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Locality based approaches to integrated care in Tower Hamlets

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Executive Summary

Overall, Tower Hamlets has successfully instituted the building blocks of an integrated care system. This includes a significant investment in governance arrangements and the development of key functions to enable integration as well as a collaborative vision at the senior levels of the Tower Hamlets Together (THT) Partnership. However, there is a need to focus on organisational development so as to address several cultural/professional barriers to integration among frontline staff. A key enabler for effective partnership working and hence integration is local leadership which acts as a catalyst for culture change. We have observed the formation of successful partnerships where there is effective leadership. The challenge for THT is to share some of the learning from the development of these successful partnerships so as to develop whole system culture change. Similarly, 'pockets' of good practice exist in terms of the involvement of service users and residents but THT could consider being more ambitious and normalise the involvement of patients and the public in the development of integrated care services.

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. (THT 2018) In 2017, the procurement of Community Health Services (CHS) was finalised with mobilisation of a CHS Alliance contract. 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. Tower Hamlets is split into four localities with two networks within each locality. This 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, addressing the wider social determinants of health.

The evaluation aims to assess how the Vanguard and the CHS model of joined up health and social care community-based services has impacted upon population health and wellbeing in Tower Hamlets. The understanding of this aim is enabled by answering three key research questions

- To what extent has the CHS model and Vanguard programme affected **collaborative working** across the partnership at the strategic, operational and frontline levels?
- How has the **implementation** of the Vanguard programme and CHS model engaged front line practitioners in terms of challenging their values and norms and changing their behaviours?
- How have service users and residents experienced care provided by CHS services and to what extent have **service users and residents** been **involved** in programme and service development activities?

Methods

This evaluation has used a model of participatory research in which the researcher has been embedded in the Vanguard programme and at the locality level. This report describes the findings from a formative evaluation in which the research team has observed (300 hours of participant observation) locality level (EPCT/LHWC), operational and strategic level THT meetings and undertaken interviews (n= 56 individual and n=6 group)) with individuals at these levels as well as patients/service users. 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 building blocks of an integrated care system at borough level are in place but cultural/professional issues remain, especially at the frontline.

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. The Vanguard was seen as an enabler for the successful implementation of governance structures as well as managerial and administrative systems. Together these structures have formed the foundation for a post Vanguard integrated care system, especially at the senior level across the partnership. This includes the formation of a Joint Commissioning executive, CHS partner Alliance board, borough wide Shared Outcomes Framework, appointment of a Director for Integrated Commissioning and CCG commissioning intentions that have been informed through discussion with THT.

Moreover, establishing certain system enablers were also seen as important in providing a platform for partnership working at all levels including; 1) Formation of life course workstreams, 2) Adult Social Care (ASC) alignment with the CHS model and 3) Co-location of health staff within the EPCTs.

Even so, we also identified some cultural/professional barriers as a result of system changes that may hinder effective partnership working and hence, service integration.

<u>System restructures – barriers or enablers to partnership working?</u>

Co-location in itself was viewed as only part of the solution to effective partnership working (Cameron and Lart 2003). Despite the improvement in estates and facilities for the EPCTs and the closer proximity of different professionals within the team, contextual issues such as major system changes around the community health service contract had resulted in a regression in partnership working and the re-emergence of previously dissolved professional boundaries.

Nevertheless, there were some notable examples of effective partnership working facilitated by co-location across community care, in particular the Neighbourhood Care Team (NCT) and their well-developed partnership with Jubilee Street Practice (where they were based) and the South East EPCT based at Newby Place Health and Wellbeing Centre. In these teams the building of social and working relationships based on trust and mutual respect was integral to developing effective partnerships.

Resource constraints particularly the lack of permanent staff was also thought to act as a barrier to partnership working and somewhat limited the benefits of co-location. Agency staff in the EPCTs

were seen as less likely to embrace partnership working; preferring to operate in their professional silo, work within the parameters of their role and be less willing to employ a holistic approach (more inclined to be task orientated in care delivery). Indeed, patients in receipt of EPCT services also suggested that agency staff were very task orientated, visits were rushed, and interaction was minimal. This results in a lack of continuity of care for patients and a reductive effective on partnership working in the EPCTs.

Why relational aspects such as professional culture are important enablers for partnership working

The evaluation revealed a need to address some of the key relational aspects relating to integrated care especially at the frontline.

A shift in health professional mindsets to an ethos of promoting self-care and management has been an enabler for more effective partnership working; transitioning from a medical model of 'diagnose and treat' to a holistic approach that focusses on prevention and involves the input of a range of other professionals from across the care spectrum. Indeed, **extended roles such as care navigators** funded in part by the Vanguard programme have become a significant component of the primary and community care service model acting as bridge between health and social care.

Nonetheless, **differences in professional culture** of health and social workers cited elsewhere were evident here and acted as barrier to partnership working. (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 across WEL. (Bussu 2018)

Many interviewees believed cultural and professional issues could be addressed with **a focus on organisational development** primarily at the frontline. At the senior level, OD activities were perceived to be partially attributable to a changing culture centred on collaboration. Nonetheless, at the frontline, issues such as different management lines, different organisational pressures and different cultures were apparent and have yet to be addressed. These issues are magnified when assessed against the backdrop of a strong professional identity and in some cases, a reluctance to work outside of the parameters of a role, or even an unwillingness to relinquish responsibility to other professionals. To assist in the development of the LWHCs we have created a Maturity Matrix – a self-assessment tool designed to enable the committees to monitor and assess how they are working effectively as a partnership.

2. Local level leadership is a catalyst for culture change.

A key emerging theme has been the role of leadership especially at the locality level. The evaluation identified the South East locality as a potential model for collaborative working facilitated by effective local service and team leadership. The locality comprises several individuals in key roles that possess some of the leadership characteristics and behaviours as described by The Kings Fund's *Leadership and Leadership Development in Health Care: The Evidence Base* (2015) which have also been cited elsewhere as important features among leaders in healthcare. (Nicol, Mohanna et al. 2014, West, Armit et al. 2015)) These features are listed in the table below include:

Characteristics	Features
Distribute leadership	Empower others Provide support and encouragement
Encourage innovation	Use of QI approaches Provide space for trying new initiatives and ideas
Work across boundaries	Engage multiple stakeholders Engage other sectors particular voluntary care
Create a collective identity	Building of effective working and social relationships between team members in EPCT
Minimise hierarchy/permissive environment	Encourage dialogue Create an environment in which staff feel comfortable to challenge each other and senior staff members

Some interviewees suggested the SE locality had a matured primary care infrastructure which may also be a contributory factor for effective collaborative working locally. The SE LHWC is underpinned by an ethos of effective partnership working with involved and engaged voluntary organisation partners. This successful approach to collaborative working is catalysed by several local level system leaders including the network managers, LHWC leads (both GPs) and the EPCT lead (a senior district nurse). In light of these factors, the SE LWHC is possibly the most developed in terms of aligning with the proposed model for LHWCs. The evaluation has actively promoted the pertinent features of the SE locality that enable partnership working with sharing of good practice with other localities as well as senior managers.

3. Service user/residents involvement is improving but requires a more concerted focus to facilitate a transition from consultation to collaboration

The evaluation findings suggest that patients/service users in receipt of the EPCT service have mixed views about their experiences:

- They suggested that some staff were quite engaging and endeavoured to build relationships, especially if the patient was likely to require medium or longer-term care.
- Other staff were more focussed on 'getting the job done' and their interaction with the patient was minimal (this was a specific criticism of agency staff).
- Patients wished for more continuity in the staff that visited them, especially with nurses.
- The extent of shared decision making was also mixed. There appeared to be minimal patient/carer involvement in the development of care plans. Indeed, some were unaware if they had a care plan at all.

In terms of service development, the user and stakeholder THT committee provided a forum for a proportion of local residents to discuss matters pertaining to the Vanguard and CHS more generally. This forum was useful in providing a platform in which resident's views could be heard with regular attendance from middle managers to discuss service planning and transformation. The committee also contributed to the CHS bid which may have been a contributory factor in Tower Hamlets being awarded the contract.

