Final Report:

A stakeholder analysis of key participants involved in the Forres (Varis Court) Health and Social Care Pilot Project.

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Contents

1.0 Executive Summary

- A team of management academics from the University of Dundee and Edinburgh Napier University was commissioned to undertake an analysis of the perceptions of key stakeholders involved with the Forres (Varis Court) Health and Social Care pilot project.
- The Forres (Varis Court) Health and Social Care pilot project — located in the Hanover Housing Association development — offers an opportunity not only to redesign the social care services within sheltered housing but also an opportunity to test out a new model of in-patient care provision.
- NHS Health Improvement Scotland is undertaking a financial/economic evaluation of the Forres (Varis Court) Health and Social Care pilot project. The current analysis is based on in-depth interviews and seeks to understand the perceptions of certain key stakeholders in relation to the aims of the Buurtzorg model of care. Note this analysis does not include service users.
- Health and Social Care Moray (2018a;b) have completed engagement activities with service users, carers and the wider Forres community. Documents and reports relating to these activities can be found on the Health and Social Care Moray Partnership website.
- Fifteen semi-structured interviews were undertaken by University of Dundee researchers between October 2018 — November 2018. All interviews were recorded and fully transcribed. A thematic analysis was then completed.
- The research was completed after the initiative had run for a year alongside the Leanchoil (community) hospital and had just recently became the sole inpatient provision in Forres. Thus, the research presented reflects views on the initiative at that particular point in time.
- Following the interviews, an interim report was produced in November 2018. Over the last six months Health and Social Care Moray have moved into phase 2 of the test of change and have already begun to implement the November report's recommendations.
- The purpose of this report is to build on this interim report, to analyse and discuss the themes that emerged in the interviews, and provide some recommendations regarding a way forward.
- Key points from analysis are as follows:

    - ❖ Most people, especially those at the core of the pilot project, have bought into the principles i.e. the more person-centred approach; the community setting; and the flexibility offered. In this respect, we consider that the strategy is appropriate, has been largely effective, and has provided some significant pointers for the future of health and social care integration in Moray and further afield.
    - ❖ But, it is more difficult to implement than first realised due to cultural, political and embedded issues, especially in establishing new and effective multi-disciplinary teams and differences in perception between professional groups (i.e. professional boundaries are marked).

- ❖ There were also some concerns over utilisation and finances, especially from those less-engaged with the day-to-day operations of the pilot project.
- ❖ In addition, it was not clear how success is, can be and will be measured.

- Recommendations and Next Steps

  - ❖ More extensive involvement of and engagement with medics and senior managers from Dr Gray's hospital.
  - ❖ Greater thought be given to the criteria for evaluation — quantitative and qualitative — and how these criteria may change over time.
  - ❖ Continue to develop team working between all stakeholders (focusing on identity management and inter-professional working).
  - ❖ Further development of Buurtzorg and understanding if this less-medicalised model may enable a quicker flow through the integration of health and social care.
  - ❖ Further thought will be required on next stage research — clarity will be required on operational objectives of this new approach and establishing what metrics are indicators of change.
  - ❖ In terms of the health and social care system in Moray, this learning could then be beneficial in terms of continuous learning and the future redesign of services.

2.0 Introducing the Context

In October 2018 Health and Social Care Moray decided to close Leanchoil (community) hospital temporarily to patients. Subsequently, on 29th November 2018, Health and Social Care Moray decided to decommission and close permanently the hospital. These decisions were the result of a combination of problems related to difficulties in recruiting sufficient numbers of nursing staff to sustain safe operating practices and the major capital investment required to ensure that the physical fabric of the building would be fit for purpose over time. In recent years, these problems had led to rising concerns over the hospital's long-term sustainability. Consequently, prior to the closure, Health and Social Care Moray investigated a range of contingency plans to provide alternative community care for residents within the Forres locality. One of these was a test site launched in the Forres Varis Court development (part of the Hanover Housing Association complex) intended to explore a new model of in-patient health care provision. This Augmented Care Unit (ACU) was conceived as the provision of 24 hour/7 days a week nursing care being provided at 5 of the 33-unit Varis Court development by 8 whole time equivalent NHS nursing staff. The nursing team (including health care assistants) from Leanchoil are now working as part of the Forres Neighbour Care Team (FNCT) at Varis Court. Varis Court has had its funding increased to November 2019

Unlike a traditional hospital ward, the five flats have two bedrooms and a small kitchen to assist with re-ablement and recovery, which are key aims of the test site. The site has also adopted the application of the Buurtzorg principles in terms of how the nursing team (FNCT) organise themselves and deliver care and support in relation to the 5 units within the development and also to people in their own homes in a community setting.

At the time of writing this report, significant insights and areas of interest have arisen from experiences in this test site. To understand these insights further and to offer an independent/objective view, a team of management academics from the University of Dundee and Edinburgh Napier University were commissioned to undertake an in-depth qualitative analysis of the perceptions of key stakeholders involved with the Forres (Varis Court) Health and Social Care pilot project.

