Health and Wellbeing SUFFOLK

Agenda Item 10

Suffolk Health and Wellbeing Board

A committee of Suffolk County Council

Report Title:	Neighbourhood Nursing and Care Team – Buurtzorg Inspired Test and Learn
Meeting Date:	26 September 2019
Chairman:	Councillor Tony Goldson
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What is this report about and why is it coming to the Health and Wellbeing Board?

1. This report provides an introduction and summary of the findings from the review of the Suffolk Buurtzorg test and learn approach by The King's Fund and the Evaluation undertaken. The report focuses on the learning from the review and evaluation outlines the next steps to harness the learning and implement the Buurtzorg inspired principles into the developing Neighbourhood Teams and wider localities.

Key questions for discussion:

2. The key questions for discussion are:

   a) Is the approach to embedding the learning and associated principles into the Integrated Neighbourhood Teams and wider localities in keeping with the expectations of the Health and Wellbeing Board?

   b) Is the Health and Wellbeing Board happy to support the approach on the future development of the Integrated Neighbourhood Teams embedding the Buurtzorg inspired principles developed from the learning of the test site?

What actions or decisions is the Board being asked to take?

3. The Board is asked to review the learning as provided in the King's Fund and Healthwatch reports and consider the recommendations of embedding the Buurtzorg inspired principles into the developing Integrated Neighbourhood Teams and wider localities.

Why this action/decision is recommended

4. To ensure that as the sponsoring body, members are informed of the content of the review and evaluation of the Neighbourhood Nursing and Care Team – Buurtzorg Inspired Test and Learn and are supportive of the proposed way forward embedding the principles into the Integrated and Neighbourhood Teams and wider localities

Alternative options (if appropriate)

5. N/A

Who will be affected by this action/decision?

6. Staff in the Integrated Neighbourhood Teams and the individuals and their families being supported will ultimately be positively affected if the decision is taken to support the suggested approach going forward.

How has co-production been involved in this work?

On 13 July 2017, the Health and Wellbeing Board approved its principles of co-production.

A key principle of the Buurtzorg inspired model has been around establishing a partnership between the team, patients, informal networks (including families, carers and the voluntary and community sector) and formal networks (GPs, wider health service, social care, housing, police etc.) In addition the evaluation report provided by Healthwatch has provided the patient and family carer voice to help inform developments going forward.

Sources of further information

No other documents have been relied on to a material extent in preparing this report.

Main Body of Report

Background

7. In 2017 a coalition of partners, including Suffolk Community Healthcare, Suffolk County Council, West Suffolk Councils, West Suffolk Foundation Trust, East of England Local Government association and West Suffolk Clinical Commissioning Group, agreed to work together, to design and deliver a project to test a Buurtzorg inspired model of working. A test and learn approach was agreed with a shared purpose of testing a new, holistic approach to delivering

community care in west Suffolk. The aim of the early work was identified as 'establishing a stable operational blueprint inspired by the Buurtzorg Model, through a process of adaptation and review. The test site was funded with £200,000 from the Transformation Challenge Award and 'match funding' of £50,000 from each of the four key stakeholders: Suffolk County Council, West Suffolk Clinical Commissioning Group, west Suffolk NHS Foundation Trust and West Suffolk councils.

8. When starting the test and learn there was agreement to adhere to a series of key design principles which included:

   a) Enabling the test team to provide both nursing and personal care

   b) Facilitating self-managing teams with no hierarchy, which have freedom and responsibility

   c) Creating the right environment in which teams can thrive with support provided through an effective back office and coach

   d) Allowing decision making where possible to rest with the teams

   e) Supporting a principle of practice, which includes interventions that are intense at first, preventative, holistic (health & personal care), wrap around patients and their carers (informal network) and pull in support from other professionals (formal network)

   f) The test and learn patient profile was defined as people needing care and support at home having varying complexity of care needs, to test the model robustly with the adult population accessing community care services in west Suffolk.

9. At the time the test and learn was being agreed and developed the approach in west Suffolk to integrated health and social care teams was embryonic and partnership working was still in early development so the landscape for testing out a new and exciting model was very fertile. Nationally, Suffolk was increasingly being observed by other care systems expressing an interest in the model.

10. To support the development process the Test and Learn worked with the King's Fund and Healthwatch both of whom have reported their findings. (appendix 1 and 2) The King's Fund and Healthwatch have worked collaboratively over the course of the test and learn to support learning and adaptations to the model

Key Learning

11. The Kings Fund report recognised that the west Suffolk test site was a highly ambitious project which has made some significant positive achievements in the past 18 months despite the challenges it has faced. West Suffolk system leaders involved in the project recognise that some of the core principles of self managed or self directed teams, delivering health and care within a framework of trusted assessment and working with local communities are excellent foundations of practice for our locality teams and should be protected into the future development following the test and learn. The King's Fund report summarises that the purist model is difficult in a system that is now quickly maturing integrated

working and alliance partnerships. It concludes that emerging integrated care systems should consider working towards a more Buurtzorg inspired model of delivery taking on the very best of the original principles into the emerging Integrated Neighbourhood Teams rather than the purist approach which is more suitable to the Dutch health and care system.

12. Recruitment and retention were a major challenge in the test (as they continue to be in nursing and social care more widely) - the model as tested required strong management and leadership skills and an entrepreneurial drive to develop a new service – a key question for Alliance systems going forward is how to collectively recruit and develop our workforce to ensure we develop the leadership skills of our clinical workforce to support them to deliver transformational change.

13. The challenges in establishing the infrastructure to support the test and learn have been identified by King's Fund, this included identification of premises, acquisition of IT equipment, sharing, access and recording of data/information. A number of these issues have begun and will continue to be explored / resolved as localities become more integrated.

14. Service development and self-management including the non-hierarchical ethos combined with an initial expectation that the test team would develop much of the organisation infrastructure (with the support from the working group) has been one of the greatest sources of difficulty for the project.

15. The Kings Fund report acknowledges that the local context for the test and learn shifted throughout the duration of the test as new forms of integrated working through the West Suffolk Alliance partnerships and Integrated Neighbourhood Teams take shape. Reference is also made to the new national guidance in the form of the NHS log-term plan and the new GP contract, which require the establishment of Primary Care Networks with aligned interdisciplinary community health and social care teams

16. Healthwatch evaluated the test site in terms of patient reported outcomes and experience / satisfaction and whether patients felt supported to greater independence and self-care. While the evaluation provided some useful insights into individual patient and carer experience and outcomes it is difficult to draw generalised conclusions due to the size of the sample and scope of service provided. Respondents were however extremely satisfied with the support they had received from the service.

Next Steps

17. A fundamental part of the West Suffolk Alliance is the development of Locality working and integrated neighbourhood teams. This approach has progressed significantly over the period of the test and learn. The learning gained from exploring the benefits and challenges of the Buurtzorg model has already informed the working in the teams and we are committed to ensuring that it continues to do so.

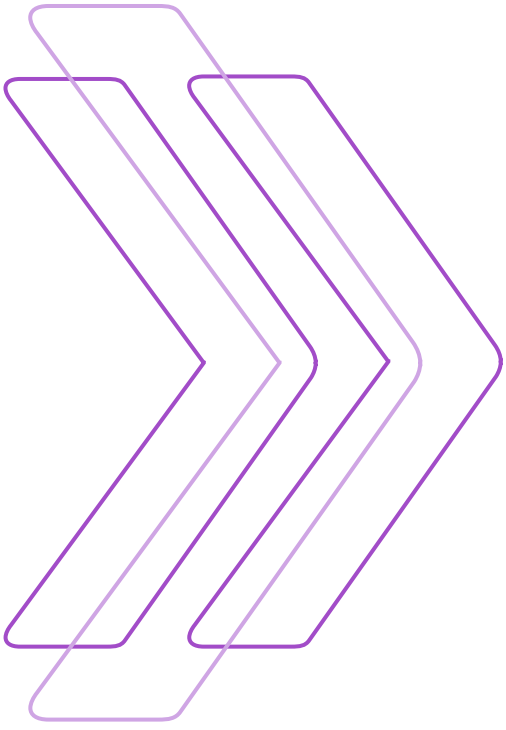
18. We are currently developing a maturity matrix to enable local teams to measure their progress in working differently together to support individuals in their communities. The analysis of the successful factors in the test and learn (outlined in Appendix 3) will be included as the aims of the most mature of the teams.

19. We will also continue to develop the working of the team in Barrow and in the Bury Town Locality to build on and deepen the understanding of how this model can be promoted with the Alliance. We are looking to build on the empowerment of front-line staff in caring for individuals and promoting independence without the Buurtzorg focus on self-management which proved to be very challenging for staff.

20. It is anticipated that the model for Bury Town will require additional capacity for frontline teams which will be funded through transformation resources. The Transformation Fund has provided £200,000 to support the second phase of the project, there is also an agreed investment of £90,000 from the Improved Better Care Fund (iBCF) to support social care provision and learning from the model.

The Kings Fund Ideas that change health care

A review of the West Suffolk Buurtzorg test-and-learn in 2017-18



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This independent report was commissioned by the East of England Local Government Association on behalf of the partner organisations of the West Suffolk Buurtzorg test-and-learn. The views in the report are those of the authors and all conclusions are the authors' own.

The King's Fund is an independent charity working to improve health and care in England. We help to shape policy and practice through research and analysis; develop individuals, teams and organisations; promote understanding of the health and social care system; and bring people together to learn, share knowledge and debate. Our vision is that the best possible health and care is available to all.

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1 Background

The origins of the test-and-learn

In 2015, the East of England Local Government Association (LGA) initiated the 'third floor integration project' with the aim of developing professional relationships between a group of statutory organisations who had recently come to share the third floor of an office building. Those organisations were Suffolk County Council, NHS West Suffolk Clinical Commissioning Group (CCG), Forest Heath District Council and St Edmundsbury Borough Council. A theme was chosen for the project, with the design question 'how can we support older people to sustain their independence after leaving hospital?'. Project leaders adopted human-centred design principles, which involved 'interviewing people, users… older people… people in the community… about how you can improve the system' and drawing on these interviews to identify criteria for selecting possible new approaches to providing care. The Buurtzorg model of care was identified as the strongest candidate to prototype (*see* A brief overview of the Buurtzorg model on the following page).

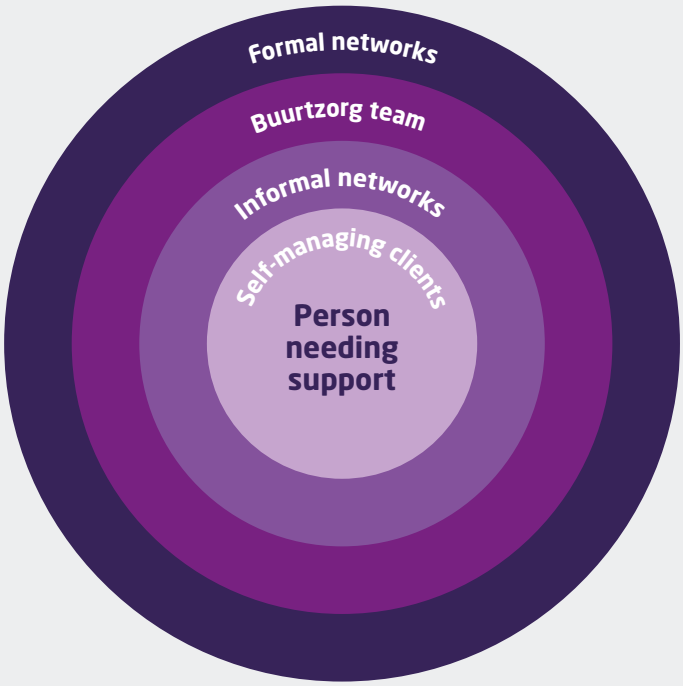
The project secured £40,000 in seed money from the Regional Improvement Panel to investigate whether the Buurtzorg model could work within the local system. This funding covered costs until January 2017. With the help of Public World, a Buurtzorg-specialist consultancy commissioned in March 2016, stakeholder workshops were conducted to develop a shared vision for the project, and an operational framework was developed to provide a foundation for how the test-and-learn was to be run.

In the summer of 2016, a group of project leaders and stakeholders visited the Netherlands to learn more about the Buurtzorg model. Out of this visit, the steering group for the project began to form. Later that year, a dinner was held with senior leaders from the council, CCG and the local trust to 'socialise' the project, and those leaders gave in-principle support for the test-and-learn. The leaders asked the project team to seek sponsorship for the test from the local health and wellbeing board, which they did successfully. In June 2017, a memorandum of understanding was signed by the EELGA, NHS West Suffolk CCG, Suffolk County Council, Forest Heath District Council and St Edmundsbury Borough Council, and West Suffolk NHS Foundation Trust, setting out how they would work together to deliver the test-and-learn project. This included an agreement to 'match' the £200,000 funding that the

project had secured from the Transformation Challenge Award, with Suffolk County Council, the CCG, the West Suffolk Councils, and the West Suffolk NHS Foundation Trust each committing £50,000. This £400,000 funding package was intended to cover the costs of a 12-month test-and-learn project.