However, there were also concerns about the extent of the involvement of service users/residents in service redesign and development. The streamlining of podiatry services exemplifies the lack of engagement with service user/resident groups in the borough who were disappointed in the decision to reduce this provision but were also concerned that alternative affordable provision had not been considered (until very recently). Overall, the evaluation findings suggest that service

user/resident involvement in service development in Tower Hamlets is somewhere on the public participation spectrum between consultation and involvement i.e public feedback is sought, concerns and aspirations are understood and considered, but partnership in decision making processes is limited. (IAP2 2007)

Yet, there are some notable exceptions:

- Residents are part of the core membership of the life course workstream groups and will form part of the LHWCs in the near future.
- There is discussion about a resident being part of THT, although some partners have cautioned against this citing 'tokenism' as a concern.
- East London Foundation Trust have a prominent patient and public involvement function and anecdotally are thought to lead the way across London in terms of PPI in healthcare. The Local Authority also has developed a programme on co-production.

Suggested actions and recommendations

In light of these findings we make a series of suggestions for consideration so as to facilitate the implementation of the locality model and the development of EPCTs and LHWCs. Some of these recommendations have been co-designed with the evaluation steering group.

1. A focus on organisational development at the frontline. We suggest implementing OD activities that enhance partnership working between frontline professionals especially in the EPCTs and LWHCs. 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 EPCTs and LHWCs.

Suggestions to improve collaboration include:

- Joint training and education sessions (between health and social care staff).
    - EPCT staff are participating in 'health coaching' and with the recent ACS restructure this is an opportune time to involve social care partners.
- Less structured (frequent) meetings and more social gatherings.
- Shadowing each other to develop a deeper understanding of roles and responsibilities
    - Especially across organisational and professional boundaries.
- Partnership 'champions' (O'Daniel and Rosenstein 2008) - responsible for encouraging different professionals to come together, facilitating collaboration through organising social events and meetings that focus on problem solving specific inter-professional issues while ensuring principles of trust and respect are upheld.

Of added importance is the concern that EPCTs are currently demonstrating a 'them and us' culture between permanent and agency staff, although this is caveated with the understanding that some long-term locums have seemingly adapted to the existing team culture. Nonetheless, with a substantial reliance on agency staff, OD activities may improve dialogue and team working between permanent and agency staff.

2. Encourage bottom up engagement and involvement of frontline staff and services users/residents. Ensuring frontline staff and service users/residents are engaged in several aspects of service development and design is a key learning from this evaluation. Meaningful bottom-up engagement through involving staff in strategy and planning through distributing leadership

warrants consideration. Favouring collegiality over consultation – asking 'how' and 'why' will facilitate engagement while also capitalising on the extensive knowledge and experience among frontline staff of the services within which they work.

Involvement of services users/residents is a challenging task, although there are pockets of good practice in terms of developing approaches to engagement, with the work of ELFT and the Local Authority being pertinent examples. Nonetheless, these examples of good practice are the exception, not the norm and a concerted strategy to involve service users/residents in service development seems to be lacking. This requires a system wide strategy that mandates the involvement of services users/residents where appropriate in system steering groups but also in service development at the frontline. This juncture – the early stages of forming a post-Vanguard system provides an opportune time to involve service users/residents in more meaningful and less tokenistic ways.

For example, the LHWCs should involve users/residents at this early stage in their development. This maybe a significant culture shift especially for health professionals but it is necessary so as to understand the specific needs of the local population that goes beyond health service provision.

3. Empower and support local leaders to enable culture change

At the most recent staff engagement event an important theme arose that was centred on the notion of creating a permissive environment where service managers, team leaders and individual professionals can make decisions around service provision as well as create space for testing new ideas. In the evaluation of the NCT model we found that senior managers espoused autonomous practice for the nursing team and had also attempted to create a forum for open dialogue in which nurses could challenge certain operational decisions. Even so, the nurses struggled to embrace autonomy and were somewhat reluctant to challenge senior managers which we concluded was a result of the embedded hierarchical culture within nursing. Better understanding of the existing hierarchical culture which is particularly prominent in health care will ensure that a permissive environment results in empowered and confident staff.

Using the SE locality as a case study, the evaluation has also shown that local leadership is paramount in enabling culture change. Moreover, primary care leaders that are willing to build partnerships across different sectors will be key to the development of a collaborative culture at the locality level. We suggest the THT board invest in the all localities in terms of providing senior support and targeted OD to accelerate the cultural change that is required. THT could consider the learning presented from the SE locality in this evaluation as a basis for developing the other localities so as to facilitate diffusion of good practice.

4. Review co-location arrangements

We would caution against co-location being viewed as panacea for effective partnership working. We suggest reviewing the current setup of office space in Beaumont House. NE and NW teams should be allocated their own office where possible such that the different professionals within the team share the same working space. This will contribute to developing social relationships limiting the risk of professional silos developing (which is currently the case). Even so, we also recognise that co-location can enable partnership working. We have referred to the NCT and the SE EPCT as positive examples of co-location where regular informal discussion and dialogue enabled patient focussed discussion. We also found that frontline professionals, particularly GPs preferred informal person to person interaction with care professionals believing such discussions to have a positive impact on patient outcomes. The Single Point of Access maybe an effective referral mechanism, but

it is a barrier to person-person communication. Hence, we advocate for more effective communication between community and primary care.

5. Managing system restructures so as to minimise impact on frontline staff

In this evaluation, frontline staff (primarily in the EPCTs) were not averse to system changes but felt that the CHS restructuring processes could have considered the impact on individual team members and team dynamics. They expressed concerns that the time period for the consultation process for the EPCT restructure was too long and created much uncertainty which perpetuated disharmony in the team while also causing anxiety to individual team members. Frontline staff in this study wanted to be reassured sooner and requested swift decision making around employment and changes to roles and responsibilities. This is useful learning for future system restructures.

6. Clarifying the role of LHWCs

There remains an absence of understanding of the precise role of the LWHCs among its members which is compounded by a lack of clarity of the vision of senior managers for these committees. Current short to medium term plans include creating system dashboards with locality level data and OD plans to encourage better collaborative working.

However, their end goal remains unclear and poses a series of questions that need to be considered by senior managers:

- As a committee will they have decision making capability and will members that attend meetings have the authority on behalf of their organisations to make decisions?
- If they, have decision making capability, then who will provide the resources?
- How will the LHWCs develop a local level learning culture**?**
- Are the LHWCs too primary care centric and is this a barrier to other partners engaging?
- Will their future structure include primary care relinquishing some control to other sectors?

Concluding remarks

In an ever-changing policy landscape, commentators have emphasised the need for focussing on the relational elements of integrated care.(Ham 2018) In particular, it is thought that the formation of partnerships upon which integrated systems have been built require sustainable culture change that develops collaborations and creates a permissive environment that supports local leaders to enact change.

The findings from this evaluation have largely focussed on the relational aspects of integrated care at the localilty level; organisational development, engaging staff, service users and residents in service development and developing local leadership. Overall, Tower Hamlets has successfully instituted 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 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 of health. Future system developments must focus on addressing some of the barriers presented above so as to facilitate partnership working which in turn will reduce care fragmentation and duplication and improve the experience of patients and service users.

Contents

Introduction

Health and social care systems in the UK are facing unprecedented pressures to manage rising demand from an ageing population. This is compounded by an overburdened 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. (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. (2013) Integrated care enables a focus on the relationships between those who promote and optimise health. It 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)

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. (Goodwin and Smith 2011, Eyre, George et al. 2015) More recent evidence suggests that integration approaches have increased patient satisfaction and improved both the perceived quality of care and access to care services.(Baxter, Johnson et al. 2018) However, a recent report on Integrated Care from the Commons Health and Social Care committee suggested that up to now integration had been shown to have a minimal impact on reducing costs for services. (DHSC 2018) Many of the 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. (NHSE 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. These include:

- Promoting prevention and self-care (especially amongst the highest risk groups)
- New or changing roles of health and social care professionals to maximise their effectiveness; moving services from hospitals to the community
- 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, leadership and demography. (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. (THT 2017) The social and health determinants in Tower Hamlets provide unique challenges for the local care system. 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. (LBTH 2017, THT 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 develop 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 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 or integrated care teams comprising GPs, community/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 with two networks within each locality. 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

Localilty 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. Moreover, the LHWCs aim to improve the health and wellbeing of their local population with a focus on prevention that considers the wider social determinants of health. In 2018, the commissioning and provider committees/boards at locality level merged and future developments include a proposal for a LHWC to report directly into the Alliance board whilst retaining a tactical commissioning role. All LHWCs have aligned their monthly meetings to the THT life course workstreams i.e. growing well, living well and promoting independence with an additional quarterly meeting centred on organisational development.