3.0 Previous Work and Report Aim

This report develops the Interim Report produced in November 2018 and presents the thematic findings of semi-structured interviews with 15 stakeholders including members of the team directly involved and representatives from partner organisations (including the Integrated Joint Board (IJB), local GP surgeries, Dr Gray's Hospital, the wider district nurse and multi-disciplinary care teams and Hanover (Scotland) Housing Association Ltd (Note: the study does not include service users, which was outside of our remit). The current study

complements the financial evaluation undertaken by Health Improvement Scotland's iHub (2019) which examined:

- Changes in emergency admissions, 28-day re-admissions and length of stay following the introduction of the FNCT.
- Before-and-after hospital admission costs of people cared for by the team.

The findings of this financial evaluation were published in April 2019 and indicated that the new model has begun to show signs of positive impact on emergency hospital admission rates. Moreover, for those individuals cared for by the FNCT, there is some evidence of reduced costs associated with hospital admissions (in terms of reduction in number of admissions and length of stay) (iHub, 2019).

The interim qualitative report explored participants' perceptions around (1) what is going well; (2) associated challenges; and (3) opportunities. The pilot project was generally thought to be working (relatively) well, in that it provided a much-needed step-up and step-down facility for local service users and patients. The FNCT was found to be engaged and working effectively across the community. Understandably, given the timings of the interviews, it was felt that there was a need to better integrate the new nursing staff who had moved from Leanchoil into the FNCT. An important challenge for those leading the initiative was improving communication with with wider stakeholders. It was suggested that greater collaborative working with the wider multi-disciplinary team, in particular allied health professionals (AHPs) (such as physiotherapists and occupational therapists) would improve operational planning and help achieve the Buurtzorg objectives. There was also some uncertainty around what good outcomes 'look like' with some suggesting that outcomes (such as hospital admission rates) can be interpreted in many ways.

To address these findings, Health and Social Care Moray have recently embarked on a logic modelling exercise, facilitated by iHub with senior managers and other stakeholders. The aim of this to help clarify stakeholder assumptions, further develop the initiative to achieve an enhanced multi-disciplinary team model and reach group consensus on the objectives and short- and long-term outcome criteria of the initiative and to ensure that these criteria are adopted and fully supported. To complement this, the current report presents a more in-depth analysis of the interviews focusing on the core Buurtzorg principles.

4.0 Buurtzorg Theory and Principles

The Buurtzorg Model was developed in 2006 in the Netherlands by Jos de Blok, a Dutch nurse, in response to challenges within the health and social care system including: fragmentation of cure, care, prevention; over standardisation; financial constraints; and nurse capacity issues (Sheldon, 2017; RCN, 2015). Buurtzorg started in 2007 with a team of just four district nurses,

in Almelo, a small city in the east of the country, but now it has 900 teams with 10 000 staff who care for 90 000 clients a year (Sheldon, 2017). Buurtzorg translates to 'neighbourhood care' and offers an alternative model for care in the community for elderly and vulnerable people. The model is guided by four core principles related to:

1. Self-management (clients and teams),
2. Continuity of care,
3. Building trusting relationships, and
4. Building networks in the neighbourhood (Buurtzorg online, 2019).

Fundamentally, it is a nurse-led, person-centred approach that puts client/patient self-management at the centre and seeks to involve service users and their families/informal networks in the design of care solutions (Buurtzorg online, 2019). The model advocates the development of small self-managing community nursing teams, each with a maximum of 12 nurses. Sometimes a team will also oversee Nursing Assistants (the Dutch equivalent to Health Care Assistants) (RCN, 2016). Teams take a holistic approach to an individual's care and provide co-ordinated care for a specific locality (Buurtzorg online, 2019). The aim is, where possible, to support the service user in his/her social environment (ibid). Teams not only work alongside wider formal care providers (including GPs and AHPs) to provide coordinated care, but also attempt to map networks of informal care and assess ways to involve these carers in an individual's care plan. Trust is built by involving service users in decision-making, sharing information, power and responsibility and demonstrating respect for service user needs and choices (Fox and Reeves, 2015).

Analysis by KPMG (2015) into different approaches to healthcare and their impact on staff motivation and productivity have suggested that Buurtzorg methods can lead to greater productivity, work satisfaction, supply of professionals, revenue, quality and motivation. They also found it can lead to reduced costs, resources per patient, cycle time, unplanned care, absence through illness and staff turnover. However, since home care in the Netherlands is paid via a network of private insurance companies, there are some doubts over the transferability of the model to the UK healthcare context (Kaloudis, 2016). Nevertheless, several test projects have been developed across the country which have shown some initial positive results (iHub, 2019). For example, Recent research by Drennan et al. (2018) at one of these test sites found that an adapted Buurtzorg model of community nursing was thought to have improved continuity in care, helped the service to become more responsive and enabled more proactive care. Yet, challenges were reported by nurses and managers in relation to the recognition and support of the concept of self-managing teams within a large bureaucratic healthcare organisation.