A brief overview of the Buurtzorg model

Figure 1 The Buurtzorg model of care



Source: Buurtzorg Nederland

Buurtzorg Nederland is a not-for-profit social enterprise providing long-term home care to people in neighbourhoods across the Netherlands. The model has two defining characteristics. The first is its holistic approach to care, in which nurses and nursing assistants, working in small teams, provide a wide range of personal, social and clinical care to a small number of clients. Continuity of care, integrated needs assessment and supporting client independence (including through informal and community-based networks of support) are all described as key features of the model (de Blok 2011, 2013; Nandram 2015). Nursing team members have a target to spend 60 per cent of their time on direct client care, in an effort to prioritise 'humanity over bureaucracy' (de Blok 2016; Buurtzorg International n.d.).

Buurtzorg nursing teams work with people with long-term illnesses, elderly people with multiple pathologies, people with dementia, people needing end-of-life care, and people recovering from acute treatment (de Blok 2013). Some interviewees for our review suggested that the clinical needs of clients treated by Buurtzorg teams in the Netherlands tend to be less complex than those of patients treated by district nursing teams in the UK (a claim also made in a report by the Royal College of Nursing, 2016). We do not have suitably detailed data to make a robust comparison here, and suggest that further inquiry in this area might be warranted.

The second central feature of the model is its flat organisational structure. Small, non-hierarchical, self-managing teams of nurses and nursing assistants make their own operational and clinical decisions, with functional support (but no oversight or direction) from a small central office. Developmental support is provided by Buurtzorg coaches. Teams are responsible for recruitment, organising and delivering care, determining whether to take new clients on and managing their own performance. The central office is responsible for a range of administrative functions, including salary payments, sales contracts, IT support, and accounting (Nandram 2015). Bureaucracy and overheads are kept low: in 2016, when there were 10,000 Buurtzorg nurses and nursing assistants, there were just 45 staff in the central office (de Blok 2016).

The Buurtzorg organisation was founded in 2006 with a single team of four nurses. By 2016, there were 850 teams across the Netherlands, with 10,000 nursing team staff (de Blok 2013, 2016). Organisational expansion happens from the 'bottom–up'. New teams are set up by groups of nurses and nursing assistants, who approach the organisation with an application to establish a team (Johansen and van den Bosch 2017). This means that members of new teams tend to have already bought into the Buurtzorg vision and have a sense of ownership regarding the team and their work. Additionally, team members tend to have worked together before, and tend to have at least one member with prior Buurtzorg experience (Nandram 2015).

New teams are supported heavily in getting the model up and running. Training is provided on self-management, the Buurtzorg approach to care, and the organisation's internal systems. The teams are provided with standardised plans of action and are guided by a coach throughout the process (Nandram 2015).

About this review

Purpose

In 2017 the East of England Local Government Association (LGA) commissioned this review on behalf of the test-and-learn project partners. Through qualitative research the review team were asked to provide:

- a record of the activities which took place during the first year of the test-and-learn (January–December 2018), attending to any adaptations which had to be made to the Buurtzorg model to enable it to function effectively in the West Suffolk context

- an account of the experiences of staff and stakeholders involved in the test.

In addition to providing a written report at the end of the review period, it was agreed that the review team would provide regular feedback via the partnership facilitator to enable emerging findings to inform the development of the test in an iterative learning cycle.

A complementary piece of research was commissioned from Healthwatch to provide an understanding of patients/clients' experiences of care during the test-and-learn.

At the time of writing, that review was able to provide a small number of individual case studies; but had not yet had access to a sufficient number of randomised or representative individuals to draw reliable conclusions about the quality of care provided by the team overall.

Methodology

This is a primarily qualitative review designed to understand the 'lived experience' of people working in the test. The review uses a longitudinal case study approach to identify the activities which have taken place in the name of the test-and-learn; how and why those activities have been achieved; and what has been staff members' experience of this work. We have also drawn on basic descriptive quantitative data to support our analysis.

Data sources

The data sources for the review comprise the following:

- two rounds of in-depth semi-structured telephone interviews were conducted in January–February 2018 and October 2018–January 2019

with: all members of the nursing team and working group in post at these times; a sample of the steering group; and (in the second round) two district nurses and a social worker who had been involved in supporting the team. In total, 31 interviews were conducted. The review team made notes during the interview, and the interviews were audio recorded and transcribed for analysis

- observations from a two-hour workshop about the test with all members of the nursing team and working group who were in post in June 2018. Contemporaneous fieldnotes were taken by the two members of the review team present at the workshop

- five telephone calls with the partnership facilitator to receive updates on the progress of the test between interviews and the workshop

- routine administrative data on the activity of the team from the first two quarters of 2018 that included categorised referral sources, patient/client contacts and their type (phone/in person), and the length of time spent with patients/clients. These data were analysed to provide some basic context for the qualitative data that described the caseload and referral processes. They were not used to compare clinical metrics prior/post the test

- management documents associated with the test including: the operational framework drafts from November 2017 and April 2018; the memorandum of understanding addressing the parameters and funding of the test-and-learn; minutes from meetings of the health and wellbeing board; a document drafted by the neighbourhood nursing and care team (NNCT) describing individuals' roles within the team; and other project planning documents provided by the partnership facilitator.

Analysis

We used an inductive approach to analysing the interview transcripts and our notes of the workshop. We used our experience of carrying out the interviews and workshop observation together with our contemporaneous notes to create initial themes based on what we heard to be important for the test team in relation to the focus of this review. We used these themes (and an analytical description of their component parts) to create a framework for coding the interviews. We used computer software, Dedoose, to support the coding of this data. We tested the initial coding framework by triple coding a subsample of interviews to improve inter-coder reliability, and iteratively amended the framework (re-coding previous interviews when making major coding framework changes). We used this to establish key events and decisions in

the development of the test; participants' understanding of the reasons for these; areas of concordance and discordance between different participants' accounts and views; and participants' reports about their personal experiences of the test. The resulting themes were used to structure the communication of our findings in this report.

We received a round of comments from participants on an early draft of this report which we interpreted in the context of our existing data and analysis to inform the final text.

2 Key findings

Overview of the development of the test-and-learn in 2017–18

A draft operational framework for the test-and-learn, first circulated in May 2017, states that the project was intended to generate 'a greater understanding of the [Buurtzorg] model's application in the English health and care system', which 'is required before a formal pilot of the model is undertaken'. The project would 'adhere to the principle of starting close to the Buurtzorg model and adapting with knowledge from the Test and Learn over the period of delivery'.

The East of England LGA played a coordinating and leadership role in the project and in the summer of 2017 local managers in partnership organisations took on various support roles in the test: a 'coach' who supported the team with problem-solving and self-management; a 'clinical lead' who provided support with specific managerial functions and clinical oversight of the team's work; a partnership facilitator who helped secure ongoing support from senior partners and unlocking system barriers for the project; and 'heatshields' charged with protecting the team from the administrative requirements of the health and social care systems and liaising with those systems on their behalf. All of these individuals performed this work in addition to their existing day jobs.

The working group was the term used in practice for the coach, clinical lead, heatshields and partnership facilitator working together to problem solve (though they were not described as a group in the operational framework). A steering group was formed whose membership comprised those individuals together with senior representatives from West Suffolk CCG, Suffolk Community Healthcare, Suffolk County Council, West Suffolk councils, West Suffolk NHS Foundation Trust and the East of England LGA. The work of the steering group was described by its members as including: unblocking system obstacles (for example in relation to HR processes); connecting and championing the test with other parts of the local health and care systems; providing strategic oversight of the progress of the test to date; and identifying the next steps for the project. The project as a whole is accountable to the Suffolk Health and Wellbeing Board.

In the summer of 2017, the first recruitment round for the nursing team took place, and the first three recruits (two nurses and an assistant practitioner) took up their posts in early autumn that year, quickly followed by an additional nurse on secondment. They subsequently called themselves the Neighbourhood Nursing and Care Team (NNCT). The village of Barrow in Suffolk was selected as the location for the test by the first nursing recruits in Autumn 2017. The village has a population of around 1,700 and is in the centre of a rural area to the west of Bury St Edmunds.

The initial set of four NNCT recruits, along with the coach, accountable clinical lead and other heatshield members, went on a study trip to the Netherlands in November 2017 to shadow Buurtzorg nurses and receive basic training in self-management. Two additional nurses were employed on a temporary basis at the start of 2018, nominally to increase staffing numbers to make the service viable, but these individuals also brought expertise in district nursing, management and in the Buurtzorg model itself.

In February 2018 the team took on their first caseload of patients/clients, comprising the community nursing caseload for the village. The team were able to secure office space in the GP surgery in Barrow by early summer 2018. Before this base was established, they had to operate remotely from Darbishire House (the base for the other community nursing teams).

The team reached its peak of six employed staff (four nurses and two assistant practitioners) by autumn 2018.

After the initial transfer of the community nursing caseload, patients/clients were referred from various sources, most frequently GPs from within the same surgery. New referrals also came from community nursing, re-referrals from patients/clients and the local vicar. The three-month period before August 2018 saw the caseload vary between 16–20 patients/clients at each month's end, remaining very small by comparison to traditional community nursing and care worker caseloads.

Aside from the requirement established at the outset of the project that patients/clients needed to have a health need to be eligible for NNCT care, the referral criteria for the service were flexible. This allowed the team to adapt their approach to taking on patients as their understanding of the care model developed.

The clinical needs of the NNCT's patients/clients related to long-term conditions, recovery from acute treatment such as surgery, or from being at the end of their lives. The social care needs of the people on the caseload were generally described as limited. They were most commonly related to a need or desire to have greater social contact (which, though significant to health and wellbeing, would not normally be supported by statutory social care services except for people with profound disabilities). Some clients on the caseload continued to receive personal care support from standard social care agencies alongside their NNCT care.

In the autumn of 2018, the NNCT's capacity was reduced substantially by a series of resignations, which left the team with two members of staff, one of whom works part-time. At the time of our interviews with the team in late Autumn 2018, a new district nurse post was being recruited to provide some senior clinical leadership within the team as it is rebuilt for the next phase of the test.

Comparing the test-and-learn to the Buurtzorg model

The table below sets out the key features of the Buurtzorg model as it operates in the Netherlands, and provides comparative information on the model being developed in the test-and-learn.

It is important to note that where the Buurtzorg Nederland column describes an established model, the West Suffolk NNCT column describes a new model in its early stages of development, as it was operating in practice in the first year of the test-and-learn. Some of its features have been determined by contextual challenges rather than by design (as we describe later in this report), and the shape of the service is in a state of continual evolution.

Table 1 Summary table comparing features of the Buurtzorg Nederland model and the West Suffolk NNCT during year 1 of the test-and-learn.

Buurtzorg Nederland*	West Suffolk Neighbourhood Nursing and Care Team (year one; in practice)
Team make-up	
8–12 nurses and nursing assistants.	At any one time two–six nurses and assistant practitioners were in post. In addition, there was temporary input from two additional nurses.
Working patterns	
Flexible, aligned with client needs. Rotas agreed by teams in weekly meetings. Teams available 24/7.	Working patterns influenced by availability of staff. Rotas agreed by team in weekly meetings. Team available: 9.00am–5.00pm weekdays; 8.00am–12.00pm weekends (12.00–4.00pm on call) The local admission prevention service and the Early Intervention Team covered any clinical care that had to be delivered to patients/clients outside of these times.
IT system	
Bespoke system, Buurtzorgweb, which supports appointment scheduling, client records management, clinical governance, email communication, and HR.	TPP SystmOne unit run by West Suffolk NHS Foundation Trust for patient records and recording nursing activity. Separate activity recording system, Liquid Logic, for social care to which the team do not have direct access. Separate NHS trust-based systems for HR.
Technology	

Nurses are given iPads to enable effective remote working. E-care desk provides IT support.	Tablet PCs with access to some features of SystmOne, but online connectivity (both when visiting patients/clients and in the office in the GP practice) was problematic. IT support provided by the NHS trust.
Back office	
Small, expert back office dedicated to supporting nurse team functioning.	Back office business and administrative support, including with IT and HR, provided by a member of staff at the West Suffolk NHS Foundation Trust. Members of the heatshield provided additional ongoing support with a range of issues around HR, IT, and cross-organisational working.
Approach to care	
Continuity of care: named team member assigned to each client. Arrange appointments directly with clients. Mobilise informal support networks. Co-produce personalised care plans with clients. Cases discussed and co-managed at weekly team meetings.	Continuity of care: named team member assigned to each client. Arrange appointments directly with patients/clients. Mobilise informal support networks. Assessment and care planning in early stage of development Cases discussed and co-managed at weekly team meetings.
Types of care delivered	
Clinical care consistent with community nursing. Personal care (supporting people with washing, eating, dressing and toileting), reablement & wider social care support work.	Clinical care consistent with elements of community nursing (most commonly: wound care, medicines monitoring and administration, blood tests, some palliative care). Personal care (very limited), reablement and wider social care support work.