The transitional status of the LHWCs provided 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 LHWC in the context of partnership working were established to assess the extent to which the committee's overarching objectives were being met. To assist in the development of these committees, UCL created a Maturity Matrix – a self-assessment tool designed to enable the LHWCs to monitor and assess how they are working effectively as a partnership. As this tool is still being piloted, preliminary results and insights will not be provided in this report.

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 LHWCs 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 of the evaluation

Assessing integrated care at the level of the locality in Tower Hamlets will provide a lens for understanding the effectiveness of the CHS service delivery model and the impact of the Vanguard programme. Hence, the evaluation aims to assess how the Vanguard and the CHS model of joined up health and social care community based services has impacted upon population health and wellbeing in Tower Hamlets. The understanding of this aim is enabled by answering three key research questions:

1. To what extent has the CHS model and Vanguard programme affected **collaborative working** across the partnership at the strategic, operational and service delivery levels? What is the perceived impact of the Vanguard/CHS model on staff and person outcomes?

2. How has the **implementation** of the Vanguard programme and CHS model engaged front line practitioners in terms of challenging their values and norms and changing their behaviours?

3. How have service users experienced care provided by CHS services? To what extent has the Vanguard programme and CHS model **engaged and involved service users and residents** in programme and service development activities?

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:

- The key building blocks for integrated care such as governance were in place but a gap between strategic and service delivery levels remained and there was considerable scope for cultural, professional and organisational development.
- There was a need to ensure that a shared strategic vision was supported and owned by organisations.
- Integration between health and social care professionals required further development.
- 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 resident 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)

Furthermore, while the evaluation explored integration at the locality level, the drivers for integration at the borough level through the Vanguard programme and the CHS contract were also assessed. There is an association between the development of a borough wide integrated care system and the formation of collaborations and partnership working at the locality level.

The literature identifies several barriers (and enablers) 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 Oandasan 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 cultural 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 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 and ii) take into account professional roles and responsibilities

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.

We will also refer to relevant findings from a specific service evaluation of the Neighbourhood Care Team community nursing model based on the principles of the Dutch Buurtzorg model piloted between June 2017-Auagust 2018 in Tower Hamlets. (Lalani, Fernandes et al. 2018)

Evaluation design

Evaluation setting and subjects

The evaluation commenced in June 2017 and was completed in November 2018. The researcher has been embedded in the THT programme, primarily at the locality level evaluating the LHWCs 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 of the care system; strategic, operational, service delivery and service user. 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 LHWCs and EPCTs.

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

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

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 facilitated the mobilisation of existing knowledge (from the academic and policy literature) and newly created evidence (generated by the research) across the localities that will hopefully optimise implementation and development of the LHWCs and EPCTs.

To understand the patient/user experience of utilising services provided by the EPCTs (and NCT) we recruited a service user partner (JF) to the evaluation team. JF was responsible for designing the patient/carer interview tools, undertaking interviews with patients/carers in receipt of the service, analysing the data from both staff (NCT) and patient/carer interviews and co-interpreting the findings.

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

Data collection and analysis was centred on the Vanguard programme with a specific focus on the locality level. Data was collected from observation of meetings, interviews (individual and group) 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 the evaluation are outlined in table 2 below:

Table 2: Proposed methods and participant groups for data generation

Method	Stakeholder/participant group	Description	Period
Participant observation (300 hours)	Senior and middle management/frontline professionals	Observation of meetings/workshops: • THT monthly board meetings • THT transformation steering group meetings • THT and life course workstream meetings and workshops • LWHC monthly meetings in each locality • EPCT monthly meetings	July 17 – November 18
Semi structured interviews (n=56)	Senior and middle management Team leads, service managers Frontline staff Patients/carers	Purposively selected participants including strategic and operational level stakeholders for LHWCs and EPCTs. EPCT nursing leads and therapies leads. Social work managers/team leads GPs Patient/carers in receipt of EPCT and NCT services	March 18-November 18
Group interviews (n=6, 16 participants)	Frontline staff	Community/district nurses, community mental health nurses, therapists and care navigators.	
Documentary review	Relevant THT, LHWC and EPCT documentation		
Informal discussions	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 – November 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, EPCT and NCT meetings totalling approximately 300 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 were communicated to the boards, committees and teams 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=56) were held with key stakeholders at all levels including patients and carers. 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. We also undertook 6 group interviews involving 16 members of the EPCT teams from two of the four localities.

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.

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 service user/resident 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.

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.

A summary of the final findings was presented to the ESG to enable co-interpretation. Some of the recommendations are presented later in this report have been co-produced.

Findings

Overall, from the data we have identified three overarching themes that address the research questions. Firstly, using the theoretical framework described above, emerging themes associated with **partnership working** were categorised as enablers and barriers and grouped under three headings; organisational, cultural/professional and contextual. Secondly, the data also revealed an

important theme of **leadership** and its role in facilitating culture change and as a potential enabler for partnership working. Finally, the data has enabled the understanding of the role of **service user/resident engagement** in the Vanguard programme and the CHS model. In the rest of this section we will explore each of these themes using quotations and vignettes to exemplify the relevant findings. While the evaluation focussed on the locality level we also provided relevant insights from the borough level. These insights are key to developing an understanding of the wider care system i.e. the context within which care services operate on a day-day basis.

A brief description of each of the thematic headings is provided in the table 3 below:

Table 3: Key themes arising from the qualitative data

Partnership working	
Organisational	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 compared to less measurable factors such as communication and information sharing?
Cultural/Professional	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?
Contextual	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?
Leadership	
What is the role of local leaders in developing system/team culture? What are the key characteristics of local leaders? How have they succeeded in changing the culture of their team?	
Citizen Engagement	
What has been the experience of patients/service users in receipt of health and social care services? To what extent are service users/residents involved in individual care planning and in the design and development of services in the borough?	

1. Effective partnership working

Organisational factors

a) 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 espoused by most senior/middle management and was reflected in a concerted effort to planning and implementing initiatives. Senior and middle managers believed that the Vanguard had been crucial in acting as a vehicle for positive change especially at the senior management level. At this level, funding from the Vanguard and CHS contract had provided 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.

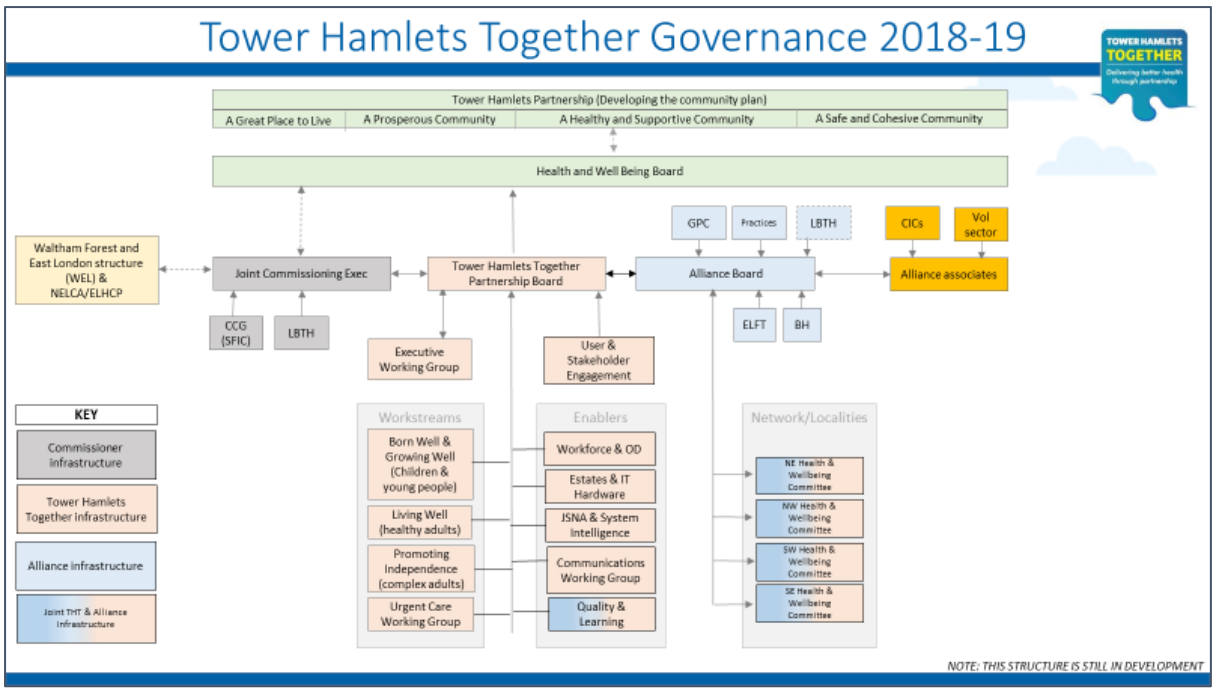

Figure 2: THT operating framework

Crucially the THT partnership board overseeing the transformation of a system focussed on integrating care – case management and care coordination for 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 ill health. This requires managing population health and wellbeing - promoting independence among residents to better self-manage their health and care needs.