The Buurtzorg model aligns well with the recent policy focus on the Integration of Health and Social Care in Scotland. Buurtzorg is fundamentally about integrated care processes, not structures. It focuses on building relationships, practitioner autonomy and is based on trust, transparency and simplicity (Health and Social Care Academy, 2016). Such joined-up approaches to service delivery require new ways of working and have implications for workforce planning involving job re-design and evolving practitioner roles and responsibilities (Leadbetter, 2008). The aim of Buurtzorg is not only to simplify bureaucracy for care teams but also for the patient as it gives them one point of contact to help them navigate their care (Health and Social Care Academy, 2016). The Buurtzorg model emphasises changing language usage e.g. 'network rather than hierarchy, coaching rather than managing to support a change in culture (ibid, p.3).

Alongside the Buurtzorg model, Gittell's (2000; 2009) theory of relational coordination is also relevant. Relational coordination has been used thus far to examine inter-professional working in hospitals and hybrid private-public collaborations and offers a salient lens for analysing how the integration of health and social care is enacted (Hargerink et al., 2014; Caldwell et al., 2017). This theory proposes that when care practitioners working across boundaries are connected by shared goals, shared knowledge and mutual respect, their communication tends to be more frequent, timely, accurate, and focused on problem solving. In turn, this enables them to provide more cost-effective, high quality patient care (ibid). Organisations with high levels of relational coordination have been found to have better care outcomes and lower overall costs (Gittell, 2009).

These ideas may provide helpful in the current context given the desire to improve collaboration across the different care teams (FNCT, MDT, and DNT) in Forres.

5.0 Method

The research began after the initiative had run for a year alongside the Leanchoil (community) hospital and had just became the sole inpatient provision in Forres. Stakeholders associated with Varis Court were interviewed by the University of Dundee and Edinburgh Napier University researchers during the period October 2018 - November 2018. The interviewees — sourced from NHS Grampian, Health and Social Care Moray and Hannover Housing Association — were selected by Health and Social Care Moray staff.[1] Fifteen semi-structured interviews were conducted in person in Forres and Elgin and via telephone due to the nature of the distance involved between Dundee and Forres/Elgin.

The interview questions are at Annex A. The University of Dundee's Code of Practice for Research Ethics was followed and participant confidentiality was maintained. All interviews were recorded and transcribed for detailed analysis. The aim of the stakeholder and thematic

[1] In this research, no patients were interviewed.

analysis was to examine the perceived effectiveness of the project with regard to the Buurtzorg principles and wider theories of teamwork. The intention was to identify areas of success and potential areas for improvement from the perspectives of key clinical, care and administrative staff.

A thematic analysis was completed with the aid of NVivo 11 (QSR International, 2015), a software that is used to analyse text. The process involved two main stages. First, we read the interviews transcripts and conducted a series of NVivo queries to identify empirical themes taken from the participants' descriptions and the issues that they raised. Second, this first stage of coding into empirical themes was followed by coding into more abstract, conceptual categories. Specifically, we sought to investigate these empirical themes in relation to the four key principles of the Buurtzorg model, namely: (1) Self-management (clients and teams); (2) Continuity of care; (3) Building trusting relationships; and (4) Building networks in the neighbourhood (Buurtzorg online, 2019). At this stage, we also reflected on our wider knowledge of the literature on managing culture change, autonomous teams, and relational coordination. We also considered the outcome measures for the initiative that were agreed by Moray IJB board meeting in April 2018. These included:

- An Enhanced role for the Community Nursing Staff (both for FNCT and the District Nurse Teams).
- Alternative treatment locations for medical staff to consider in the treatment of frail older people.
- Faster re-ablement and recovery.
- Improved social interaction and less social isolation.
- Improved Informal Carer Experience.
- Improved quality of life.
- A more rewarding workplace for the FNCT staff.
- Best value.

Given the timing of our interviews and the selected sample, we have found it difficult to address all of these outcome measures. Nonetheless, several of them relate to the sub-themes identified during the analysis. The main findings of our analysis of the interviews are discussed in the following section.

6.0 Findings

Six core themes emerged from 'working back and forth' between the data and our knowledge of the literature during the analysis process. These were:

(1) A person-centred and integrated care approach.
(2) A community model.

(3) A step up/step down provision.
(4) Continuity of care.
(5) The FNCT – self management, trust and autonomy.
(6) Relationship and network building – thinking beyond the FNCT.

A word cloud developed from the interview text below highlights the top 50 stemmed words (discounting common stop words such as 'and', 'they' and 'thing). In itself, this word cloud does not give an in-depth picture of the interview data but when combined with the cluster analysis in Annex 2, it provides some insight into participants' perceptions. Moreover, it can be seen that the top words can be aligned with our thematic codes.

Figure 1: 50 most frequently mentioned words within the interviews (common 'stop' words have been removed to improve relevancy and usefullness)

6.1 A person-centred and integrated care approach

As suggested by the word cloud, putting people at the heart of the process was regarded as a core element. Participants frequently referred to adopting a patient-centred or person-centred approach to care, suggesting that they had bought into the vision for the initiative. Some participants referred to the importance of a change in language in moving away from 'patient' or 'service user' having things 'done to' them towards 'client' actively involved in their care. This was particularly noticeable among those directly involved in the FNCT, some of whom claimed it had established radically new ways of conceiving their work:

> So, the way I go about my role is that I look far beyond what is going on medically and… Far beyond that and look at that… Look at the different… Loneliness, isolation, cleanliness [A02].