Support	
Buurtzorg coach Comprehensive guidance materials on Buurtzorgweb Inter-team peer support Training courses on self-management and care	Coach Draft operational framework Heatshield for health and social care Clinical lead Partnership facilitator District nurses in local community team Study trip to the Netherlands (for the initial set of recruits only)
Management structure	
Self-managed teams Peer appraisals Non-hierarchy: no line-managers or team leaders	Self-managed teams (later described as self-organised teams) Some peer appraisals, some appraisals led by the clinical lead Non-hierarchy: no line-managers or team leaders Team's progress supported and overseen by working group and steering group
Recruitment	
Teams hire new members themselves, with support from the coach	Nursing team involvement in the recruitment process varied. After the initial recruitment of three nurses and an additional nurse on secondment, the nurses were involved in all subsequent recruitments, with strong input into 'standard' recruitments and lesser contributions when it came to appointing temporary staff and a clinical leader
Caseload	

40–60 clients per team at any one time	16–20 patients/clients between the team at any one time throughought the summer of 2018
Team member to client ratio roughly 1:6	Team member to patient/client ratio roughly 1:3 (Note that the NNCT model is not yet running at full establishment or with finalised referral routes and criteria – these are the numbers to date)

* Sources: de Blok 2011, 2013, 2015; NHS European Office 2017; Nandram 2015; Royal College of Nursing 2016.

An ambitious project in a challenging context

The Buurtzorg model of care differs in two fundamental ways from the standard provision of care in the English health and social care systems. It combines health and social care into one service, where in England these two types of care are traditionally provided by two separate systems with different funding and financing arrangements, separate professions and distinctive cultures. Buurtzorg teams in the Netherlands are also non-hierarchical and self-managed, by contrast to nurses in England whose professional identity and employment status are organised according to a strong hierarchy, and whose professional practices are bound by often detailed protocol. As a result, the West Suffolk test-and-learn is a highly ambitious transformation project.

Transformational change by its nature tends to lack precedent or blueprint; it is emergent and does not develop in accordance with a neat plan. In this context, solutions are unknown, 'learning is often painful' and 'significant change is the product of incremental experiments that build up over time' (Heifetz *et al* 2009 pp 16, 17; The Leadership Centre 2015; Timmins 2015; Dougall *et al* 2018).

In addition to the challenging nature of the transformation required by this project, two specific obstacles in the health and care system, beyond the control of the project, have significantly hindered the test's progress: the recruitment crisis in nursing, and the lack of adaptive IT infrastructure in health and social care.

Nationally, one in eight nursing posts is vacant and over the last five years there have been significant increases in the numbers of nurses leaving the

NHS, particularly at younger ages (Health Foundation *et al* 2018). The test has struggled to recruit sufficient numbers of suitably qualified and engaged staff, never reaching full establishment in its first year. It has also struggled to secure an IT infrastructure to support the team to record, share and analyse information on holistic assessments and care. The progress of the test in its first year needs to be interpreted in light of these two contextual challenges, explored in further detail below.

Achievements

Staff and patient/client experiences of care

We heard that the NNCT's service has provided some outstanding holistic care for patients/clients. NNCT members, working group and steering group members and local district nurses all gave examples of how the team were providing people and their unpaid carers with person-centred, holistic care which was enabling those individuals to make significant improvements to their health, wellbeing and independence. These reports of high quality care are supported by the emerging findings from a parallel review by Suffolk HealthWatch of the experiences of the NNCT's care by patients/clients and unpaid carers (though at the time of writing only nine interviews had been conducted and the representativeness of those individuals of the wider caseload had not yet been established; more robust data is required).

Early on in the test, some NNCT members felt strongly that by enabling team members to provide holistic care the model has the potential to re-engage the vocational drive of nurses. NNCT members have indeed described a strong personal satisfaction with the care they have been able to provide to people on their caseload, which they identify as the result of having more time to spend with patients/clients, and the time and license to act on things learned in these conversations. The team had established good links with non-statutory services in the village, and they were using those links to introduce people to services (such as a befriending service), supporting them to build social connections and to regain their independence.

The team were also beginning to build relationships with care agencies and the hospital to share information and coordinate care for specific individuals. We heard that locating the team's base within the GP practice was allowing the team to routinely share information about patients/clients with practice staff, making referral processes more meaningful and effective.

Partnership working among senior leaders

We were struck in our review by the strength of commitment to key elements of the Buurtzorg vision among senior partners across health and social care in West Suffolk, and by the energy and drive of a host of skilled staff involved in developing, supporting and overseeing the project.

The working group for the test (comprising the coach, the clinical lead, the heatshields and the partnership facilitator) have all invested significant amounts of time and energy into the test's development, which they have had to do on top of demanding day jobs. They describe spending more time on the test than on comparable projects they have been involved in, and the scale of the cultural and system changes required by this project has meant that they have regularly been required to work outside of their professional comfort zones, learning as they go.

There has also been strong and positive engagement in the project at steering group level and by the health and wellbeing board, where individuals from partner organisations have played important championing roles for the test. When the test has encountered problems, individuals have used their senior positions to require other parts of the local system to remove barriers to progress, and they have provided the test with 'air cover' from the performance management pressures typical in the NHS.

A small number of individuals on the steering group have played an important leadership role in the project by continuing to remind colleagues of the original vision for the test, challenging them to resist reverting to siloed working and traditional staffing hierarchies. Participants identified this senior support as essential to enabling the test to develop this far.

Senior stakeholders described how the process of designing and overseeing the test-and-learn has helped to develop and strengthen the working relationships between the different organisations involved, building on and contributing to other efforts to integrate services in the area.

Challenges

These achievements notwithstanding, a number of significant challenges were encountered in the first year of the test-and-learn.

Service development and self-management

The introduction of non-hierarchical self-management, combined with an initial expectation that NNCT members (with support from the working group) would develop much of the organisational infrastructure and service design for the test, has been one of the greatest sources of difficulty for the project.

For the Buurtzorg model in the Netherlands, this initial phase of infrastructure development and service design was led by a highly experienced collection of nurse-managers and entrepreneurs. That team had a powerful personal drive to develop a new way of working, a strong set of management and leadership skills, and the knowledge and resources to commission a bespoke IT platform to support their work from an early stage. Once the model was established, new teams (with pre-existing relationships and at least one member with past experience of working in the Buurtzorg way) would request to join the network. Once accepted, they would be provided with user-friendly IT systems designed for Buurtzorg-style care, as well as expert back office support and (initially intensive) organisational development support via a coach.

The work of building an infrastructure and a service design which realises those Buurtzorg principles in the West Suffolk context, requires a significant amount of highly skilled management, leadership and organisational development work. At the start of the test, responsibility for much of this translation and development work was given to the nursing team, with the support of the working group. This reflected a commendable effort on the part of managers involved in the test to commit to new ways of working with more distributed forms of leadership and true self-management. However, members of the NNCT did not have sufficient leadership experience, motivation, training or support to be able to effectively play this role.

The NNCT members did not know one another or have much (if any) familiarity with the Buurtzorg model prior to joining the test. Some NNCT members had not been fully aware of the nature and demands of a test-and-learn of this kind, including the extent to which they would have a role in developing the service model. Most of the team's members were motivated by an interest in providing holistic care, but not by a desire to engage in self-management.

The initial four recruits had a three-month period prior to taking on patients/clients in which to get to know one another and were taken on a study trip to Buurtzorg in the Netherlands to learn about the model and self-management in particular. The coach also provided support with self-management and relationship-building.

However, subsequent recruits described receiving only minimal information about the Buurtzorg principles and model in the Netherlands, and the way in which it was being adapted by the project for the UK context. While support for self-management from the coach and other working group members was appreciated by the NNCT, individuals across the test reported that those colleagues could not make sufficient time available to meet the needs of the team, who at times felt abandoned. In addition to the demanding day job, working and steering group members were at times pre-occupied with other projects underway in the local area, including the establishment of the alliance commissioning arrangement, reorganisations to the local authority and adult social care services, and a review of the work of the local LGA.

As the nursing team struggled with self-management, support for them from the working group and others sometimes took a more directive (rather than coaching) form. The NNCT were in some ways grateful for being 'rescued' by these interventions but were also left unclear about how management responsibilities and authority were distributed between the NNCT and other actors in the test.

Within the NNCT, leadership was often conflated with management; and self-management sometimes translated into no-management. Interpersonal relationships in the team were strained, and disagreements sometimes descended into conflicts. This experience with self-management put the team members under considerable stress, and (in our view, and the view of a number of the people we interviewed) contributed to the high number of resignations among the team.

Partly in response to interim feedback from this review, the working group have been seeking since late summer 2018 to commission self-management support in the form of workshops for the staff. However, they report that the requirements and pace of NHS procurement processes have created long delays.

Recruitment, retention and staff experience

There is a major recruitment crisis in nursing at a national level, and the test struggled to recruit nursing and clinical staff with the relevant skills, experience and motivation. The NNCT didn't reach its full establishment in this first year of operation despite multiple recruitment rounds.

Recruitment challenges were described as being exacerbated by the time and energy required to renegotiate existing rules in HR procedures (for example around amending core job descriptions); and by what some described as slow turn-around times by the trust's HR directorate in response to the team's requests to upload job adverts or process DBS checks.

In addition to the opportunity cost of NNCT and working group members having to spend so much time on recruitment, difficulties recruiting staff also meant a reduced capacity on the team with consequences for the development of service (particularly in relation to personal care visits); and made it more difficult for the NNCT to develop bonds of trust as a team as new individuals joined every few months.

In addition to national challenges around nursing recruitment, participants identified factors specific to the test-and-learn which in their view had put off would-be recruits from applying. These included the short, fixed-term nature of the test (even though recruits were guaranteed a permanent post in local community teams if/when the test was terminated); the advertised requirement to cover 12 hours shifts; change-fatigue following recent reorganisations in community services in the area; a perception that team members might not be able to develop and practice advanced clinical skills; scepticism about the efficacy of self-management; and the affordability of a model in which nursing staff provide social care.

During the project, two innovations were implemented to boost recruitment efforts, with observable positive impacts. The first was enabling recruits to join the project on secondment from other roles; the second was holding pre-application drop-in days in which potential applicants could find out about the project and receive support for the application process.

The project also struggled to *retain* NNCT members. In addition to temporary contracts coming to an end and a seconded colleague being called back to their original post, there were a number of resignations from the team. By late autumn 2018 the team had fewer than two whole-time equivalent staff.

This seems particularly problematic in the context of a model that is intended to improve staff experience of work.

These departures were attributed (by those who left and those who stayed) to team members feeling: overwhelmed and under-supported in the management work required of them; frustrated by what they saw to be the slow pace of the project and the small size of the caseload; unable to practice more advanced clinical skills; and fearful that the project would soon be terminated, with associated uncertainty about their future role. There were at times strong interpersonal tensions within the NNCT, and we heard that the team were sensitive to the resentment reportedly directed towards them by local community nursing teams, who were operating with a much less favourable staff-to-patient ratio.

Social care provision

What is 'social care'?

Social care is a spectrum of different kinds of support provided to people in their homes and other community settings to support them to live independent lives. Here we describe our taxonomy of the different types of social care we heard described in the West Suffolk context:

Personal care: supporting people with basic activities such as washing, toileting, getting dressed and preparing and eating meals.

Wider support work: supporting people to engage in leisure, work and social activities, to manage their finances and carry out everyday tasks such as shopping.

Reablement: physiotherapy, occupational therapy and other activities (often including personal care), delivered for an intensive, time-limited period to support someone to regain independence. They are often put in place when someone is first discharged from hospital and requires support.

Personal care and wider support are only provided by local authorities to people with low assets and/or income, following a means test. Those who do not qualify must pay for it themselves. However, everyone who needs it is entitled to six weeks of publicly funded reablement care under the Care Act 2014.

The expectation described in the operating framework is that the NNCT would ultimately become the default providers of social care for their patients/clients, including meeting their personal care needs (*see* 'What is social care?' box above). This would entail financial assessments that would enable the social care element of their work to be subject to means testing, as is standard. In practice the development of social care support by the NNCT (particularly in relation to personal care provision) remains at a much earlier stage of development compared to the clinical care provided by the team. There are a host of inter-related reasons for this.

The NNCT's caseload has been principally established through district nursing and GP (rather than social care) referral routes. A number of interviewees reported that there were, as a result, insufficient social care needs on the caseload to fully test this element of the model. More broadly, many of our interviewees came to the view by the autumn of 2018 that the wealthy, elderly demographic of the village served by the team meant that there are already strong local support services available to people and relatively small numbers of people with complex social needs.

However, others pointed out that there are *some* personal care needs in the village which are continuing to be met by standard social care agencies rather than the test team. That limited capacity of the team to staff frequent home visits to provide personal care support was emphasised by some as the most significant obstacle to the development of this aspect of the service.

In addition to these practical challenges, there has also been uncertainty within the test about what counts as 'social care', with varied understandings among and between the social care heatshields (a role played by a number of staff from the local authority), the working group and the NNCT.

Some in the test commented that the training and support for the team to provide social care has not been sufficient. Social care training was made available to the team, including a number of learning sessions and shadowing opportunities with both social care teams and the reablement provider Home First. The introduction of support from a social worker at the team's weekly meetings from spring 2018 was valued by the team, but NNCT members nonetheless commented that they would still like further social care training.

The challenge of how to manage the means-testing requirements associated with personal care has also not yet been resolved. Social care managers have circumvented some of these challenges by limiting and framing the NNCT's

input as reablement care (which is state-funded for six weeks for eligible clients in standard social care provision). In practice the team has been providing very little personal care, focusing more on some wider social support work, of a kind which would usually be available from statutory services only to adults with profound disabilities rather than older people, though such support can be critical to person's health and wellbeing.