In addition, several other key system components have been implemented:

- The formation of a Joint Commissioning executive
- A borough wide Shared Outcomes Framework acts as a key driver for future change to enable the care system to meet both the needs and the aspirations of residents
- Appointment of a Director for Integrated Commissioning
- CCG commissioning intentions that have been informed through discussion with THT

However, the vision of integration at the senior level is somewhat less recognisable at the service delivery level. Indeed, many of the service managers and frontline staff interviewed were unclear about the purpose of the Vanguard. They regarded the Vanguard 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 patient care.

b) Key components of an integrated care system

Several components of the integrated care system were perceived among the interviewees to be both barriers and enablers to effective partnership working between organisations and professionals.

Formation of life course workstreams: Post-Vanguard, THT has established three life-course workstreams: Born Well, Living Well and Promoting Independence (focusing on adults with complex health and social care needs). Each workstream involves a range of stakeholders from health and social care organisations as well as residents. These workstreams exemplify a key success of the Vanguard; partnership working at the senior and middle management level, engaging all actors,

which is typified by the Local Authority chairing all three life-course workstreams. The workstreams employ 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.

Adult Social Care (ASC) alignment with the CHS model: The local authority has undertaken a significant restructuring of their community social work programme. This has involved aligning ASC care systems with those of community health care to include a combined 'front door' and reducing duplication around rehabilitation and reablement. Furthermore, there have been concerted efforts to develop their community social work team so as to align with the CHS model to create a long term care locality model with named social workers assigned to each locality to work alongside the EPCTs.

LHWCs: This report has already described the proposed role of the LWHCs in the post-Vanguard system. Current integrated care policy (Buck 2018) is shifting to address population health needs with a focus on prevention and self-care centred on 'neighbourhoods' that act as the building blocks of a wider integrated care system. The proposed diverse membership of the LHWCs should enable the development of a forum that is capable of addressing a multitude of determinants for health including education, welfare and housing. Aligning the LHWCs to the lifecourse workstreams with specific themed monthly meetings has been welcomed by most stakeholders. These approaches will facilitate the transition of the LHWCs from a primary care focussed committee to a forum that broadens its focus to consider whole person needs.

Just as THT have adapted governance across organisations to meet the needs of the wider partnership, there is a need to adopt a similar approach with the LWHCs. The findings suggested that the vision for the LWHCs, even at senior levels, has not as yet been clearly articulated. Hence, there remains some confusion among stakeholders at the locality level about the role of the LWHCs. Committee members have expressed uncertainty about their individual role on the committee and the purpose of the LWHCs. A key issue is the lack of local level data that can be used by committee members to better understand the care needs of the local population and the associated demands on the locality care service provision. Moreover, committee members are concerned at the lack of accountability among some members. There is an expectation for primary and community care to attend but it remains unclear if other partners are expected do so by their organisations.

To assist in the development of these committees, we have created a self-assessment tool designed to enable the LHWCs to monitor and assess how they are working effectively as a partnership. We hope that this tool will identify specific areas of improvement for the LWHCs over the coming months with early findings being shared with the committees and the THT/Alliance board. We have also observed some changes to the LWHCs that are similar to the recommendations made in our interim report.(Lalani 2018) This includes a THT board member assigned to each LWHC. Board members have been attending meetings regularly with a standing agenda item to provide a THT update. The board representative acts as a conduit for vertical top down and bottom up communication and information sharing. This is a crucial role at a time when the LWHCs are still evolving and senior management support will aid their development.

A model of effective partnership working; the SE LHWC

The SE LHWCs appears to have adapted well to the transformation of the LWHCs. Recent meetings have been attended by a range of stakeholders including representatives from the voluntary sector, housing, public health, children's centres and head teachers, extending its current membership beyond representation from primary/community care. There is considerable variation in the adoption of the new LHWC 'model' across the borough with the SE much further developed in comparison to the other localities. A fundamental reason for this is local leadership (discussed later in this report). Other relevant reasons include:

- The SE networks have a history of partnership working
    - The Island Health centre has historical ties with voluntary partners.
    - Reportedly, the first social workers to be co-located with health professionals in Tower Hamlets were in the SE locality
- The locality benefits from an active and engaged voluntary partner – Poplar HARCA.
- One of the current LHWC chairs is a previous THT and THIPP board member.
- Experienced network managers with intimate knowledge of local care system and the needs of the population. Both are advocates for partnership working across boundaries.

Management and supervision: 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 requires further consideration in light of the proposed ASC and CHS restructure. 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. 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

Within the EPCTs, health professionals were receptive to being line managed by a different professional. Indeed, as part of the recent CHS restructure two of the EPCTs are led by therapists and two by nurses. In these teams, the line management (operation and delivery) is provided by the EPCT lead, whereas clinical supervision is from a senior (Band 8) of the same profession. Nurses/therapists appeared to be satisfied with the structure perhaps suggesting that there has been some dissolving of professional boundaries.

Access to patient/user data and records - while primary and community care health professionals were able to view combined patient notes (providing a sharing agreement had been signed), social workers had limited access to records 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, by care navigators who were seen as a 'bridge' between health and social care.

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. 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 person to person element of inter-professional communication.

c) Co-location barrier or enabler for partnership working?

At the strategic and operational level, co-location of the EPCTs with nurses, therapists, mental health practitioners and care navigators 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 co-location had not as yet fostered effective inter-professional working among EPCT teams.

When co-location works: The Neighbourhood Care Team (NCT) and their well-developed partnership with Jubilee Street Practice (where they were based) and the SE EPCT based at Newby Place Health and Wellbeing Centre are notable examples of co-location as an enabler for partnership working. In these teams the building of social and working relationships based on trust and mutual respect was integral to developing effective partnerships:

- The adaptation of the NCT to a new model of community nursing was assisted by an 'open door' policy and effective communication from the staff at Jubilee Street Practice.
- The SE LWHC benefited from excellent leadership. The team lead was committed to distributing leadership and encouraged the trialling of improvement initiatives

'The SE team are a model for co-location with all professional, working in the same open plan office. With the team lead also situated in the same office there is a solid foundation for effective communication and partnership working. Some of the team members tell me they enjoy this set up – it enables good communication – they can discuss patients easily. They seem to have built excellent social relationships too. There is a really harmony about the team that I have yet to observe elsewhere in the borough. Field notes ML

When co-location alone is not enough: One of the north locality EPCT teams was relocated to Beaumont House, Mile End in early 2018. EPCT staff perceived that the estates and IT facilities at Beaumont house were a significantly improvement on their previous location. Nonetheless, staff in the north localities were assigned separate offices dependant on professional roles e.g. care navigators located in a different office to nurses. This was a viewed as a physical barrier to effective communication.

> *'The move to come to this building was good because we were having problems with IT. But the problem is the communication isn't too great, because we (care navigators) sit in a separate office to the nurses. We thought we would all be together…. so we form our own social group and friendships based on where we sit.'* Care Navigator

Also, under the current model for community ASC, the local authority having assigned social workers to each locality to align with the EPCT teams. Embedding social workers in EPCTs was seen as likely to be more challenging:

- Due to a reliance upon agency social workers only one EPCT team were able to identify a social care colleague as a regular point of contact for the team.
- 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 partnership working.

d) System restructure

Between April and October 2018 as part of the CHS contract arrangements, Tower Hamlets community healthcare underwent a significant restructure. Among the major system changes were:

- The formation of a central triage community care team to assess all referrals in the borough.
- A reduction in the number of care navigators across the borough.

Interviews involving EPCT staff were undertaken between August-October 2018 and coincided with the final phase of the restructure consultation. It appears as though the restructure caused uncertainty among staff members who were concerned about their employment status, having to reapply for their current posts while also competing with colleagues. Based on the responses garnered from interviews, the restructure had resulted in a regression in partnership working and the re-emergence of previously dissolved professional boundaries.