> I think within Varis and the Forres locality the Buurtzorg model is a really good example of we don't just go in and do our own bit, we look at the wider picture, and I suppose until you've had experience of working in that way, it's really challenging [C02].

> What it's about is really trying to deliver care in a different way. And the comparison that I would probably use is that we know that when we take people into hospital, particularly those people that are a bit older and frail, that one of the most horrible things that can happen is the isolation. Is the deconditioning, so the loss of mobility. …Here it's about maintaining confidence …independence …[helping] families stay involved. [A04]

The quotes above emphasise the view that the FNCT adopted a more holistic approach to a person's care and moved beyond the 'clinical' aspects to deal with the wider 'social' aspects, such as helping users feel safe in their environment, tackling loneliness and helping service users eat and shower. These social aspects are fundamental to achieving faster re-ablement and recovery. This is in-line with the Buurtzorg suggestion that having more highly skilled nurses delivering and coordinating care can give improve care outcomes.

However, questions were raised by several participants concerning the extent to which the Forres initiative was following the wider Buurtzorg principles:

> It doesn't really use the Buurtzorg principles fully… The Buurtzorg principles would have the whole community team working, not a community team and then this [district nursing] team as two separate teams. [A01]

The quote above links to the suggestion (discussed further in section 6.6) that introducing a separate 'self-managed' FNCT (informed by Buurtzorg) alongside a more traditionally structured district nursing team had created tensions and that communication between the two teams could be improved. Others spoke of the project in relation to wider Buurtzorg principles including delivering care in the neighbourhood, building networks with wider professionals, and involving the patient/service user in designing their own care:

> You're very restrained because you're not in their own homes, … Buurtzorg as well, to me, is like neighbourhood. ... I think it's very different in the home than it is here, but I think that we're trying to get people into neighbourhood. [A02)

> The people. It's about being people-oriented, I think sometimes. Actually, what do they need? It's not just what the patient needs, it's what the relatives and other people who are involved need… I think, from day one, there was always going to be a challenge of putting a new service and a pre-existing service together. Because a lack of understanding about who's doing what and

> why would we need this … One of the things we're working on at the moment, is trying to get that multi-disciplinary approach. …we're just in the process of trying to get our AHP colleagues, allied health professionals, bought into this as well…Because they're now really pivotal to any service and I think that was one of the things that was missed at the start [A03].

> It's an exciting model for nursing, to do something different …that's fairly transformational but you need all the bits attached really. …Nursing's always been a fairly caring profession, while allied health professionals come from a completely different approach - which I believe they want to create within this type of environment - around self-management and re-ablement. …that could further enhance this type of model, if you get that bit right…. I suppose I feel that it's not all been connected yet, but it's early on. [A05]

These quotes and the general tenor of the interviews raise doubts over whether Buurtzorg principle around achieving 'self-management' clients were evident in practice. This also reflect a wider picture across Scotland where few service users design their own care plan despite being given the opportunity to do so.

Several participants also noted that Varis Court offered both 'step up' and 'step-down' care, including end of life care. However, these were seen to require quite different approaches and had different resource implications. Nevertheless, they were clearly linked to the notion of a person-centred approach:

> So, it's about how we promote a person-centred approach but also giving the patient the choice, because I don't hear an awful lot of that either. You know, we talk to patients and say to them, this is what we're going to do. We don't actually say, well, where would you like to be, because, you know, the palliative care side of things, well, some patients want to go home, some patients don't want to go home and I know that's a separate but Varis Court do support end of life or, you know, the Forres neighbourhood team do support that with our community colleagues. So, I think that's another consideration, that we do start to put the patient in the centre [D02].

> So, most patients, in terms of being there, they have their own space, they have their own kitchen, you know, so they can continue to live as, indeed, we all do and be less dependent on others … I believe that people are very often, older people in particular can be... their stays in hospital are elongated, simply because they don't really have a very powerful voice …the Buurtzorg model is to try and put the person at the centre of process. [D03]

One further point to note was that several participants referred to confusion over the main purpose of the Varis Court apartments and how they should be allocated. There also was a suggestion that they have not been fully occupied because, until recently, the test site was run alongside Leanchoil. Thus, as the following quote illustrates adequate staffing to meet a possible menu of options for allocating Varis Court apartments would be crucial to its success:

> You know, my main issue at this point is that I would like this to be something that is adequately resourced and the right staff being in the right post in order to be able to have a successful service, not perhaps settling for a workforce which is not as well-skilled as it could be because it's what we're able to get [B02].

6.2 A community model

Unsurprisingly, community was a key theme of the interviews mentioned in relation to the closure of the community hospital, but also more optimistically in terms of the aspirations and practice of the ACU initiative at Varis Court and the wider FNCT.