IT

Establishing well-functioning IT systems suited to supporting the work of the test has proved a significant challenge. Getting access to basic digital infrastructure such as devices, internet access and email took many months. When the team took on their first patients/clients in February 2018 they were still sharing one office computer between them. Problems with connecting to online systems when in the village and in the base were still outstanding as we concluded this review; a common challenge for staff working in rural areas.

In terms of systems to document and share information about patient/client care, plans to use a translated version of the Buurtzorg IT system were thwarted when it was not made available as had been expected. A pragmatic decision was taken to use TPP's SystmOne in the test, though its facility for documenting the social and holistic elements of the care provided by the team was reportedly limited, in part because the system was originally designed for GP care. Efforts to modify that system to better support the team's way of working were limited by restrictions on the availability of local IT support, as the host trust's IT team were focused on supporting the recent integration of community services with the West Suffolk Foundation Trust.

The test also ran up against the difficulty experienced more widely in health and social care provision of having to contend with different software packages for social care and for different healthcare services, which are not interoperable. The team do not have access to social care recording systems and there is no facility to share information with social care teams through their current configuration of SystmOne. The social worker who attends the weekly meetings has been collecting information on the team's activities with their existing clients at these meetings then uploading her notes to the relevant local authority system (now Liquid Logic) when they constitute changes to assessments in care plans for existing clients.

The lack of a truly integrated assessment form for health and social care has hindered the ability of the team and managers involved in the test to meaningfully analyse and learn from their social care activities.

Oversight and accountability in the test

There was not yet a shared and codified understanding of the respective roles of the working group, steering group and health and wellbeing board in providing oversight of the test and holding its members to account. While interviewees described the importance of the project being given space to develop outside of the strong performance management culture common to the NHS, they also recognised that there needed to be a clearer articulation of what the project was expected to deliver, to enable account holders to recognise success or failure to progress.

Information flows between the NNCT and the working and steering groups were described as inconsistent and insufficient by some members of each group. Although NNCT members sometimes attended the working group and working group members reported that NNCT members were always invited, we heard that in practice NNCT members were often unsure of the latest decisions from that group or the strategic direction for the project (which should be set by the steering group).

We heard that working group members were at times out of touch with the operational and other pressures being faced by the NNCT members. The connecting function the working group could play between the NNCT and the steering group is not seen as having been effective, and as a result there was often a delayed response to problems experienced in the NNCT, which allowed morale among the nurses and assistant practitioners to deteriorate. The new district nurse role in the NNCT, established at the end of our review period, was described by some interviewees as intended to serve as a bridging role between the NNCT and the working group.

Some colleagues described individuals on the steering group and the health and wellbeing board as holding an overly positive and idealistic view of the test which was disconnected from the reality of the NNCT's experiences. We heard that the health and wellbeing board (to whom the project is accountable) played an important role in championing and supporting the test, but it was not clear that the board offered challenge as the account holder for the project.

Steering group members identified a broader challenge within the test and the wider integration work in the area to develop clarity around the allocation of responsibility and accountability for services in the context of multiple statutory organisations collaborating in new ways; this is a challenge which is being grappled with across the country.

Learning

Through the experience of the challenges and achievements described above, and by commissioning this review and the parallel review from HealthWatch, the test has produced valuable learning for teams working in West Suffolk and elsewhere in England to transform care.

We cannot say from this review whether the Buurtzorg model 'works' in the English context: this review was not intended to examine the efficacy of the service model and the scale and duration of the test meant that a quantitative analysis was not appropriate. Furthermore, as we described in our interim feedback to the project, insights from research into policy transfer and translation advise that efforts at purist implementations of models from different settings will invariably be ineffective, since trying to do the 'same' thing in a different context will have different meanings and outcomes.

A central task for the next steps of this project then is for relevant partners to revisit the vision and purpose for this work in the context of ongoing changes in the local and national context. We return to this issue in the next section of the report, where we distil what we think are the most important lessons to be drawn from the experience of the test-and-learn to inform future work in the area.

More detailed findings from our review, including supporting data, are provided in an Appendix to this report. The Appendix has been shared with staff working on the project, but it is not being made publicly available because of the challenges of truly anonymising the contributions of the relatively small number of people involved.

3 Strategic priorities for a next phase of the project

Drawing on the findings from this review, the literature on managing change and innovation, and our professional leadership and organisational development expertise, we suggest six areas where the steering group could focus its attention to support the development of the test.

1 Recognising and celebrating successes to date

This is a highly ambitious project which has made some significant positive achievements in the past 18 months. The holistic care and support provided by the NNCT to people in the area has been described by other clinicians as 'fantastic' and having a 'big impact' on the lives of those individuals and their families. We have heard of high levels of satisfaction among some NNCT members with the care they are able to offer patients and clients. Co-location in the GP practice has enabled a new level of communication and coordination between the service offered by the GPs and the NNCT. And the project has continued to receive strong in-principle support from senior leaders in the area.

Staff involved at all levels of the project could benefit from routinely recognising and celebrating the specific successes of the work to date.

2 Developing a renewed, collective vision for the service and purpose for the test

The original motivation for the test-and-learn project was identified some years ago and some of the lead actors involved in that process have moved on from their roles on the project. In addition, partly in response to this review, leaders in the test have recognized that fidelity to a pure version of the Buurtzorg model should not be the central purpose of the project (since doing the 'same' thing in a very different context has different effects).

In addition to these internal changes in the project, the local context for the test has been shifting as new forms of integrated working through the Alliance and Integrated Neighbourhood Teams take shape. There is now also relevant new national guidance in the form of the NHS long-term plan and the new GP

contract, which require the establishment of primary care networks with aligned interdisciplinary community health and social care teams. The networks and integrated community teams are to be jointly charged with offering an 'Anticipatory Care Service', providing 'more proactive and intense care for patients assessed as being at high risk of unwarranted health outcomes' (NHS England 2019).

Taken together these developments provide an opportunity and a need to rearticulate what problem this care model is trying to solve; to build on learning to date and to develop a theory of change to identify which aspects of the model the project wishes to retain and pursue; and to identify and articulate how this vision for a new way of providing care complements other work around integrated, person-centred care being developed locally.

Relatedly, there is a need to articulate the purpose for the next phase of the test-and-learn itself (as distinct from the care model). In practice the last year has involved work to establish a functioning version of the model in this context, whose viability and impact could then be evaluated in future phases. It would be useful to revisit what criteria need to be met for the project to be ready to move on to the next phase.

Having a clear, renewed, shared vision for the service model and an agreed purpose for the next phase of the project will provide the foundation for other important aspects of project management work to be undertaken in relation to clarifying:

- roles and responsibilities on the project (while recognising that roles and responsibilities within the service itself may still be evolving)
- lines of accountability within the project, specifying who is accountable to whom, and for what
- how this work fits with and complements other services and service developments in the area.

This work would provide a new opportunity to seek to engage existing community nursing teams more directly in the test. We would also expect this work to include public and patient engagement and to be informed by robust, independent data on patient/client and carer experiences of the service to date. This will enable the team to ensure that the service is and will effectively meet peoples' needs; and can serve as a useful resource when seeking to secure buy-in for the new service from other clinicians, staff and communities.

3 Engaging with the impact of workforce on the test

Recruitment and retention have been a major challenge in the test (as they are in nursing and social care more widely). The model as it was tested required: strong management and leadership skills among NNCT members and an entrepreneurial drive to develop a new service and effectively a new form of organisation; a highly experienced group performance coach who could provide intensive support to the team in their task; and clinical oversight and leadership, arguably from someone with district nursing experience. The people recruited to these roles brought considerable commitment, skill and expertise, but did not have expertise or specialisms in these critical areas. The key support roles in the working group were not funded.

There needs to be a balance struck between establishing a vision for the model and service and developing a workable set of arrangements given the staff, skills and resources available. The future development of the test should be informed by an assessment of the availability, skills and motivations of nursing staff and managers in the local health and care economy, and should recognise the importance of (and resources required for) 'capability building' as an integral part of developing the new service model (Horton *et al* 2018). This includes focusing time and resources into developing appropriate induction, training and support for current and future members of the NNCT.

The struggles with self-management in the team were a result of a combination of limited motivation on the part of NNCT members to be self-managing; limited management and leadership experience among the NNCT; insufficient training and support for the NNCT; and ambiguity around the responsibility and power of the NNCT compared to other actors in the test. For these reasons we do not believe that this experience has shown fundamental flaws in using self-management in this context *per se* but has rather highlighted the skills (both technical and relational), motivation, training, support, and organisational and team-building framework which are necessary for self-management to be given an opportunity to flourish.

4 Attending to staff experience

There is a strong evidence base on the association between positive staff experiences of work and positive patient experiences of their care, and one of the attractions of the Buurtzorg model in the Netherlands is that staff report a very positive experience of their work. The current recruitment and retention crisis in nursing in the UK adds further weight to the case for prioritising staff experience.

Many of the NNCT members and some members of the working group reported experiencing considerable stress in the context of working on the test. The managers involved in the test described their commitment to providing the NNCT with management freedoms in order to be true to the Buurtzorg principles, which is particularly laudable in the context of the traditional NHS culture of strong hierarchy and tight performance management. But in practice this 'freedom' was often experienced by the NNCT as pressure to play management and leadership roles for which they were not adequately skilled, supported or indeed motivated. Combined with not developing bonds of trust as a team, team members described feeling under pressure and under-supported.

Research on the conditions for effective team working and learning within organisations emphasises the primacy of 'psychological safety', in which colleagues feel comfortable, valued and able to speak up about ideas, questions or concerns without fear of negative consequences (Edmondson 1999; Wisdom and Wei 2017). Trust among team members is also seen as critical to enabling people to share innovative ideas on ways of working (see for example Clegg *et al* 2002).

Debriefing the team members involved to this point and creating psychological safety for current and future staff members through attention to team building should be a priority for the project. The complexity of the task being taken on by the team means that they need to have a particularly strong foundation from which to work. This should include a clear sense of leadership within the test which provides the team with a sense of containment; clarity over where and when they have freedom to take initiative; structure and clarity about roles and responsibilities wherever possible (see above); and properly resourced support for both their management and care responsibilities.

As part of this it is important that the team has protected time when they are not discussing their caseload, to collectively reconnect to the vision for the service; celebrate specific wins; identify the learning from difficulties; and to put contemporary struggles into the wider context of the test and its purpose.

The experiences of the last year also highlight that there needs to be clearer mechanisms in the project for senior colleagues to hear what staff in the nursing team are experiencing, and to recognise poor experiences as a priority for attention and action. There also needs to be greater agility on the part of the wider system to respond when staff identify and request changes.

5 Adopting a purposeful and disciplined approach to experimentation and learning

Ambiguity around roles, responsibilities, power and accountability within the test were strong themes in our data. A test-and-learn should allow for discovery and requires flexibility on the part of everyone involved as new ways of working are tried and amended in an iterative cycle of learning. In any transformational change project, leaders need to be comfortable working with partial and emergent solutions (Heifetz *et al* 2009; The Leadership Centre 2015).

But we found that at least part of the ambiguity we observed was the result of issues not being discussed or gaps in communication, rather than an artefact of purposeful experimentation. Beyond the role assigned to this review, it was not clear to us that the NNCT or working group were routinely finding space to reflect on, share and record their learning in an explicit and systematic way.

The project would benefit from establishing clear communication and documentation about the status and development of roles and working arrangements (however provisional or temporary they may be) and dedicating time and resource to supporting the groups involved to take responsibility for identifying and acting on their learning.

There could also be real benefits to the test (and other services) of establishing peer-learning networks both with other integrated projects within West Suffolk and other Buurtzorg-inspired teams elsewhere in the UK (Horton *et al* 2018). We heard that a link formed between working group members and two projects in Cambridge had provided very useful insights to both; as has a link with Helen Sanderson's Wellbeing Teams. Is there an opportunity to cast this net wider to identify other relevant sites the test could be regularly

sharing learning with, and to include NNCT members more directly in these networking activities?

6 Continuing to develop the infrastructure

A key piece of learning from this first phase of the test is that in an ideal world, the infrastructure for the service would be set up by colleagues with relevant management expertise prior to the nursing team taking up their posts. There is an opportunity to try to make further progress on some of these areas before the team is expanded further.

We have seen above that training and induction processes for the team need further attention.

The care record system currently used by the NNCT does not allow them to adequately record and analyse social care activity. Improving IT support for the service will require investment of time and resource to develop the systems to support the team, but also realistically depends on change across the English health and social care system in implementing standards and infrastructure for sharing patient/client-level information across the health and social care systems. The team and those supporting them will have learned a lot about how IT can support, or hinder, their ways of working; these lessons could be usefully fed into the development of wider digital strategy in the local area as part of the Health Service Led Investment programme.

In terms of the location of the current service (and future tests), there is an emerging consensus among staff involved in the project that the model should serve a population with greater social care needs and/or more complex combined social care needs, probably in a more economically-deprived area.

Once the vision for the service and the purpose of the test have been revisited, project members can identify which services it makes most sense for the team to be co-located with (mindful of the potential added advantages of co-location with social care colleagues while the NNCT cannot access their record systems remotely), and how this service relates to new national policy requirements to develop primary care networks and inter-disciplinary community teams.

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Any errors or weaknesses are the responsibility of the authors.