> *'This consultation in a nutshell has caused hostility, low morale and anxiety. Up to now there was a tremendous respect and continuity in this particular team. There is good leadership too... but what this consultation has done has threatened all the things…it has divided the team because some of our colleagues are having to interview against each other. If I had to do a swot analysis…a lot of threats, this team has a lot of strengths going forward, but I think the consultation has caused an imbalance.'* EPCT member

However, more recent interviews with EPCT members suggest that there is a degree of acceptance of the new structure among staff, who acknowledged that restructure is commonplace in the NHS. Indeed, a few interviewees believed that the new structure would provide both cost savings and improve the quality of care in the future as it would allow staff to manage patients more holistically reducing the previous prominence of task orientated care.

We provided feedback to the CHS management team about the themes emerging from interviews with EPCT staff relating to the community care restructure, especially where staff expressed specific concerns about engagement and communication. We understand the management team has been quite communicative and engaged staff following the restructure, although it is difficult to attribute this approach to the findings from the interviews.

e) 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) In this section we focus on communication at the different levels of the care system and between levels

Senior level: Communication across all partners was quite effective with regular meetings and workshops. Organisational development workshops in the first quarter of 2018 focussed on establishing the post-Vanguard care system and prompted candid discussion, surfacing important issues both within partner organisations and between organisations.

Service delivery level: communication and information sharing between frontline health professionals was thought to have improved in part because of co-location. Across primary and community care, 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
- A primary care centred focus causing a power imbalance between GPs and other professionals
- Degree of engagement from all stakeholders

The role of key individuals: Through observations and interviews it is apparent that pre-established relationships between key actors from different organisations and professions has been an enabler for partnership working. This is a similar finding from the previous evaluation in the borough that highlighted that relationships between individuals were key to integration of services. (Eyre, Farrelly et al. 2016) Even so, some interviewees suggested that the vision of the THT partnership and the historical ethos of partnership working had now embedded itself at the middle management level. Hence, the impact of a departure of a senior leader would be lessened and would be less detrimental to the partnership than would have been the case before the Vanguard programme.

Communication between levels: A previous evaluation in the borough suggested a gap in communication between senior management and frontline professionals. While this gap still exists, it has been narrowed somewhat, through the course of the Vanguard programme.

The improvement in communication has been attributed in part to staff engagement events held throughout the course of the Vanguard programme. These events were seen as 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. Nonetheless, 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. Some middle managers 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

The publishing of the THT interim evaluation report prompted THT to centre a recent staff engagement event on ‘evaluation.’ This provided a forum in which findings from three evaluations undertaken in the borough were shared with staff at all levels representing health, social and voluntary care as well as a few residents.

Some frontline professionals (outside of the EPCTs) believed that the CHS restructure consultation was not appropriately communicated to primary, social and voluntary care staff as well as patients/service users. The often-cited issue was that of podiatry services. The service had been significantly streamlined in the borough, with new criteria for referral. This meant that most individuals in previous receipt of the service would have to seek alternative treatment from private providers, many of whose cost was thought to be prohibitive.

Bottom up engagement: Overall, across the Vanguard programme and CHS there was reportedly nominal bottom up engagement of frontline staff. This issue 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, there are some notable exceptions such as the formation of the Vanguard children's programme.

Vanguard children's programme; fostering a positive programme team culture and encouraging bottom up engagement.

The Vanguard children's programme exemplifies how engaging frontline staff in an entire programme cycle; planning, implementation and delivery of specific initiatives can foster a positive programme culture. The children's team developed their programme with frontline staff as equal partners. This included the involvement of health visitors, children centre staff, therapists, paediatricians and social workers in the initial stages of the programme. Despite limited engagement initially from the THT board, the programme was deemed a relative success. This was due to bottom up engagement as well as the involvement of individuals at all levels (including service users) who's combined vision and sense of ownership resulted in the development of a positive culture resulting in a programme that aligned with the aspirations of the staff and needs of users.

f) Agency staff/locums

Across the system there was a significant reliance upon agency staff and locums with some of the EPCT district/community nursing vacancy rate at around 50%. This is a pervasive national issue, but the consequences of recruiting agency staff have been magnified as a prominent local problem. We suggest that a reliance upon agency workers has at times, affected team dynamics and possibly had a reductive effective on partnership working.

Permanent staff perceived that agency workers were less likely to embrace partnership working, preferring to operate in their professional silo as well as work within the parameters of their role. Some of the community/district nurses thought agency staff were quite cautious about employing a holistic approach which resulted in a lack of continuity of care. In turn this hindered the development of intra-team relationships with permanent staff and agency staff approaching their roles differently. Through participant observation we witnessed these differences manifest themselves in various ways:

- The language used (agency staff were introduced as such)
- Team member interaction – cliques formed between permanent staff
- Minimal participation of agency staff in non-clinical team meetings
- A reluctance to participate in the evaluation unless permitted to do so by their agency

These issues are barriers to partnership working - the approach of permanent staff creates a 'them and us' team culture which is compounded by the apparent reluctance of agency staff to adapt their ways of working.

Patients in receipt of EPCT services also suggested that they could distinguish between permanent and agency staff simply by the extent of care provided – agency staff were very task orientated, visits were rushed, and interaction was minimal.

Cultural/professional factors

a) A shift in professional mindsets

A shift in health professional mindsets to an ethos of promoting self-care and management among patients can in part be attributed to the Vanguard programme. This shift has been an enabler for more effective partnership working; transitioning from a biomedical model of 'diagnose and treat' to a holistic psycho-social approach that focusses on prevention and involves the input of a range of other professionals from across the care spectrum. There is some academic 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)

b) New or extended roles

In this evaluation, health professionals appeared to be willing to pursue 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.'

Care navigators; a highly valued enigma

A care navigator is a new role that has embedded itself into the care system with relative success. Care navigators address a gap in the care system managing the needs of patients/service users that cannot be met by either health or social care services. Patients/service users usually referred to care navigators will have a multitude of complex care needs. Until the new restructuring of community care (October 2018), care navigators worked within a loose professional framework. Through the redesign process the care navigator role has become more defined. GPs and social workers appeared to highly value the general local health and social care knowledge of care navigators. Indeed, social workers describe them as 'a bridge to health', acting as conduit to the EPCTs. Care navigators and social workers often conducted joint visits to service users and the role in itself was an enabler for partnership working. Hence, there was much concern among GPs about the loss of care navigators from the system as a result of the CHS restructure. However, across the system there was still some uncertainty about the precise role of a care navigator which may lead to a duplication in service provision.

> *'Care navigators are incredibly skilled in what they do, so to lose them will have an adverse effect on patient care and 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

> *'..are they doing tasks in the home for people? Are they sort of like running errands? Where does their role start and finish? So, if someone has needs in relation to care and support, you know, we would usually commission a Home Care Provider to do that. So, what's the difference between what the Care Navigator does and what the Home Care Provider does? Because you know, they'll go and pick up drugs from the chemist, they'll help pay bills. If someone needs a GP appointment, a Home Carer can do all of that. So, what else does the Care Navigator do?'* Service manager

c) 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 has been described elsewhere and is somewhat apparent here. (Kharicha, Iliffe et al. 2005) 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/user but when reassessed by social care, a less extensive care package would be implemented. This issue exemplifies a key difference between health and social care approaches with the latter assessing user needs and understanding which of these needs could be met by the user themselves, family members or a somewhat smaller care provision. Such issues 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.

> *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, its not the case.* Social worker

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. Indeed, as part of the changing role of EPCT staff there was a concerted focus to reduce the traditionally task-orientated approach to community health care. This included tasks such as administering insulin and eye drops, both of which could be undertaken by family members, carers and the patient themselves.

d) 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.

e) Organisational development

A proportion of Vanguard funds were allocated to organisation development (OD) activities with an aim of developing culture change, addressing some of the boundaries between organisations and professionals both within healthcare and across health and social care.

Some interviewees perceived the OD strategy to have partially contributed to changing organisational/professional culture. This was most evident at the senior and middle management levels where the OD programme had facilitated challenging discussions about the development of the post Vanguard care system. At the frontline some of the cultural/professional challenges cited in previous and similar work including different management lines, different organisational pressures (e.g. funding of care packages) and different cultures were apparent and have yet to be addressed.