> The ACU team [FNCT] do a significant amount of outreach work, within the community, because the primary objective for them is to provide a resource that has the capacity to bring people into the ACU. …The staff are also able to follow them in terms of before they came into the ACU and follow them after they come out of the ACU, so there's that continuation and consistency of involvement. And that's a major reassurance for people who are receiving health and social care services. [B03]

A community model was seen to be very important to patients and their families to prevent unnecessary admissions to acute services:

> We're looking at having a community model that helps prevent unnecessary admission to acute services by providing care in the community. Whether it is at the person's home or whether it's in an in-patient setting is our aim. Acute services would take someone who's really unwell, who's needing further assessments etc. Whereas we would look at… Well, traditionally, what would happen is if there's no community service to provide it, they would get put into acute care. Because there's no in between [A03].

> You'll be aware of some of the challenges we've been having around staffing in community hospitals, which are largely bed-based models, the Varis Court initiative is an attempt to move away from that. They are trying to provide an environment that supports a cohort of, shall we say, clients to either support their return to home or chances of returning to home after a hospital admission or as part of a hospital prevention strategy, but I think it about improving people's confidence, maintaining their independence as long as possible. I'm not aware its anything longer term than that [C04].

> Forres community nursing team/Varis Court as an inpatient type facility to try and look after our patients in a step-up/step-down manner, either avoiding unnecessary hospital admissions by using GP-led beds in the Varis Court facility or by taking over care from any patients that might be stepping down from the ACE unit in Dr Gray's [B02].

The FNCT is based at Varis Court but also provides care in the community in patients' homes. This approach has helped to provide continuity of care and individualised care plans. There

was a suggestion that this approach was underpinned by a wider awareness amongst primary and community professionals of the benefits of providing care close to home.

A key ongoing element of the project is engaging the acute staff in this philosophy, which is illustrated in the quote below:

> So, when they're medically stable to be transferred out of hospital, we have to consider getting people back as close to Forres as we can… patients were being placed outwith the Forres locality…I guess for the patients themselves, it also might feel a bit disrupted or a bit far from home …the bus route to Speyside is very limited. …So, at the moment we're trying to change the mind set of our Acute colleagues by saying, you know, if somebody from Forres is in Dr Gray's and they're medically stable to be transferred, we have to think about Forres … So, my focus is to try to look at what's safe. Forres first, what have we got in Forres? So, Varis Court is an obvious option as well as home [D02].

However, there were a number of issues raised concerning capacity usage, measuring the effectiveness of the pilot and, importantly, whether it was being properly funded. The funding issue was raised by a number of participants:

> I don't think we are rewarded for (meeting targets)…I think qualitative measures are a better measure….we work together more than we did but does that make things better….I don't know. It needs to be funded and I don't think it is [C01].

> I think, yes, it would be wrong for me to say, no, no, everything's hunky dory. It's not. There'd be concerns around the finances moving forward. You know, it doesn't come cheap to try and do something different and deliver services in a different way. I don't want to see people being admitted to the acute hospital and Dr Gray's when they don't need to be. Likewise, I wouldn't like to see the service users of Forres have to travel to other areas of Moray. …and I suppose, you know, one of the worst things would be is if, you know, Leanchoil Hospital had to reopen for any reason, because it isn't fit for purpose as it currently stands. So, these are all concerns for me. So, it is about right place, right person, right time and I think we've managed to do a good majority of that [B01].

> I have concerns more to do with the financial... we're made aware that, you know, there is no new money … there are financial, you know, restraints. … At the end of the day, it would be nice, if you were going to do a pilot like this, to ensure that people are attracted to the job and are able to be retained in the job so that we can actually see whether it works [B02].

This last quote also highlights a view raised by several participants from a range of backgrounds surrounding a desire for the 'pilot nature' of this initiative to be removed to allow for longer term planning, greater job security for the nursing staff involved, and developing the MDT aspects of the initiative. For instance, one participant from Varis Court said:

> I'd like it to not be a pilot anymore, I'd like to go forward … the amount of accommodation that can be provided, and the capacity for the service can go up or down, because it's flexible. These flats could be returned, and we could use them in terms of extra care. Or if the ACU needs more capacity, then we can look towards identifying any vacancies that come up, and certainly utilise those. And that's a flexible response that could be done. And the ability for the informal and formal working together, of the teams, there is much more that is probably to come. …The ACU initiative, and what Varis Court does, is a very positive example of what we can do if we just change the culture and get people out of their silos. [B03]

The participant above observes that there is flexibility in the design and potential for further collaboration with the wider team at Varis Court. The quote also raises the importance of working across professional and organisational boundaries and changing the culture.

6.3 A step up/step down provision

Participants were positive about the initiative providing an an additional service to deal with bed blocking, which was seen as a major problem for service users:

> Essentially, if you're in a hospital space there will be an element of, we need the bed again. Which is not a nice thing to be on the receiving end of [A03].

Moreover, a common theme in the interviews referred to occasions when medically 'fit' patients were unable to leave hospital because of the lack of follow-on care:

> People's care packages tend to get withdrawn if they stay in hospital and then they have to wait, often much longer, for a new care package, so it goes to the local brokerage where care agencies pick up that care package, and if there isn't one available that person will remain in a hospital…that can take some time, weeks and months. People then tend to lose their independence and skills…things are done for people in traditional hospitals and care systems, rather than with people [C04].