Appx 2

healthwatch Suffolk

Evaluation of the Neighbourhood Nursing & Care Team

Published July 2019

If you need this document in an alternative format, please contact 01449 703949 or email info@healthwatchsuffolk.co.uk

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1. Introduction

About Healthwatch Suffolk

Health and social care services work best when users of these services are involved in decisions about their treatment and care. Local Healthwatch were established by the Health and Social Care Act 2012 to be the "consumer champions" for health and social care services. Healthwatch aim to ensure that service user's and carer's voices are heard where it matters and where decisions are made.

Healthwatch Suffolk is an independent organisation that works to determine what local people think about their health and social care services. It has statutory powers that enable it to use experiences to influence, shape and improve the services now and in the future.

Healthwatch Suffolk also provides an information and signposting service to help people navigate the health and social care system.

What is the Buurtzorg Model?

Founded in the Netherlands in 2006/07, the Buurtzorg model is a unique district nursing system which has garnered international interest because of its breakthroughs in achieving:

- high levels of patient satisfaction,
- high levels of staff satisfaction due to the increased control and autonomy nurses have,
- significant reductions in the cost of care provision by reducing:
    a) administration and managerial costs,
    b) bureaucracy and time spent on paperwork,
    c) hours of care required through promotion of self-care and patient independence.

The key to the Buurtzorg approach is that it empowers nurses to deliver all the care that patients need. The nurses are 'generalists,' taking care of a wide range of patients and conditions. They are highly educated and skilled. Teams consist of up to 12 professionals providing care for 40-50 clients in a specific locality. Nursing teams are autonomous, self-organising and non-hierarchical. A small back office supports the teams, resulting in lower overheads.

The West Suffolk Test and Learn Trial

Like many areas in the UK, West Suffolk faces considerable challenges in delivering quality health and social care services to a rapidly ageing population, with limited resources (workforce and funding). In response, key partners in West Suffolk have joined together to explore innovative solutions to meeting patient's needs.

In 2016, a group of health and local government representatives from West Suffolk undertook a study visit to the Netherlands to observe and experience the Buurtzorg Model of care firsthand.

While it was recognised that transferring an international model to a new setting could be complex, the outcomes observed in the Netherlands indicated that there was real merit in investigating the model in West Suffolk. In 2017, a Test

and Learn trial was established with a specific aim of exploring ways in which the Dutch model could be adapted for use in the UK.

The trial was designed to be delivered in three phases, with a process of check and review between each stage:

1. **Early Pilot:** to establish a team (the neighbourhood nursing and care team - NNCT) and an operational framework for the Suffolk model of Buurtzorg, (Sept 17-Feb 18).

2. **Pilot:** robustly test the model and evaluate against desired patient, staff and system outcomes and benefits (Feb 18-Jan 19).

3. **Scaling:** Consolidating learning into the wider system and rolling existing teams into the model (Feb 19 onwards).

The trial was jointly funded, with £200,000 secured through Transformation Challenge Fund and a further £50,000 from each of the four key stakeholders – Suffolk County Council, West Suffolk Clinical Commissioning Group, West Suffolk NHS Foundation Trust, and West Suffolk Councils (Forest Heath and St Edmundsbury).

The aim of the trial was to adhere as closely as possible to the Buurtzorg model of care i.e.:

- a self-managing team,
- able to make their own decisions,
- staffed with individuals who could deliver both nursing and personal care,
- focussing on intensive interventions at first but also considering longer-term preventative and person-centred solutions to facilitate the best possible independence for patients.

The target audience for the trial were adults needing care and support at home and the NNCT aimed to work with patients with varying complexity of care needs, in order to robustly test the model.

2. Methodology

Healthwatch Suffolk (HWS) were commissioned to evaluate the local adaptation of the Buurtzorg model, from the patient's perspective, during the pilot phase (Feb 18-Jan 19). The King's Fund were separately commissioned to undertake an evaluation of the model from the perspective of the health and social care professionals implementing the new model.

It was agreed that the Healthwatch Suffolk evaluation would focus on the five following areas:

1. Patient-reported outcomes and experience of the Suffolk-based Buurtzorg model.

2. Patient satisfaction under the Buurtzorg model.

3. Whether the patients felt enabled to have their preferred priorities of care.

4. The impact of the model on the carers/family of the patient.

5. Whether the patients felt supported to greater independence and self-care.

The primary method of data collection was semi-structured face-to-face and telephone interviews with service users, family members and informal carers.

Healthwatch Suffolk proposed to undertake 40 interviews in total, (28 with service users and 12 with families/ carers. The HWS proposal did not include any set criteria for who could take part in the evaluation, other than they had to have received a service from the Neighbourhood Nursing and Care team during the pilot phase.

The NNCT was solely responsible for contacting potential participants, asking if they would like to take part in the evaluation.

Between Mar 2018 and Dec 2018, the NNCT provided a service to 90 patients. Of these only 26 were considered suitable, by the NNCT, for inclusion in the study, because they had received both health and social care support during the trial.

Of the 26 patients contacted by the NNCT only 20 individuals subsequently volunteered to take part in the evaluation.

There are several issues that have affected the low patient numbers during the trial and have subsequently impacted on the numbers of people eligible for taking part in the evaluation:

- **Recruitment of staff** was an issue throughout the pilot. Lack of staffing affected the team's ability to cover the full working pattern for the service (8am-8pm Monday to Friday, with weekend working too) and also impacted on the total number of patients the team could engage with.

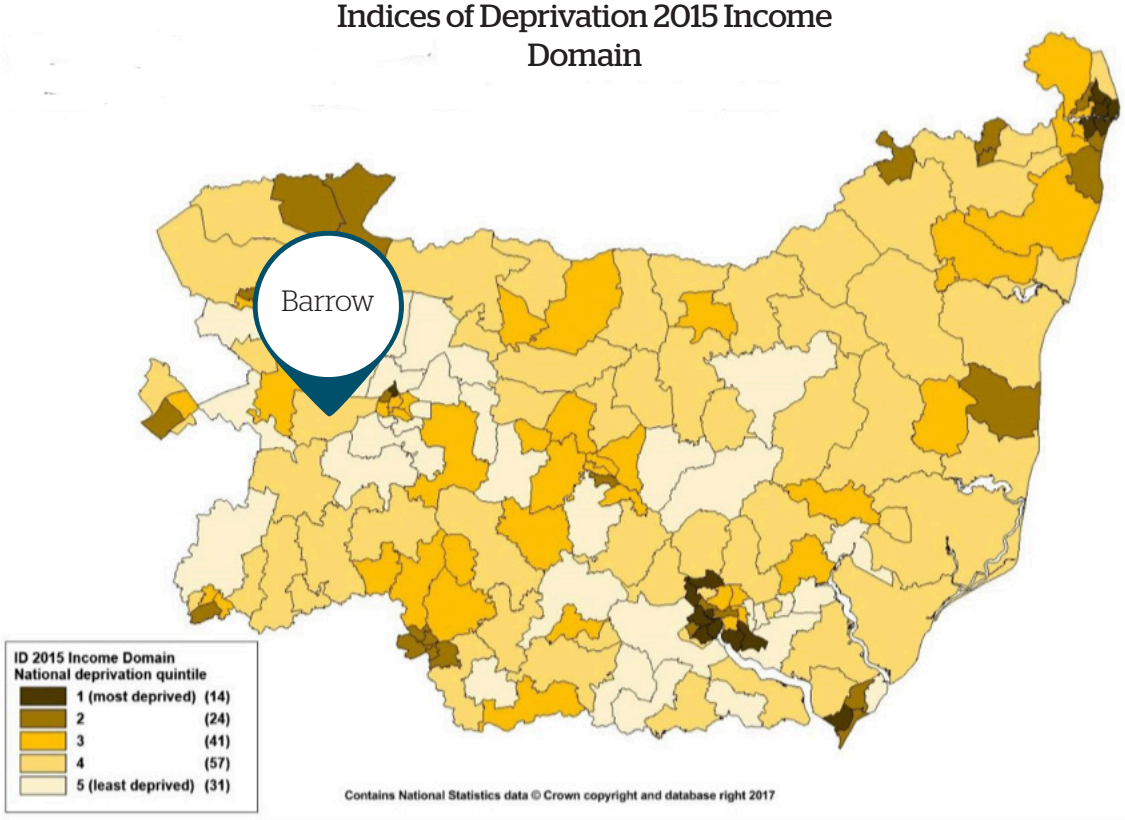
- There have been challenges with **integrating personal care into the model**. Additional support was provided during the test phase to help develop the team's knowledge and ability in delivering holistic care. However, the team's lack of confidence to deliver both elements of care may have restricted the numbers of patients with dual needs that the team felt able to work with. Consequently, this will have impacted on the numbers of patients who met the NNCT's requirement, of having

received both health and social care support from the team, in order to be considered eligible for the evaluation.

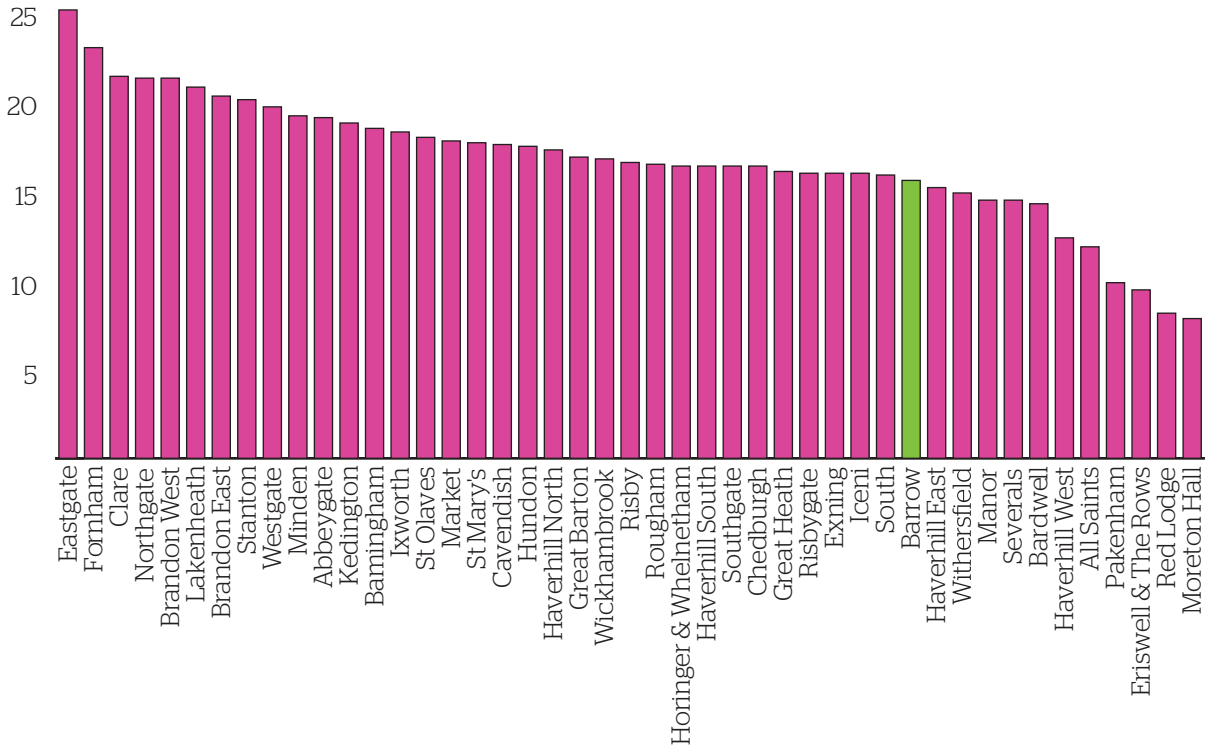
- **Socio-economic and health profile** of the test site. Compared to other areas in West Suffolk, Barrow is less economically deprived, has fewer people self-reporting that their health is bad or very bad, and has less people whose daily activities are limited due to health problems or disability. This will have had an impact on the complexity of needs presented by patients referred to the service.

- The **geographic scope** of the NNCT test site has also presented challenges. Although located in the same building as the Barrow GP practice, the boundaries for the two services were not the same and feedback from the practice manager was that they had several 'perfect patients for referral', albeit they were outside the defined area for the trial.