Overall, interviewees viewed OD as piecemeal at the frontline. This was for three main reasons:

- The lack of a focussed and extensive strategy
- Departure of the OD lead during the Vanguard programme
- Inadequate senior leadership around the OD workstream and not enough board engagement

  'Yes that sort of at scale vision around training frontline providers and culture change…..And Tower Hamlets Together is very much high level, it doesn't percolate.' Senior manager

  '… and again I think a bit of that is OD is really hard to do and we probably haven't, the level of investment and focus and capacity that would be required to do that, we probably haven't scoped out and given one hundred per cent on this if that's what we were really aiming for. Middle manager

Interviewees remarked upon the need for OD work at the frontline as a primary area of focus for the post Vanguard care system. Building trust and respect and creating a culture in which frontline staff are committed to collaborative working across professional boundaries will require further investment in OD. Without this investment at the frontline there is a risk that the successful formation of an integrated care system may be hindered by the prevalent cultural issues mentioned above which in turn may perpetuate siloed working.

Contextual factors

a) 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.

Another issue that was raised in relation to the national policy context was the proposed merger of CCGs across North-East London (NEL) and the supposed formation of a NEL integrated care system as part of the ever-changing landscape for healthcare nationally. This was a particular concern for local authority partners who suggested that the commissioning intentions would be determined at the WEL or even NEL level resulting in THCCG losing some of its autonomy which in turn may hinder the role of the joint commissioning function locally.

Local context - local contextual enablers for effective collaboration across boundaries mentioned through interviews included:

- A history of partnership working
- A collective commitment to addressing some of the wider social determinants of health (including among children) with a focus on prevention
- A vibrant and engaged voluntary sector

Overall, despite a long-established ethos of partnership working in Tower Hamlets that was further emboldened through the Vanguard, there were concerns that achieving a fully integrated care system at all levels remained a significant challenge especially at the frontline due to elapsed Vanguard funding and the changing national context as discussed above.

b) *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 would be nirvana.'*

2. Leadership as a catalyst for culture change

A key emerging theme from the data has been the role of leadership especially at the locality level. At the locality level in Tower Hamlets, the evaluation identified the South East locality (GP networks 7 & 8) as a potential model for collaborative working facilitated by effective local service and team leadership.

South-east locality

The locality comprises several individuals in integral roles that possess some of the leadership characteristics and behaviours as described by The Kings Fund's *Leadership and Leadership Development in Health Care: The Evidence Base* (2015). (West, Armit et al. 2015) In addition, some interviewees suggested networks 7/8 have a matured primary care infrastructure, with a history of partnership working (especially with the voluntary sector). The successful approach to collaborative working is catalysed by several local level system leaders as described in the table below:

Network managers	Highly experienced and proactive project managers who have developed relationships with various stakeholders over many years and have intimate knowledge of the health and wellbeing needs of the local population as well as the various community/voluntary services available.
GP leads (both LHWC leads)	One of these individuals had a previous prominent role on the THT/THIPP board and both are advocates for multi-disciplinary working across boundaries. Furthermore, interviewees suggested that both maybe effective leaders due to their role as medical educators.
Nursing (EPCT lead)	The EPCT lead in this locality has been in post for a few years which is in contrast to the other localities where leads have been more recently appointed. This continuity of leadership, has enabled the development of a positive team culture, with engaged team members who have built good working and social relationships with each other based on trust and respect, regardless of their profession. The team lead encourages and supports staff, is comfortable in delegating responsibility and is keen on fostering improvement using QI approaches to test new initiatives.

'I think you've got excellent primary care leadership there, network managers and the GPs. Is it because [Name] and [Name] are educators, they train people up?....You know and then the voluntary partner there, [Name]. She has played a role in getting that committee to change the way they frame things; their language. It all plays a part, it feels more collaborative'
Consultant

Of further interest, in 2 out of the 3 other localities, the appointed EPCT leads previously worked in the SE team. It is conceivable that being managed by a progressive team lead in a conducive environment in which they could develop their personal capability, capacity and experience may have resulted in them being identified as effective leaders capable of leading their own team.

Working across boundaries and promoting innovation - Palliative champions model.

The model was conceived by the SE EPCT lead and has now been rolled out across the borough. The model involves formal and informal meetings organised by palliative champions (nurses) in each locality to raise awareness about palliative care and end of life pathways and strengthen joined-up working with the local hospice – St Josephs. The designated palliative champions in each team are also responsible for training nursing, therapies and care navigator colleagues.

The evaluation has actively promoted the pertinent features of the SE locality in enabling partnership working with sharing of good practice with other localities as well as senior managers. We have advocated the palliative champions model as an exemplar of partnership working and horizontal integration with the hope that similar approaches can be employed in other parts of the system, in services which are delivered by multi-professional teams.

Leadership characteristics

The SE locality acts as a pertinent case study for transferable learning with regard to the role of leadership in developing local systems. This evaluation has identified several key leadership characteristics (see table 4 below) and behaviours common among the individuals in lead roles in the SE locality that have been cited as important features among leaders in healthcare (Nicol, Mohanna et al. 2014, West, Armit et al. 2015):

Table 4: Key features and behaviours of leaders in healthcare

Characteristics	Features
Distribute leadership	Empower others Provide support and encouragement *e.g. prior to the CHS restructure triage in EPCT was conducted and often led by care navigators with support from therapist and band 5/6 nurses*
Encourage innovation	Use of QI approaches Provide space for trying new initiatives and ideas *e.g. palliative champions model*
Work across boundaries	Engage multiple stakeholders Engage other sectors particular voluntary care *e.g. ease with which SE LHWC's membership has been extended beyond primary/community care*
Create a collective identity	Building of effective working and social relationships between team members in EPCT
Minimise hierarchy/permissive environment	Encourage dialogue Create an environment in which staff feel comfortable to challenge each other and senior staff members

3. Service user/resident involvement and engagement

This section addresses two aspects relating to service user/resident involvement. The first provides an overview of the findings from 6 interviews with patients in receipt of EPCT services with a focus on their experiences of the care received. The second aspect relates to findings that are associated with the role of service users/residents in the design/redesign and development of health and social care services.

Patient experience of EPCT services

The findings suggest that patients in receipt of community health services have mixed views about their experiences:

- They suggested that some staff were quite engaging and endeavoured to build relationships, especially if the patient was likely to require medium or longer-term care.
- Other staff were more focussed on 'getting the job done' and their interaction with the patient was minimal (this was a specific criticism of agency staff).
- Patients wished for more continuity in the staff that visited them as they wanted to build trusting relationships, especially with nurses.
- The extent of shared decision making was also mixed. There appeared to be minimal patient/carer involvement in the development of care plans. Indeed, some were unaware if they had a care plan at all.

Service user/resident involvement in service design and development

In terms of service development, the THT user and stakeholder (THTUS) committee provided a forum for a small proportion of residents to discuss matters pertaining to the Vanguard and CHS more generally. This forum provided a platform in which resident's views could be heard with regular attendance from middle managers to discuss service planning and transformation. The committee also contributed to the CHS bid and some interviewees speculated whether user involvement had been a significant contributory factor in Tower Hamlets being awarded the contract.

However, there were also concerns about the extent of the involvement of service users/residents in service redesign and development. For example, as part of the restructuring of CHS there was a substantial streamlining of the borough podiatry service. The THTUS suggested that there was a lack of meaningful consultation on the planned restructure which was further compounded by inadequate measures taken by the organisation to identify alternative affordable services. Costs of the service provided by local private organisations were thought to be prohibitive. Indeed, it was eventually the voluntary sector that identified a potential provider, addressing the gap in affordable foot care provision in the borough. This issue demonstrates how easily service user/resident engagement can be undermined. Interviewees suggested residents were often willing to accept that organisations are operating within tight financial parameters and that cost savings have to be made but communication has to be effective and residents need to feel that they are being engaged and involved in decision making.

> *'I think one of the problems is we are not very good at being totally honest about things with people. So you know there's an element of this is the reality, this is how much the pot is... What we probably don't say to people often enough is 'How do you want us to use this money, because that's all we've got?'* Middle manager

Overall, the evaluation findings suggest that service user/resident involvement in service development in Tower Hamlets is somewhere on the public participation spectrum between

consultation and involvement i.e. public feedback is sought, concerns and aspirations are understood and considered, but partnership in decision making processes is limited. (IAP2 2007) This issues reflects a wider problem within healthcare whereby some health professionals and organisations struggle to embrace the notion of partnership with patients and even feel threatened by the idea of active involvement, favouring consultation over collaboration. (Tritter 2009)

The term co-production was consistently used across the borough in a variety of settings. However, in reality, true co-production has rarely been achieved, especially within healthcare in Tower Hamlets. While some senior and middle managers champion co-design and co-production they can seldom actually implement an initiative in which service user/residents are involved in key components of a programme cycle. When initiatives are undertaken to engage service users/residents they are often seen as tokenistic or involve the same individuals most of which are members on various user groups across the borough.