A majority of interviewees were enthusiastic about the project's demonstration effects in moving towards an integrated model of care, especially in showing how care could be provided in community settings most effectively:

> For me, working with the project has been absolutely invaluable; some of the people we look after who would have otherwise been put into hospital or in a nursing home or respite home because their care needs would have increased and they wouldn't have been able to return to the community, so by having the nursing staff and the Hanover care staff, that allows people to live independently for longer in a home environment rather than a hospital [C04].

> The feedback we've had is that people are able to stay at home longer, they are able to get drips, they are able to get IV treatment…you know if people are dehydrated from example, they are able to get treatment immediately rather than wait to go into hospital [C03].

This demonstration effect was especially noticeable in providing palliative care:

> Nurses are able to do work in the community. An example of that would be palliative care; we've been able to keep people at home, people don't want to go to hospital to die, they don't want to be in a nursing home environment … We've had several tenants who've chosen to die at home, so they've been able to stay in the property, their families have been able to stay with them, visit them when they want, their family can cook for them, eat with them…they can have that intimate time, so important when someone is dying…if there's such a thing as a good death, this is it [C03].

> I do feel it's an alternative to keeping people within the local areas who can't stay at home or who need to get out of an acute environment fairly quickly. For me, it supports that. So the wins, for me, here are absolutely there. Families can get a wee bit more involved with care. …I think this is what they should go for palliative care because the environment is really good. You're in a home environment. Do what you like. Your family can come in …can do what they want. They can come in with the kids. You're not upsetting anyone else. …It is holistic. [A05]

However, there was still some uncertainty about what FNCT was offering, and whether service users understood what was being offered, e.g.

> Because that's the other thing I do think. So, it comes… This, I think, comes under the NHS, but… It's not a care home facility, but yet it's not a hospital facility, either. So, in terms… If I think about the things that the director of nursing wants us to do with community hospitals, this is a… This is like somebody's home, but yet it's a bit of an inpatient facility too … the boundaries are a bit blurred … it is like being in somebody's own home … But, do the patients coming in here think they're coming into a hospital-type [setting]? [A01].

This excerpt illustrates that when implementing transformational change, like the Forres ACU and FNCT project, that diverge from existing models of delivery, those involved can struggle to define and place where this new way of delivering care fits within the system. Thus, it raises the importance of communicating not only the overarching principles, but also how these changes work in practice in relation to the existing environment. Clinicians were broadly positive in their assessment of the project, especially in concept, but also noted problems in delivering the benefits. These next two quotes illustrates optimism for the initiative and some progress:

> I understand some of the background, legislation, directions …health and social care integration, and how IJBs operate…in the time I've been here at a level we've been able to put in much more shape around that, and working with…..myself and my colleague we're beginning to have many more conversations about how to manage some of the priorities, for example around population

and demographic demands across Moray…how we can come together…its beginning to feel we are making a bit of progress…so that's good [C04].

What we should have, and I say should have, is a fully-staffed team of nurses that are working a 24-hour seven day a week rota, whereby they are able to look after patients in the Varis Court facility as well as our outreach service centre, our community, whereby they can come in and provide step-up nursing care. …if it was fully-staffed, then that would be something that would be remarkable, I think, with what we were actually planning…what it's like on the ground due to, you know, staffing levels, etc., at this point….[B02].

At the same time, however, they also expressed reservations, as illustrated by one interview who we cited above:

I've never been particularly clear what type of people we would expect to place in (Varis Court)…to provide a little more context…To be honest with the Varis Court initiative, I've been aware its going through a series of reviews and evaluations…but never been very clear in my role…what are the rules of engagement, what are their admissions policy [C04].

Health and Social care integration makes sense in principle…I'm assuming it was done in part to reduce middle management…and improve communication. Improved communication I think is happening… what was the question again, is it working…I guess I'm slightly cynical, in part because of the ways of measuring…they try to use all these measures (lists them)….I'm not sure you've got the valid measures…are hospital admissions a good thing or bad thing…it depends. Also it has created a lot of work, lots of meetings even to try to understand it, lots of emails…often just to read an email takes half an hour (when you could actually be doing your job) [C04].

6.4 Continuity of Care

One of the real strengths of FNCT was that it was able to provide a locus for care, in which home care was improved and the Buurtzorg principles were capable of being implemented. This was especially the case in providing continuity of care and building trusting relationships, as the following number and nature of quotes illustrate.

I have to say that I'm involved in other care services where they don't have the nursing staff they do at Varis Court and the difference is dramatic…they don't have the same continuity and level of care without that nursing staff [C03].

So we transition in and out of our in-patient status. Our in-patient venue. And I think that helps the patient generally. And it's the same people that are seeing him in home as in the venue. You get that continuity of care from the same people. You're seeing the same faces. [A03]

I think we've provided a much more seamless journey for service users and patients …when they've come through the Forres neighbourhood team, they've… you know, it's allowed them to either follow them in and follow them back out again. … So, I think there's value in that because

they obviously get to know the patients a lot better within the locality which is the other bit of the locality working that we've got to try and promote. So, it's not just all the strangers that are inputting into your life at quite serious times. … having their health and social care needs designed around them as an individual rather than just fitting into the mainstream way that, as I say, from a conventional perspective that things have always been delivered [B01].