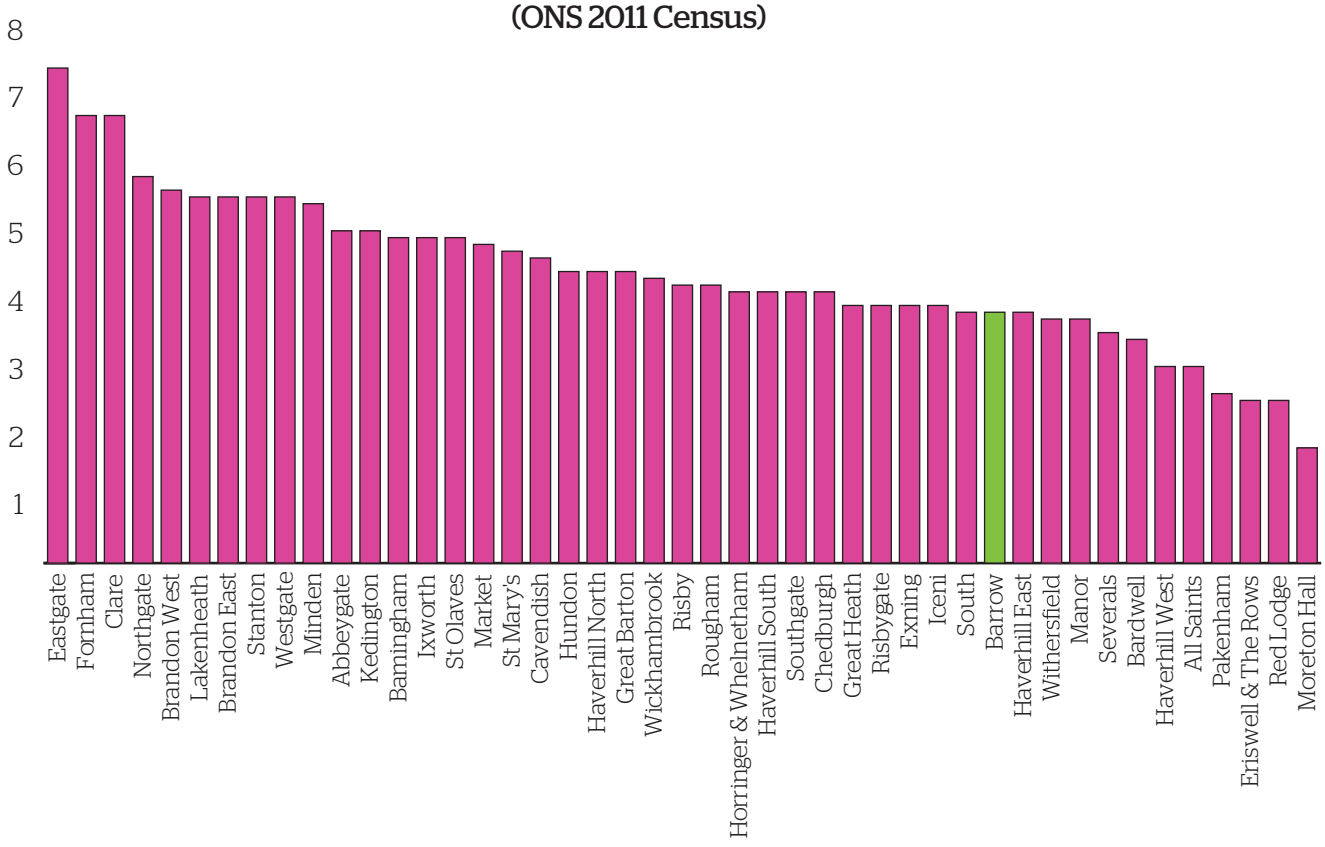
Indices of Deprivation 2015 Income Domain



West Suffolk Council - % of people reporting day to day activities limited a lot or a little by health problems/disabilities (ONS 2011 Census)



West Suffolk Council - % of people reporting bad or very bad health (ONS 2011 Census)



3. The Sample

In total, 13 interviews were conducted, involving 20 individuals who had experience of the NNCT.

- In three instances, the patient was interviewed on their own.
- In two instances, both husband and wife had received support from the NNCT and were interviewed together.
- In five instances, the patient and a family member were interviewed together.
- In three instances, only a relative was interviewed.

As the three relatives who were interviewed alone were able to report on their family members experience of the NNCT, this means that in total 15 patient experiences and 8 carers' experiences have been analysed. While this is not a sufficiently large enough basis upon which to draw generalised conclusions about the test, it does provide some insights into individual experiences and personal outcomes.

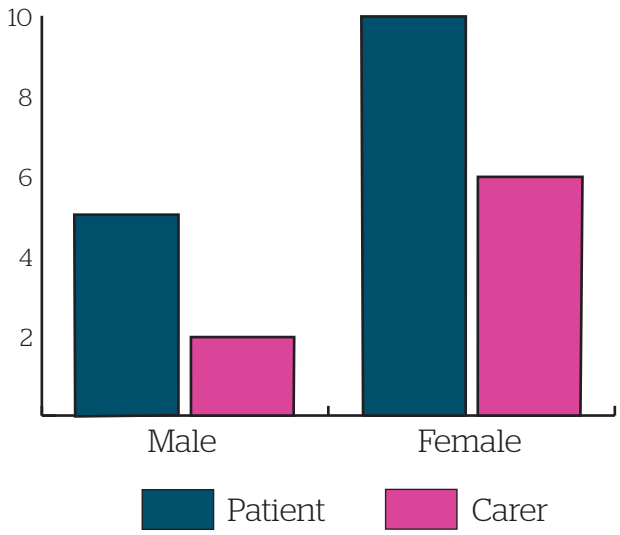
Demographic profile of respondents

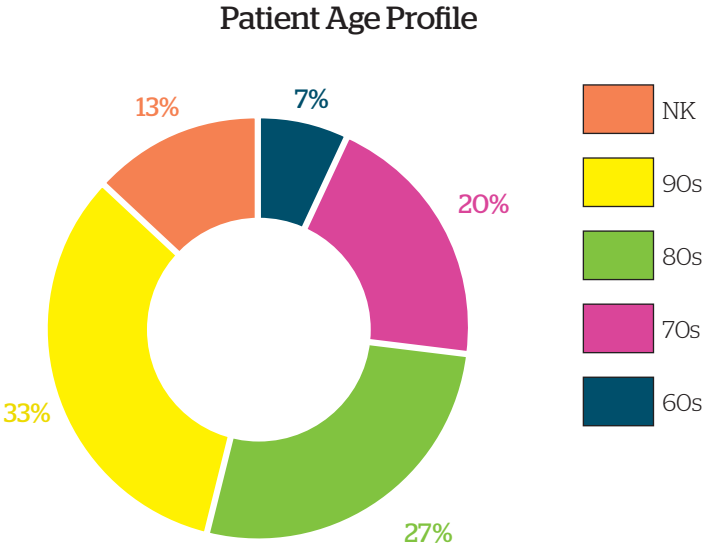
The graphs to the right show the demographic profile of the sample. Over 75% of the sample were female and a third of patients were aged over 90.

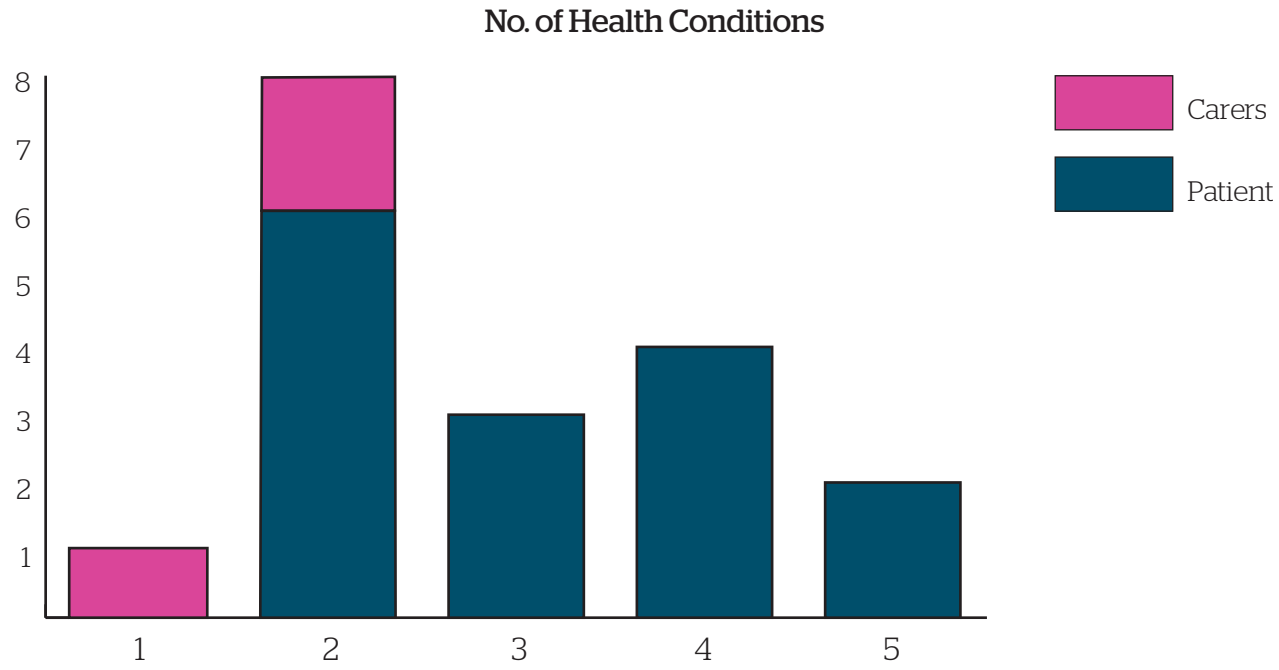
Health profile of patients & carers

One of the aims of the NNCT trial was to test the Buurtzorg model of care delivery amongst a diverse group of people with a range of complex needs.

Overall, 40% of patients had four or more health conditions. A further two family members reported significant health issues themselves, requiring four times a day home care.







The table overleaf shows the total breadth of health issues that patients and relatives within the sample experienced.

Frequency of visit and length of involvement

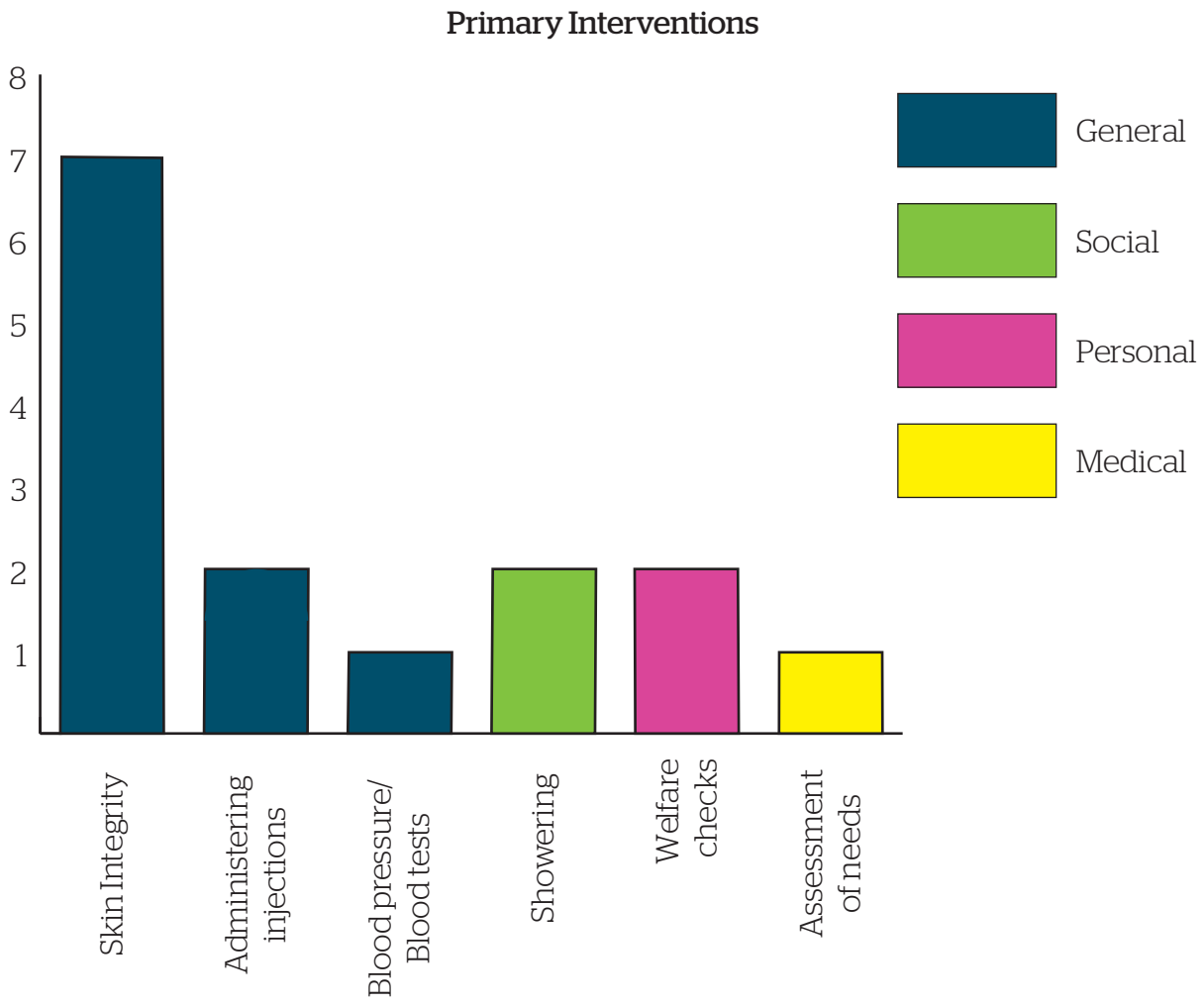
There was considerable variation in the levels and length of care received from the NNCT. In one case, a patient had received care from the team over several months, initially as a twice weekly visit, progressing to daily visits and finally to twice daily end-of-life care. Five (33%) other patients reported they only saw the nurses on three or four separate occasions, and as a result had limited experience of what the team could offer. The majority of patients (60%, 9) received multiple weekly visits over a period of several weeks or months.

