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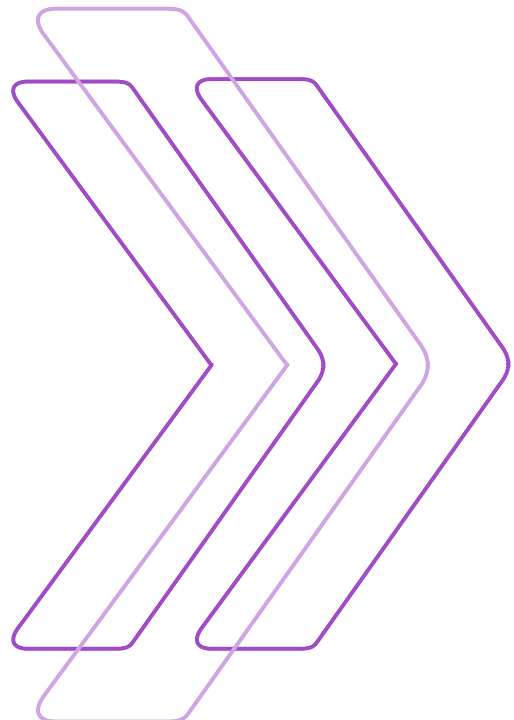
A review of the West Suffolk Buurtzorg test-and-learn in 2017-18



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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 Buurtzorg test-and-learn. The views in the report are those of the author and all conclusions are the author’s own.

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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).

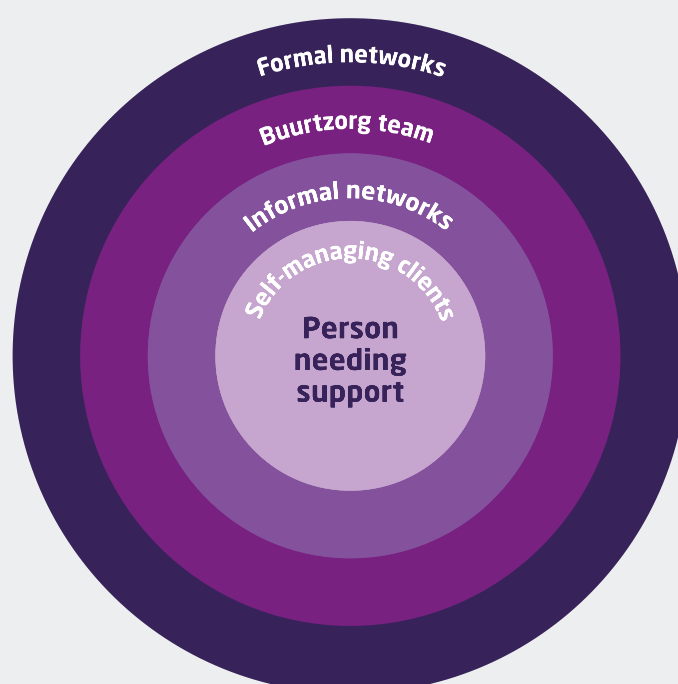
The project secured £40,000 in seed money from the Regional Improvement Panel to investigate whether the Buurtzorg model could work within the local system. This funding covered costs until January 2017. With the help of Public World, a Buurtzorg-specialist consultancy commissioned in March 2016, stakeholder 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	

<table>
<tr><td>Nurses are given iPads to enable effective remote working.

E-care desk provides IT support.</td><td>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.</td></tr>
<tr><td colspan="2">Back office</td></tr>
<tr><td>Small, expert back office dedicated to supporting nurse team functioning.</td><td>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.</td></tr>
<tr><td colspan="2">Approach to care</td></tr>
<tr><td>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.</td><td>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.</td></tr>
<tr><td colspan="2">Types of care delivered</td></tr>
<tr><td>Clinical care consistent with community nursing.

Personal care (supporting people with washing, eating, dressing and toileting), reablement & wider social care support work.</td><td>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.</td></tr>
</table>

<table>
<tr><th colspan="2">Support</th></tr>
<tr><td>Buurtzorg coach

Comprehensive guidance materials on Buurtzorgweb

Inter-team peer support

Training courses on self-management and care</td><td>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)</td></tr>
<tr><th colspan="2">Management structure</th></tr>
<tr><td>Self-managed teams

Peer appraisals

Non-hierarchy: no line-managers or team leaders</td><td>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</td></tr>
<tr><th colspan="2">Recruitment</th></tr>
<tr><td>Teams hire new members themselves, with support from the coach</td><td>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</td></tr>
<tr><th colspan="2">Caseload</th></tr>
</table>

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

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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