I like the fact that we have 24-hour nurses who are getting to know patients. They are treating them at home, but we also have the ability then to pick the patients up and take them into Varis Court if we feel that that increased observation or input is required. I have a patient at the moment who is struggling at home. He's going to be palliative. He's got a palliative diagnosis but he's not quite terminal yet but, again, the discussions and the ability is to try and keep him at home but, you know, we have the ability to have the same nursing staff who are going in and helping him and treating him at home actually take him into the Varis Court facility and that there'll be continuity there, which I think is excellent. [B02]

They live in our building and they do their traditional nursing role and they have been excellent at stepping in and helping with palliation at home where you have the proper family support and perhaps the social care that allowed that to happen whereas with this model, when the staffing is correct and they're actually able to step up into that nursing role at home, and much more so than we can ever expect at the end to, you know, there has been great benefit there and, again, it's the continuity across the service. It's the care at home as well as bringing them in into an inpatient facility. It's very nice to be able to look after people locally. [B02]

It was also felt by clinical staff that some patients can lose confidence in their own capabilities when hospitalised — a version of learned helplessness — whereas FNCT helped deal with this problem:

What you find is, with our mean age is something like 86 I think. And, for being in hospital for a short period of time, you can lose that confidence to be at home. And I don't think that's really recognised within the acute services. We will bring them into our service. We will follow them at home to ensure that they get that confidence back again essentially. To be able to cope at home. And manage the things that they would have managed but, because hospital's very debilitating [A03].

Clearly there's a change in the idea that we're now looking at trying to support people at home and trying to keep them at home more than we would do in the traditional sense whereby, if people were to go off legs or to become a bit confused, we would normally look to perhaps admit them to either Leanchoil or Dr Gray's, our main hospital in Elgin, whereas with this new band of nurses we're maybe hoping to be able to avoid hospital admissions and even maybe even for people at home rather than bring them into a kind of more supervised place such as Varis Court…..But, you know, the key really is to try and treat our patients at home and in the community rather than sending them into our hospitals [B02].

6.5 The FNCT – self management and autonomy

It was evident that some Varis Court staff felt empowered and had an increasing sense of ownership and challenge, as the following two quotes illustrate:

> You can be holistic in ward seven, I think, but you're very restrained because you're not in their own homes, so… these flats are meant to be [like]their own homes and it's their own homes in the community too, so… I think, because they're in their own homes, and you get to know [A02].

> I think… we all know what our job is and we kind of stick to that and do it very well but this initiative is really trying to push those boundaries and encourage, I suppose, staff groups to work an awful lot more closely with one another and allow those boundaries to be stretched just a little bit …. I think speaking about the Forres neighbourhood team in particular, there is job satisfaction as well because they've all come from different backgrounds and all of them have embraced this way of working. They've fed back themselves that they feel that they can practise more autonomously [B01].

However, other staff suggested the Buurtzorg principle related to self-management was not fully implemented:

> So, you would say that the team is self-managed, but, actually, you've got a band eight person there. Whereas, in the Buurtzorg team, it's a fairly flat team and you'll have coaches behind that. Not managers, but coaches who will support that team to make decisions and be more autonomous. So, we don't have that bit in place, either. [A01]

Others observed that there was potential to incorporate the Buurtzorg principles around self-management, trust and collaborations into the wider multi-disciplinary team to improve coordinated care and overcome professional silos. The quote below illustrates this view, together with the suggestion that it can be easy to fall back on traditional ways of working:

> I think it's a great philosophy. It's a philosophy we'd want our staff to adopt rather than it being a unique team. …I'm not sure how much we've defaulted at times to tradition. The environment's different, but tradition… I'm not sure how different what the [FNCT] nurses are doing is to what the district nurses are doing. I can't see the difference. I think the staff group, there has definitely been splits from what I can make out, in terms of views and how involved. Who's in and who's out? Who gets privileged? Who doesn't? And we've missed that integration principles bit.[A04]

6.6 FNCT relationships and network building: thinking beyond FNCT

A number of broader issues arose during the interviews concerning relations with other professions and team development, governance and interprofessional boundaries. Some interviewees articulated a vision of team working beyond the FNCT model that included wider

relations with clinical professions beyond the current approach. The following three quotes highlight these concerns well:

> The thought is that Varis would like to have a multidisciplinary team approach around the patients at Varis. So there's like physio, occupational therapy, social work, nursing care, GP input, district nurses' input, or the nursing model [unclear]. And I think that is a really good idea to have that approach for everybody and everybody working around one patient in terms of the discharge planning and getting everything sorted for them. The difficulty is they want that done out of existing resources. … when it [Buurtzorg] has been rolled out in other countries, they've had nurses and an occupational therapist, and a physiotherapist employed as part of that model. However, Forres has just chosen to recruit nurses. So they are very nursing-strong-led model and don't have any allied health professional involvement within their staffing and their finances. So that, to me, was a bit of a major flaw from the start [D01].

