenges of the vanguard at the strategic and operational level is reflected at the service deliver and user level.

#### **3. Evaluating the development of the LWHCs and EPCTs**

A series of group interviews (n=10) will be held with committee and team members in October 2018 to assess the key facilitators and barriers to implementation of the locality model as well as to revisit some of the aspects of partnership working described in this report. To enable this part of the evaluation we have designed a maturity matrix for the LWHCs that provides a formative self-assessment tool to monitor the extent to which they are working effectively as a partnership. The matrix will enable the LWHCs to evaluate progress and identify existing gaps in the locality model as well as recognising their organisational development needs. We will use the matrix in the coming weeks as a baseline assessment of their perceived maturity in terms of partnership working of each of the LWHCs and then again in November 2018 to understand how they have developed against some of the key domains in the matrix.

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