> *'So if we're doing co-production where are the residents? And I think people, including me, don't know how to do it or do it well. Get people involved and then we become frightened of what to say in front of 'patients and users' and so involving users becomes rhetoric, but I think there's an acknowledgement that unless we design services with the people that are using them, we are wasting our money.'* Middle manager

Nonetheless, through the evaluation we found some notable exceptions where service user/resident involvement had proceeded to collaboration on the IAP2 scale - ''to partner with the public in each aspect of the decision including the development of alternatives and the preferred solution''

- Residents are part of the core membership of the life course workstream groups and will form part of the LHWCs in the near future.
- There is discussion about a resident being part of THT, although some partners have cautioned against this citing 'tokenism' as a concern.
- ELFT have a prominent patient and public involvement function and anecdotally are thought to lead the way across London as far as PPI in healthcare is concerned.
- The Local Authority were also thought to have a driven and effective co-production programme that were relatively successful in involving residents in various aspects of service planning.

There are relatively few examples of the involvement and collaboration of residents in service development through the Vanguard programme although 'Care Confident' exemplifies how citizens can be meaningfully involved aspects of designing a service.

Care Confident – involving patients and carers in health education:

Care Confident is an educational and communication resource designed to support families with under five year olds to enable a better understanding of the signs and symptoms of the most common childhood illnesses many of which can be treated at home or by visiting a local pharmacist for advice. In Tower Hamlets there was a propensity for children with minor illnesses to visit their GP and in some cases even A&E. The resource was co-designed/produced with parents and carers through 'Care Confident Groups' held across the borough. These were attended by parents/carers and health professionals with aim of improving knowledge, confidence and skills of managing minor ailments. This approach resulted in improved confidence for attending parents. Parents also came up with name and slogan for the resource.

> *'The programme was co-designed with the local population. So parents who went to baby feeding clinics, children centres, GP surgeries, we involved them in designing the name itself. What to do, When to worry…They also informed the content. They looked at it, if was parent friendly, if they understood it. One mother who was a local resident was a member of a few of the parent groups and she did the translation for the Bengali parents.'*

Summarising the enablers and barriers

The key barriers and enablers to partnership working are summarised in table 5 below:

Table 5: Key barriers and enablers for partnership working

Category	Barrier	Enabler
Organisational	• Co-location (requires OD to address professional/cultural boundaries) • Differing data systems for patient/user records (health and social care) • THT vision not completely understood at service delivery level perpetuates the gap between levels • Top down communication exists but not effective enough with little bottom-up engagement • Agency staff	• Shared vision and collaboration at strategic level • ASC/health alignment • Life course workstreams • LHWCs • Relationships between individuals improves communication • Co-location (shared premises) • Effective communication between senior managers • Leadership – particularly at the locality level
Cultural/Professional	• Differing professional culture between health and social care • Ineffective OD • Health professionals not understanding role of social care • Restructure of EPCT model – inadequate consultation of other sectors e.g. primary care	• Effective transition from medical to psycho-social model partly enabled in community care by EPCT restructure • Recognition of new or extended roles e.g. care navigators
Contextual	• Demography related challenges • ICS/CCG mergers	• History of partnership working with established infrastructure that acts as a facilitator e.g. GP network model • Vibrant voluntary sector

The impact of the Researcher in Residence

This participatory evaluation has produced some nuanced and novel findings especially relating to the relational elements of integrated care. The RiR has been embedded at the locality level alongside frontline staff but early discussions with the ESG favoured breadth over depth and hence the findings here present a broader picture of approaches to integrated care from across all the localities. Having been embedded in an extensive programme as opposed to an organisation, initiative or team has made assessing the impact of the evaluation on enabling the programme to meet its objectives, quite challenging.

From the perspective of a participatory approach the study was co-designed, findings were co-interpreted and some of the recommendations were co-produced collaboratively with ESG. Furthermore, there are several instances in which the researcher has mobilised evidence generated from the evaluation across the programme, sharing learning. Moreover, a feature of the RiR model is 'holding up a mirror' whereby the researcher identifies challenges and presents simple solutions and some examples of these are presented in this report and summarised below. The evaluation has had its greatest impact when partners have engaged with the researcher and the evaluation findings. The SE locality, senior managers developing the LWHCs and the ESG are notable examples of individuals and groups that have engaged with the evaluation and hence, maximised its impact. Below we summarise these and other relevant examples where the formative and participatory approach may have had an impact on the wider programme:

1. **LHWCs**
    - To assist in the development of the LWHCs we have created a Maturity Matrix – a self-assessment tool designed to enable the committees to monitor and assess how they are working effectively as a partnership.
    - We have also observed some changes to the LWHCs which are similar to the recommendations for the committees from our interim report.
        - This includes a THT board member assigned to each LWHC. Board members have been attending meetings regularly with a standing agenda item to provide a THT update.
        - The board representative acts as a conduit for vertical top down and bottom up communication and information sharing. This is a crucial role at a time when the LWHCs are still evolving and senior management support will aid their development.

2. **Partnership working**
    - The evaluation has actively promoted the pertinent features of the SE locality in enabling partnership working with sharing of good practice with other localities as well as senior managers.
    - We have advocated the palliative champions model as an exemplar of partnership working with the hope that similar approaches can be employed in other parts of the system, in services which are delivered by multi-professional teams.
    - We provided feedback to the CHS management team about the themes emerging from interviews with EPCT staff relating to the community care restructure, especially where staff expressed specific concerns about engagement and communication. We understand the management team has been quite communicative and engaged staff following the restructure, although it is difficult to attribute this approach to the findings from the interviews.

3. **Other influences**
    - Through the evaluation we were able to influence THT to deliver an evaluation focussed staff engagement event which surfaced some issues relevant to OD among staff at all levels.
    - In the first 9 months of the evaluation the RiR presented an evaluation finding of the month to the THT board.
    - ESG members commented on the usefulness of the periodic meetings. The meetings were thought to generate nuanced and insightful discussion providing an opportunity for senior and middle managers to reflect on how recent service transformation had affected the delivery of services at the locality level and impacted upon staff.

Suggested Actions and Recommendations

1. A focus on organisational development at the frontline

A focus on implementing activities that enhance partnership working between frontline professionals is required. Integrated care policy is being directed toward a better understanding of the relational aspects within care systems. We suggest OD activities ought to be undertaken with EPCTs and LWHCs to enable their development. Professional identities have been suggested as a barrier to inter-professional working and cannot be overcome by 'teaching or preaching' butlearning 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 has worked 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. This tool is being piloted with the LHWCs and forms part of a comprehensive OD plan for the committees.

a. How to improve collaboration?

Suggestions to improve collaboration provided by interviewees included:

- Joint training and education sessions (between health and social care staff)
    - EPCT staff are participating in 'health coaching' and with the recent ACS restructure this is an opportune time to engage social care partners
- Less structured (frequent) meetings and more social gatherings
- Shadowing each other to develop a deeper understanding of roles and responsibilities
    - Especially across organisational and professional boundaries

b. Partnership champions

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. They facilitate 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.

c. Improve the relationship between agency and permanent staff

Of added importance is the concern that EPCTs are currently demonstrating a 'them and us' culture between permanent and agency staff, although this is caveated with the understanding that some

long term locums have seemingly adapted to the team culture. Nonetheless, with a substantial reliance on agency staff, OD activities may facilitate improved dialogue and team working between permanent and agency staff.

We also suggest that CHS managers arrange discussions with agencies and consider the following:

- Recognise that many agency staff are from outside Tower Hamlets and hence, they may struggle to grasp the ethos of partnership working.
- Agency staff adhere stringently to their role and are more likely to be task-orientated.
- Hence, where agency staff are in post for the medium-long term, the agency they are employed by should encourage them to adapt to local requirements while removing any fear of reprimand.