In two thirds of cases (10), the provision of medical care was the main reason for the NNCT's initial intervention, with the maintenance and improvement of skin integrity being the most common medical intervention required. Over the duration of their involvement with the NNCT, however, patients and family members reported that they had been provided with a wide range of support to meet health, personal and social care needs (full list provided overleaf).

Experience of other care

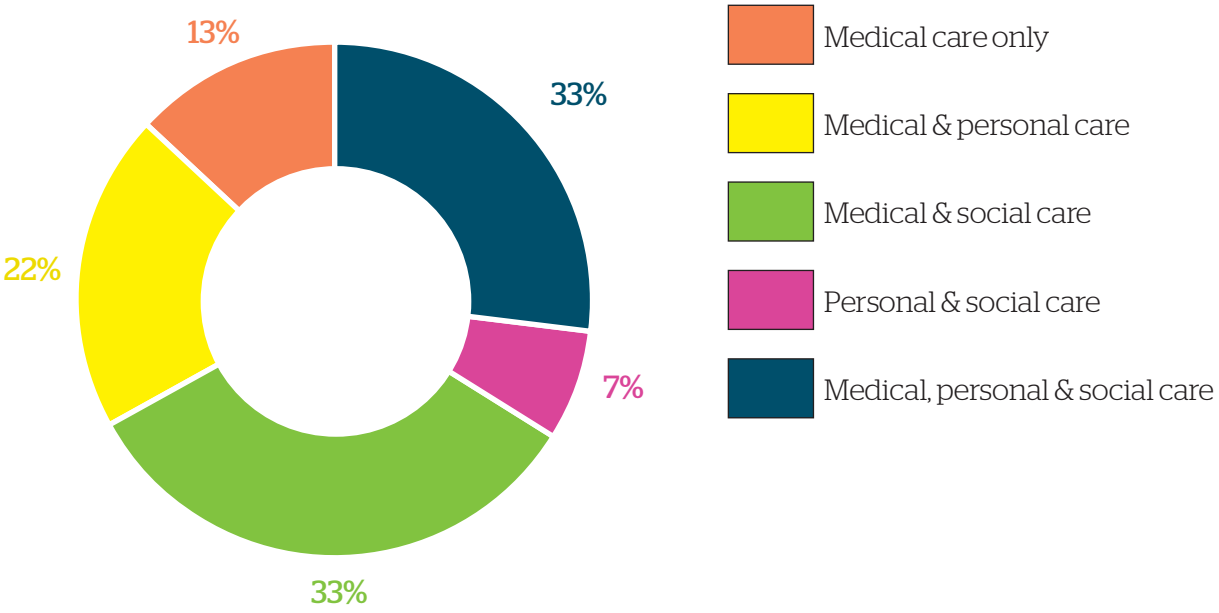
Three patients were in receipt of a homecare service, two of whom had already established arrangements before their involvement with the NNCT thereby precluding the need for any social care input from the nursing team. A further three patients had received six weeks free homecare from Home First on discharge from hospital but either did not require ongoing personal care or declined to pay for further support. One patient had a paid cleaner/companion.

Five patients had experience of receiving healthcare from district/community nursing teams either prior to the pilot or after the scheme had ended, and were therefore able to compare the different services. Ten patients had experience of recent hospital admission.



	Patient	Relative
Musculoskeletal (arthritis, osteoporosis, hip replacement, cyst on spine)	9	1
Skin integrity (leg ulcers/blisters, weeping legs, ingrowing toenail, pressure sores)	8	
Circulation (e.g. hypertension, hypotension, lymphoedema, aneurysm)	5	
Neoplasm (kidney tumour, brain tumour, myeloma)	5	
Falls	4	
Nervous system (dementia, memory loss, neuropathy, Parkinson's)	4	2
Respiration (emphysema, asthma)	2	
Endocrine (diabetes, thyroid)	3	
Eye (Macular degeneration)	2	
Genitourinary (incontinence)	2	
Cardiac (atrial fibrillation)	1	
Digestive (gall bladder)	1	
Infection (sepsis)	1	

Types of Support Received



	Total
Medical/Healthcare	
Dressing wounds/changing bandages	7
Coordinating care with GP services/other health services	7
Administering medicines/injections	6
Checking blood pressure	5
Taking blood samples	4
Taking urine specimen	1
Personal care	
Washing and grooming	7
Arranging or advising on equipment/assistive technology	6
Dressing	4
Basic housekeeping	2
Toileting/incontinence/cleaning up accident	1
Preparing meals	1
Social care	
Checking visit/responding to pendant alarm/welfare checks	6
Advice on accessing benefits/financial support/power of attorney	7
Speaking to/signposting to other organisations/services	10
Encouraging Exercise/promoting mobility	1
Advice on rehoming dog	1
End-of-life advice	1
Attended end-of-life	1
Advising on social activities/ encouraging social interaction	1
Chatting/befriending	1
Emotional support for carer	1

3. Key Findings

Patient/Carer Satisfaction

Patients and carers were asked to rate their satisfaction with the care or support they had received from the NNCT on a scale of 1 to 5, (with 5 being good). Responses were overwhelmingly positive, with nine of the 12 patients and all eight family carers rating the service as a 5.

"The current nurses (NNCT) are so good, they really are, we can't say anything against them, they're lovely and they are all brilliant" ***- Patient***

"I would say about a five. I was very pleased with the service that we received from them. From my own personal point of view, of my father and my family's too, I couldn't have asked for a better service." ***- Relative***

"I would say five. They have really gone out of their way. They have been very helpful." ***- Relative***

"Well, I'd certainly rate them five, yes, definitely. I can't praise them highly enough. And they just took such a lovely, personal interest." ***- Relative***

One patient rated the service as a 4, although was unable to provide a specific reason for not giving the highest value:

"I would probably rate them about four..... they come, do what they're going to do and they're gone. (Why did you give them a four as opposed to a five? Is it because you're not happy about certain aspects of the care?) No. If I wasn't happy, I'd have given them one or two." ***- Patient***

His wife, however rated them as a 5 because...:

"The service was excellent..... they helped me with lots of other things. When my (paid) carers didn't turn up in the morning they washed me and got me out of bed and everything." ***- Relative***

Two patients (husband and wife, both of whom had received care from the team) felt unable to rate the service because the level of involvement they had with the nurses had been minimal:

"Well, we don't really have anything to base an opinion on. They turned up on two or three days. Oh, it's nice to see them. Thank them. Goodbye. (So, the treatment and the care you've had from the nurses was actually quite limited?) Yes, yes." ***- Patient***

When asked to compare the NNCT with other experiences of health provision respondents were often just as satisfied. This is probably illustrative of the high regard in which the nursing profession is held in general and is not a reflection of the differences in the care models being delivered.

"I personally, would rate (the NNCT) as five. (What would you rate the care you received before the pilot and perhaps now?) Well, I'd still say five as well, because when they came to give the care, it was still second to none. I don't think you can judge them as being not as good carers as the pilot scheme was. I don't think I can do that. They still gave us a 100% care." ***- Patient***

"(If you were to compare the nurses you are being seen by now with the nurses that you had seen maybe a couple of years ago, how would you rate the nursing care that you're getting currently? Is it equally good? Is it better? Is it worse?). Well, it's no different. It's all very good as far as I'm concerned." ***- Patient***

"I have a very great affection for the nursing service. I think they do a wonderful job." ***- Patient***

Patient/Relative Experiences

Overall, patients and relatives were extremely satisfied with the service they had received from the NNCT, and consequently comments are generally positive in nature.

However, caution should be exercised when drawing conclusions from these results.

A significant proportion of the sample had only limited involvement with the team (i.e. due to the number of visits they received, or the scope of the service provided).

Furthermore, only a small number of respondents had experience of other district/community nursing services, and therefore most respondents had little to compare their experience against.

Themes that emerge from the interviews include:

- Nurses as care navigators (12 instances).
- Nurses as care coordinators (seven instances).
- Responsiveness and accessibility (six instances).
- Provision of holistic care (five instances).
- Promoting independence and self-care (five instances).
- Having the time to care (five instances).
- Continuity of care (three instances).

60% of the sample (12) had experience of the Nurses acting as care navigators, helping them to understand what supports and services were available, connecting them to organisations that could help and generally assisting them to navigate the complex health and care environment.

This was particularly important as, for most people, this was the first time they had faced these issues. Respondents therefore valued having someone who could offer advice and guidance. Below are examples of some of the services nurses were able to connect people to.

- Arranged for Specsavers to visit patient and husband to undertake eye tests.
- Organised Dial-A Ride service to take patient shopping.
- Organised help for people in relation to their pets e.g. dog walking, dog rehoming.
- Offered advice on accessing benefits, directed people to services that could help with financial support or setting up power of attorney.
- Provided advice to relative on end-of-life services e.g. contacting out of hours doctor, informing the undertakers.
- Engaged people in local social activities e.g. church groups, coffee mornings, Our Special Friends.
- Linked people to specialist healthcare support e.g. local hospice, Marie Curie, incontinence nurse.
- Advised on and arranged for assistive technology/equipment solutions to help people with daily living activities.

"They have been a lifeline, really. I mean, we wouldn't know where to get different things." ***- Relative***

"They called the hospice. They discussed our requirements and directed the people from the hospice to contact us. It went very well. And once the hospice kicked in. They did my hair for me last week. It was excellent. The hospice is very good." ***- Patient***

"I think the thing that was most helpful was when we had the discussion about what potentially was available to us, and that was the thing that I have seen for most people in this situation, it's a brand new experience, and trying to cope with it and find out what support potentially is there, that's where you need someone to come in and to explain what support." ***- Relative***

"I think probably the thing that would help best is as early as possible someone to give an overview in terms of what the "care" facilities are that are available because when you're dealing with this sort of situation you have a lot of things going on in terms of the daily needs of the person who is unwell. And I think the earlier that you can make clear to the patient and their carer what potentially is available and how it's organised. The earlier that is done the better." **- Relative**

"They helped me with all sorts of things. I mean things which, being an only child of course, and you've suddenly got all these responsibilities, things you've got to get sorted. Just letting us know what benefits Mum could claim if she wanted to and things, but lots of things I didn't know anything about, really. So yes. Yes. And they brought lots of information about various organisations and clubs and things." **- Relative**

In addition to their role as care navigators, seven respondents also mentioned the important role the nurses had in proactively coordinating their care. In three instances, the nurses had attended health appointment with patients in order to assist the smooth transition of care.

In addition, five patients reported that the nurses actively engaged other health professionals to support in delivering the most appropriate care. In two cases the nurses had identified and proactively responded to significant health issues.

"I said to the nurses last week, 'Oh, my neck'. She said, 'I'll have a word with the doctor. See if I can get you some patches'. Anyway, she got in touch with them and the doctor rang me [to discuss it]." **- Patient**

"The doctor comes with the nurses sometimes and that's when things are really sorted out." **- Patient**

"They looked after everything. They recognised things, phoned doctors to speak about the condition of us. On two occasions, as a result of them phoning the doctor, I was admitted into hospital. One, with pneumonia and the other one, was with another chest infection." **- Patient**

"They've actually phoned the doctor when she was unwell and sorted that all out for me. So that was another weight off." **- Relative**

"[When my Dad was discharged from hospital] the nurses actually came and did the discharge planning at times, with the consultant. They came in and onto the ward. And they came in and spoke with the team at the hospital just to find out what was happening. You didn't get the jump between hospital to the community. It was a smoother transition. My Dad was quite touched that they came into the meeting at the hospital to come and spend time with him, an hour, just to come and help plan his discharge home." **- Relative**

"They would always ring up and say, 'Look, we're going to contact the diabetic clinic at the hospital, and we're going to discuss with them about changing the insulin dose because we're worried her blood sugars are too high'. When we had a follow-up appointment [at the diabetic clinic] they came with me." **- Relative**

The responsiveness and accessibility of the nursing team was mentioned by six respondents. Overall, patients felt that it was easy to contact the nurses, and that they would be responded to in a timely manner. This was particularly important for those family carers who did not live with the patient, who had been able to call upon the nurses in an emergency.

"And it felt that if we had concerns or worries that they would help me sort them out. I mean, I would have their number, and I felt I could contact them." **- Relative**

"I knew the nurses were up the road so I rang them to see if one could come out now as [my wife] was not well at all. They came immediately and took one look at her and then called an ambulance. They saw the leg was bright red and swollen and they said they thought it was sepsis." **- Patient**

"They always come over when you need, when you think you need them. We've had in the past where we was waiting for three or four days before they answered us, but the NNCT nurses, if they're saying they're going to do something, they've been on time and they've done it." **- Relative**

Holistic care is one of the key underpinning principles of the Buurtzorg model. This means that the nurses can meet both the patients personal and healthcare needs, (thereby removing the need for involving multiple professionals in the delivery of care). It also means that they take into account the people who are around and important to the patient. Family members, either living in the home or supporting the patient from a distance, are regarded as an integral part of the patients support system. Patients and their family members are therefore supported together, as a whole. In five instances, the provision of holistic care was recognised as a positive aspect of the NNCT model. This was particularly true for family carers who were extremely appreciative of the support the nurses had offered them.