2. Encourage bottom up engagement and involvement of frontline staff and service users/residents

Ensuring frontline staff and users/residents are engaged in several aspects of service development and design is a key learning from this evaluation.

a. Involving frontline staff

One approach to increasing engagement is ensuring frontline staff are members of key operational steering groups. Yet, meaningful bottom-up engagement - involving staff in strategy and planning through distributing leadership also warrants consideration. Favouring collegiality over consultation – asking 'how' and 'why' will facilitate engagement while also capitalising on the extensive knowledge and experience among frontline staff of the services within which they work.

b. Involving Users

Involvement of users/residents is a challenging task, although it could be argued that Tower Hamlets is probably more matured than most boroughs when developing approaches to engagement, with the work of ELFT and the Local Authority being pertinent examples. This juncture – the early stages of forming a post-Vanguard system provides an opportune time to involve service user/residents in more meaningful and less tokenistic ways. The Care Confident programme demonstrates how involvement in service development can be straightforward, rewarding and impactful. Hence, we suggest that the CHS in particular, involves patients and users in developing services.

Moreover, the LHWCs should involve users/residents at this early stage in their development. This maybe a significant culture shift especially for health professionals but it is necessary so as to understand the specific needs of the local population that goes beyond health provision. This is particularly relevant at a time when national integrated care policy is developing with a view to addressing population health needs as an integral focus.(Buck 2018)

Overall, a concerted strategy to involve services users/residents in service development seems to be lacking. There are pockets of good practice where service users/residents are meaningfully involved in service planning and development but currently these examples are the exception not the norm in Tower Hamlets. This requires a system wide strategy that mandates the involvement of service users/residents where appropriate in steering groups but also in development at the frontline. For example, a patient/user voice could be involved in monthly borough wide EPCT 'business meetings.' This would demonstrate a commitment from the service to the users, that their voice is being heard and that their experiences will be considered in making service improvement.

3. Empower and support local leaders

At the most recent staff engagement event an important theme arose that was centred on the notion of creating a permissive environment where service managers, team leaders and individual professionals can make decisions around service provision as well as create space for testing new ideas. In the evaluation of the NCT model we found that senior managers espoused autonomous practice for the nursing team and had also attempted to create a forum for open dialogue in which nurses could challenge certain operation decisions. However, the nurses struggled to embrace autonomy and were somewhat reluctant to challenge senior managers which we concluded was a result of the embedded hierarchical culture within nursing. This is an important lesson when considering how best to distribute leadership and empower frontline staff. Better understanding of the existing hierarchical culture which is particularly prominent in health care will ensure that a permissive environment results in empowered and confident staff.

Using the SE locality as a case study, the evaluation has shown that local leadership is paramount in enabling collaborative working across boundaries. Moreover, primary care leaders that are willing to build partnerships across different sectors will be key to the development of a collaborative culture at the locality level. The network model has meant that individual networks have directed funding in line with their local priorities for primary care. Seemingly, in the SE, investment has been made in the quality of the network managers who have been shown to have some of the key leadership characteristics described earlier in this report. This in part, accounts for the variation in the maturity of partnership working in the different localities. We suggest the THT board invest in the localities (LWHCs) in terms of providing senior support and targeted OD to accelerate the cultural change that is required. THT could consider the learning presented from the SE locality in this evaluation as a basis for developing the other localities so as to facilitate diffusion of good practice. THT's next staff engagement event (February '19) will focus on leadership and management, values and behaviours and further explore some of the themes arising from the previous event on creating a permissive environment and empowering staff.

4. Review of co-location arrangements

We would caution against co-location being viewed as panacea for effective partnership working. This means some consideration of the current setup of office space in Beaumont House. As is the case in the SE EPCT we suggest that the NE and NW teams are allocated their own office where possible such that the different professionals within the team share the same space. This will contribute to developing working and social relationships and limit the risk of professional silos developing (which is currently the case). That said, we also recognise the usefulness of co-location in enabling partnership working. We have referred to the NCT and the SE EPCT as positive examples of co-location where regular informal discussion and dialogue enable patient focussed discussion. While MDTs may bring together professionals from primary, community and social care, (NHSE 2015) we also found that GPs in particular, highly valued frequent and informal person to person interaction and dialogue with care professionals believing such discussions to have a positive impact on patient outcomes. Hence, we advocate for more effective communication with primary care as the single point of access maybe an effective referral mechanism, but it limits person-person communication.

5. Managing system restructures so as to minimise impact on frontline staff

In this evaluation, frontline staff, especially those who had been working within NHS organisations for several years, were not against system changes but felt that the some of the restructuring processes mentioned in this report could have been better managed. They expressed concerns that the consultation process for the EPCT restructure was too long, which created uncertainty,

perpetuating disharmony in the team as well as causing anxiety to individual team members. At a time when commentators have described frontline staff as feeling overburdened and undervalued, with limited resources to undertake their day-day work, service redesign needs to be better managed.(Allen 2017) Frontline staff in this study wanted to be reassured sooner and requested swift decision making around employment and changes to roles and responsibilities. This is useful learning for future system restructures.

6. Clarifying the role of LHWCs

Through the course of the evaluation we have witnessed the transformation of the locality level committees from LICBs to LHWCs, a merging of provider and commissioning committees and some definition of the role of the LWHCs as part of the borough care system. However, there remains an absence of understanding of the precise role of the LWHCs among committee members but also lack clarity in terms of vision for their development at senior levels. At the December '18 meeting the board approved funding to develop the LHWCs centred on organisation development and progressing the vision of the commitees. Short-medium term plans include;

- Create system dashboards with locality level data
- OD plans to encourage better collaborative working

Their end goal remains unclear and poses a series of questions that need to be considered at senior levels:

Will they have decision making capability? Will the committees be empowered to make local level decisions around service provision? Will the members that attend meetings have the authority on behalf of their organisations to make decisions?

If they, have decision making capability then who will provide the resources? There was previous discussion around the LWHCs having a tactical commissioning role. If the LHWCs are charged with making local level decisions, then how will they mobilise resources to do? If an issue is directly outside the remit of primary care but has a local system level impact – who will fund a project to manage the issue?

Are the LHWCs a problem-solving forum? Many view the LHWCs as a 'talking shop' or just another meeting? Yet, some they find it a useful forum to discuss local level problems and find solutions collaboratively.

Will the LHWCs develop a local level learning culture? We have not explored the availability of data for learning purposes in this evaluation, but we are aware of various sources of relevant information that could be used as part of a QI programme to improve local level service provision. For example, the EPCTs collect patient experience data but it is not clear whether this information is used to enable service improvement. When problems are raised at LWHCs will they be addressed using a collaborative whole systems approach or ultimately be viewed as they are currently - an individual team/organisation issue?

Are the LHWCs currently too primary care centric and is this a barrier to other partners engaging? Some committee members have suggested that the LHWCs are quite primary care centric with a representation from practice nurses and GPs comprising a sizeable proportion of the overall attendance at meetings. Inevitably, this results in primary care centric discussions. Nevertheless, categorising meetings by lifecourse workstreams has diversified the attendance (especially in the SE LWHC) and hence, discussions are much broader encapsulating other sectors as well as primary care.

Will their future structure include primary care relinquishing some control to other sectors? Some LWHC members have suggested Network Managers are better placed to lead the committees than GPs given their intimate knowledge of the needs of the local population, awareness of community assets and relationships with voluntary care partners. This is possibly a consideration for the future development of the LHWC model. Nonetheless, GPs are probably best placed to lead the LHWCs in these initial stages, although there is scope for rotating chairs depending on the meeting theme e.g. public health partners setting the agenda and chairing the Living Well meetings with GPs and Network Managers retaining oversight.

Conclusions

In an ever-changing policy landscape including the development of Sustainability and Transformation Plans at a regional level and the subsequent formation of Integrated Care Systems at the borough or multi-borough level, commentators have emphasised the need for focussing on the relational elements of integrated care. (Ham 2018)In particular, it is thought that the formation of partnerships upon which integrated systems have been built require sustainable culture change that develops collaborations and creates a permissive environment that supports local leaders to enact change.

The findings from this evaluation have primarily focussed on the relational aspects of integrated care at the localilty level; organisational development, engaging frontline staff, services users and residents in service development, and developing local leadership. Overall, Tower Hamlets has successfully instituted 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. Yet, the next step for the care system must focus on addressing some of the barriers presented above so as to facilitate partnership working which in turn will reduce care fragmentation and duplication and improve the experience of patients and service users.

Next steps for the evaluation

The final phase of the evaluation will centre on the development of the LHWCs and the piloting of maturity matrix for the LWHCs. 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 the perceived maturity in terms of partnership working of each of the LHWCs to understand how they have developed against some of the key domains in the matrix. We plan to undertake some facilitated discussions on the use of the tool in January/February 2019. We will produce a short paper on the use of the tool and the progress of the LWHCs in terms of OD, using results from the assessment.

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