"She's 96, her skin is very, very thin. [You hardly] have to touch her and she bruises, and she often catches herself, which then breaks her skin and it can turn nasty. If she's got a cut to her leg, the nurses can sort that. Whereas the carers would phone me or phone the doctor, then somebody else has to go out and sort it out because she's not able to get to the doctor or surgery on her own." ***- Relative***

"When Mum first came out of hospital, she had a carer coming in the morning to help her get washed and dressed and then the district nurse came in to give the insulin. And then I was doing all the other care. The district nurse realised that we were struggling and thought that we would benefit by becoming part of this pilot scheme in Barrow. So, we changed the carers to come at lunchtime instead (and the NNCT would come) in the morning. They would come, give her the insulin, help her get washed and dressed, get her breakfast, give other medication, stay longer than the carer was staying and have a chat and gave just loads of support, I mean, not just to Mum but to me too." ***- Relative***

"They often inquired how I was, how I was coping .....they always kept saying to me, 'How are you doing? And anything more we can do for you?'. They were definitely concerned with my well-being. I wasn't just seen as a number." ***- Relative***

"When they came in, that wasn't just for my Mum. They were asking me how I was, as well, which was nice. Big difference for me because I'm on my own, a lot of the time, caring for her. And to have them in and talk to me, not just her, was nice, really." ***- Relative***

"I will say that when they came in, they were never in a rush to go again. One of them, for instance, she was here for half an hour one day, just talking to me about general things and you felt they really got time for you." ***- Relative***

Another of the underlying principles of the Buurtzorg model is that patients are supported to greater independence and selfcare. At its simplest, this can be achieved through the provision of information and advice about services to help people remain independent within their own home (e.g. daily living equipment, dog walking services etc.). Five respondents did report that they felt the support the nurses had given them/their relative had helped to improve their independence.

"They were quite good though because they tried to encourage him to enable himself to do it rather than, 'Come on. We'll give you a shower'. No, they were good. They would pop in and say, 'When I'm back, I want to see you've got yourself changed and had a wash'. So, they did work towards that with him. They definitely didn't come in and 'We'll do this, and we'll do that', they did try to get him to do bits and pieces. I think that was what he needed to do to get his enablement back." **- Relative**

"The nurse, I think it was three or four times, I can't say exactly, but I know she came in once and showered me. Second time, to check I could shower, and the third time to check that I could do it all by myself, and then came in to check that all was well, so she came in four times." **- Patient**

"You were very anxious when you first came back from hospital about going into the kitchen or using the walking frame, and the nurses gave a lot of time and support with that." **- Relative**

Five respondents had received support from both the district nursing team as well as the NNCT and were therefore able to compare the two models of service delivery. Two main themes emerged from these interviews – having the time to care and the importance of continuity of care. As mentioned earlier, respondents were keen to stress, that their comments were about the service model and not a reflection on the abilities of the nurses themselves.

Under the test model, it was generally felt that the nurses were less time pressured, giving them the opportunity to get to know the patient and their family situation better and enabling them to deliver a more personalised service.

"They just come and give the medication. Then they've got to get off and get to the next patient." **- Relative**

"When the pilot scheme was first introduced, [the nurses] stayed until I'd had a shower and then, they'd put cream on [my leg]. And while I was having a shower, they were able to talk to Margaret about her social care and such like. Now I don't have time to go and have a shower. [The current nurses] have a bowl of water and they just wash that leg. The care is there. It's just that the time isn't there. They haven't got time to do the things that they would want to do as nurses and that would benefit me, which is for me to have a shower. The scheme doesn't allow now the time it allowed when it was a pilot scheme." ***- Patient***

"Unfortunately, when he had his operation, he lost his appetite kind a bit. And I know, particularly, one of the nurses, a way of getting my Dad to eat was he would get his bits and pieces together, she would sit and drink a glass of squash or something with him and sat at the table with him while he ate something." ***- Relative***

"They've sort of really gone out of their way to forming different activities for her. Whereas if carers go in, they go and do their bit and they're gone, aren't they?" ***- Relative***

Continuity of care was another element that respondents felt was a positive aspect to the pilot but was lacking under the district nursing service. Overall, respondents reported that under the pilot scheme they had seen the same group of nurses all of the time and this had enabled them to build trusted relationships. Again, this was of particular importance to those family carers who did not live with their relative.

"I mean, sometimes on the weekend I will get here, and catch the district nurse if I had a question or a worry, it's often a different person, and it hasn't just been a nurse from Barrow. So, the other week, it was somebody from Bury. I mean, they're all great. Don't get me wrong. I don't want to criticise. It just doesn't have that same sort of - well, because it's not the same person, and of course, they've got to come in. It's slightly, 'I've got to learn what the set-up is',and everything." ***- Relative***

"I never knew if the nurse that was coming on Monday, was she coming on Thursday? And no, she definitely didn't. And didn't come the following Monday or the following Thursday. It might be about a month to two months before I saw that nurse again. Well, she's got no idea of how the progression of the healing process of my body—and one nurse didn't know [what the other one had done]. 'What did she do? What did they put on last time you were here?'. One would change the type of cream that the one before had suggested, and then this one suggested [something else], so you wouldn't know which cream was having the best result because there were so many different creams. And they all had different views on what would be in my best interest of how to treat the leg. Yeah. Continuity. You really need the same nurse nursing you all the time." ***- Patient***

Outcome for carers

In addition to the themes already explored, three further issues emerged from the interviews undertaken with family carers.

Being included

It is not always possible for family carers to be present every time the community nurse visits. This can often leave them feeling 'in the dark' about changes to their relative's care and excluded from decisions. Carers reported that the NNCT nurses were proactive in establishing methods of communicating with them and keeping them informed at all times.

"They would encourage me to write in the red book they had with a few notes about anything I was concerned about. And ideally, they would leave me a couple of bits and pieces, like your Dad needs this or what's happened with this - that sort of thing." ***- Relative***

"I mean, they were constantly in contact with me. So, any worries that I had I could contact them, and they would be in conversation with me all the time which we hadn't had just with the district nurses. And just knowing that if they had any concerns when they arrived that they would contact me." ***- Relative***

"I mean, because after she came out of hospital [inaudible] we had this ongoing issue a bit with the insulin and so they always discussed what they were going to suggest in regard to changes to the dose. Also, when it was administered and so forth. So yes, I mean, they always spoke to me about anything that they wanted to." ***- Relative***

Logistical problems

Transporting relatives to numerous health appointments or visiting a relative to deliver care several times a day, can present logistical challenges for carers, particularly if they are in paid employment. Two carers reported that the support they had received from the NNCT had enabled them to better manage their work/care balance.

"They would come in, as I say, and take bloods for him a couple of times a week which was very handy because under his chemotherapy regime that saved myself from having to run him to the hospital particularly as I was working and he couldn't drive at that time." ***- Relative***

"So obviously, [the NNCT nurses] came in and they did the social care like washing, dressing, and breakfast which saved me having to come in the mornings, which was a huge benefit because I work, and it was difficult." ***- Relative***

"She was also just a huge rock. I must admit I was at the end of my tether because it was extreme when Mum first came home. I was here six, seven times a day and during the night and I'm always about. It felt like I was about to collapse really, and they sort of stepped in and it was wonderful. They were so helpful." ***- Relative***

Peace of mind/relieving the worries of caring

Carers said that their caring responsibilities could be stressful, particularly if they did not live in the same household as the person for whom they care. The knowledge that the nurses were checking on their relatives daily, was an immense source of comfort for carers.

"They've taken the responsibilities from me. Well, I'd say they're not doing things that I used to do because I still do things but it's just-- basically, they're just taking the worry from me, really, of worrying about her [in the mornings?] and the tablets and things." ***- Relative***

"Initially, when Mum first came out of hospital, and we just had the carer coming and the district nurse, it felt like I had to be here, really. It felt like I still had to be, because the carer, when we first started, was just getting Mum washed and dressed, because Mum wasn't happy with me doing that. So, I would be giving the breakfast, and so forth. Rightly or wrongly, I didn't feel I could just let them do that. But when the community nursing team took over that duty, I knew they were going to be doing what I felt needed to be done myself. It just took an awful lot of pressure off of me. It just helped to have that feeling that, okay, I don't need to worry at this point in the day, because I know that she's having good care, you know she'll definitely have a breakfast, and they would contact me if there was any problems." ***- Relative***

4. Conclusions

While this evaluation has provided some useful insights into individual patient experiences and personal outcomes, several issues make it difficult to draw generalised conclusions about the model.

These include:

- the size of the sample. Only 20 individuals came forward to take part in the study, (12 patients and eight carers), despite frequent prompts for more referrals by Healthwatch Suffolk,
- the complexity of need of patients. Despite 40% of patients having four or more health conditions, the primary intervention of the NNCT was wound dressing,
- scope of service provided. Five patients (33%) had minimal involvement with the team because they had only received three to four visits. In addition, many respondents had established circles of support (both paid care and from family members) which meant they did not require much input from the nurses beyond wound dressing and some signposting. Only three patients receive a truly holistic service that included health interventions, provision of personal care and advice on social supports.

Respondents were however extremely satisfied with the support they had received from the NNCT, and comments were positive in nature. Key themes that arose from the interviews were reflective of the underlying principles of the Buurtzorg model and included:

- The value of the nurses acting as care navigators, connecting to people to organisations and services to support them remain independent at home.
- The nurses' role in proactively coordinating care, linking with other health professionals to deliver the most appropriate support and to smooth the transition of care across health settings.
- The general responsiveness and accessibility of the nursing team.
- The provision of holistic care – both in the sense of nurses delivering health and personal care, but also the consideration of the needs of the people who are important to the patient.
- The support provided to patient that has helped to improve their independence.
- Nurses being less time-pressured under the pilot model, (compared to district/community nurses) and therefore able to deliver a more personalised service
- Continuity of care was recognise as a hugely positive aspect in the trial model and an important factor in developing trusted relationships between healthcare professional and patient/family members.

Family members, caring for a relative they did not live with, were particularly appreciative of the support they had received from the NNCT.

In the three instances where patients received a full holistic package of care from the team, the Buurtzorg model clearly delivered good personalised outcomes. However as one carer observed “we felt well supported, but could you offer that level of service to everybody else?”.

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Appx 3

The Role and Attributes of an INT in practice team

The Buurtzorg Way (the purpose and attributes of the role)	Values (required to deliver the role)	Behaviours (actions and attitudes which demonstrate the values)
To work in a small fellowship styled and non-hierarchical culture, supported by a coach and back office support rather than a traditional manager. The team will work collaboratively to be responsible for their own workflow. To collect, report, maintain and share information for health and personal care delivery purposes. To care according to the professional norms including professional values and behaviours	**Responsibility and respect**	Work collaboratively, but also with a high degree of autonomy and responsibility Seeks a trust-based approach including a positive attitude toward colleagues, a focus on principles above personalities, solutions above problems, and demonstrates a supportive attitude toward colleagues. Initiates ways of working that dignifies everyone at the same time as holding self and others accountable for actions and attitudes in relation to shared purpose and values. Takes responsibility for his/her own performance and for the team's performance. Adheres to the highest standards of quality and care
	Openness and honesty	Works together effectively by being accountable to each other and to the people they support. Takes collective responsibility for giving each other feedback, about what we do well, and where we can improve.
To be highly motivated to achieve better outcomes for people	**Authenticity and integrity**	Develops a trusting relationship with the people they are caring for. Maintains the privacy and dignity of person and works with integrity. Develops an understanding of and builds a relationship with the informal and formal networks of the locality.
To take a holistic view of the needs and capabilities of the person and their family system.	**Care and compassion**	Provides support that is designed and tailored to the individual, is person-centred and flexible, and delivered in a way that keeps the person at the centre.

Appendix 3

To design and deliver holistic individualised care plans with a focus on wellbeing and independence. To ensure that the person only has to tell their story once to help reduce duplication of care and improve communication. To focus on using and building the person's capabilities to focus on securing increased independence. To work with the person or their representative to agree the care they receive. To assess, coordinate, and evaluate the professional (formal and informal) and social network around the person, and with the person, to draw in additional support.	**Analysis and accountability**	Keeps people at the centre of decision-making about their care and support, appreciating people's rights and dignity. Manages both simple and complex care situations and manages continuity of care / effective handover as required. Continuously seeks to promote independence. Contributes to the development of Trusted Assessments Health coaching and Signs of Safety and Wellbeing models of practice 'Right response, right time'
To work in a model which differentiates from a 'task and time' approach that is common in many services. To continuously evaluate the care and adjust to any newly identified needs.	**Flexibility and adaptability**	Uses autonomy and authority to use resources creatively and flexibly to make the most of every moment, every opportunity. Shows an openness to sharing tasks amongst the team / locality teams and is flexible and adaptable to taking on different tasks and roles as required by the team. Focuses on locality working with strong links to formal and informal networks Contributes to the development of Trusted Assessments.
To seek the best solutions to promote independence and improve the quality of life. To focus not only on current needs of individuals, but to also focus on preventing future problems for the person and their network of support. (Including work to identify 'rising risk' cohort)	**Proactive and open minded.** **Multi-disciplinary outlook**	Are problem-solvers and innovators. Seeks optimal solutions for each care situation through use of full-spectrum, holistic care. Driven by the idea of being involved with a Locality that is changing the way care is delivered at home.

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