> Well, for good and bad, it probably was seen much more as a nursing opportunity. Now, it's good in that, I suppose it simplified the opportunity a little bit because in some way this has got complexity but bad in that it sort of aligned itself too much with nursing. … [I knew early on that] the GPs were fundamental to it ….. the failure or success of this would ultimately rely on how the GPs embraced it or not. [D03]

> Yes. So, I think we need to start… If it rolls out, I think we need to start from the starting point of joint teams of the community team and the team who will be… And also, educating the carers within that team, and social work, and AHP, so it's one full team [A01].

The quotes above emphasise the importance of wider professionals to the success of the FNCT and ACU project within Forres and the desire to become 'one team'.

Although not a widespread view, how governance and service user safety could be assured was also raised. This was seen as a broader issue for IJBs which have less control over professional and clinical governance than acute services because of their distributed nature:

> So, I suppose my concerns are around the governance around what the patient's perception is of the level of care that they're going to get here, that it's going to be low-tech, not even middle-tech, the same as you might get in a community hospital [A01].

Other interviewees stressed that Varis Court and the wider FNCT care at home approach was one of many options and wasn't suitable for all patients/service users. They argued that contingent on their needs some individuals would be better suited to care in a Community Hospital outside the locality or in Dr Gray's:

> We have taken on a lot of patient's care to allow them to be discharged from hospital, in their own homes. But, we're just here for the short-term, rather than the long-term. … So [after about 6 weeks], it's trying to get the social worker to… and then start that care with the carers … It fills

> a gap. It's somewhere in the middle between a home and hospital. … In the flats, you couldn't have somebody who's quite cognitively, mentally impaired or needs a lot of support… If they're on a hospital ward, they're watched. You can see them. Whereas, here, they're in flats. It's not the best place for everybody [A02].

The issue of identity and conflict over inter-professional boundaries was also raised, with some some clinical interviewees there was scepticism around what the Varis Court initiative was able to deliver, and this has created tensions between the different professionals involved:

> I've had various reports that the (Varis Court) initiative is not hitting the target's set, people are staying longer than is necessary or not hitting the type of people they were supposed to take on board….I'm aware there are a lot of mixed views about it, different opinions about its value, from clinician to clinician and perhaps among some of the different professionals involved ….but I don't have any hard data on that…it's just anecdotal…I don't get the sense from the clinical community about overwhelming support for it…to be honest I think it was about how the whole project was commissioned and decided…there's a little bit of a difference between the clinical community and the care community if you like…and therefore what can be considered to be a good thing to do, almost presentationally from an health and social care partnership perspective [C04].

> This seems to be a more social work set of objectives but doesn't really replace or offer anything like what is required for the types of patients from a clinical perspective that would be necessary…some of that might be the way in which it's been implemented and tested…some people haven't been involved enough early on [C04].

These quotes highlight that despite the policy drive towards integration and the centrality of joint working within the Forres project, there is still a perceived disconnect between social work approaches and clinical practice, and whether they can be effectively integrated in how they are valued and delivered.Those on the ground also suggested that there were different levels of buy-in locally and admitted that there have been overlaps between the FNCTand the District Nursing Team but suggested that this is something they will be working on going forward:

> It's historic, but I think social workers particularly. There's always this divide between health and social care…But there's also that between acute and secondary, primary and secondary care. There's still a barrier, albeit invisible, but there's still that lack of… I think its communication honestly, that affects the whole system… It's trying to get them on board and realise what it is we're trying to do which can help them [A03].

> So, Forres isn't that big. We've got the district nursing team, we've got our [FNCT] team, and then we have Leanchoil. That's quite a lot going on in a small town and … I think the district nurses and us have had issues of overlapping of whose patient is who … it is going to be addressed… in Forres. There's two practices … [we get] more referrals from [x] Practice, than we have from [y] Practice [A02].

There were a number of participants that offered interesting observations on thinking beyond the original FNCT. One good example related to collaborative working:

Until recently, although there has been some engagement between the FNCT, the district nurses and wider multi-disciplinary care team, they have mainly worked independently — there is potential for, and a desire amongst some participants, for greater collaborative working going forward.

> There's elements of it that are going really well and I think that it is mapping out how we would want to deliver care in the future. There's obviously some financial elements to that that we still have to work through and, as I say, for the initiative to really, I suppose, take off, it does now require this next bit of integrated working with all the other MDTs that are located in the Forres area to really actually truly take it to the next stage [B01].

> A good outcome would be that we spend the next brief while understanding better the value added. What can we optimally do with that facility as part of our range of interventions? But probably more importantly is that MDT really coming together and working out how they operate together. And what they can optimally do with the range of resources available to them. [A04]

With the recent closure of Leanchoil, staff from the community hospital had begun working at Varis Court, which represented a significant cultural change for these staff, particularly those who had not actively sought to work in the new mode or organising. Support was felt to be necessary for those staff:

> I suppose the other challenge as well is that we have got some nurses from Leanchoil Hospital who are placed in Varis Court, working there at the moment, and I don't think that they've quite got the concept because they, again, are very... within the mind set of being managed whereas it's a very self-managed model. It's that sort of principle. It's very different. So, I think there's a bit of education [D02].

Going forward it became clear that communication with staff and service users was going to be key. It was suggested that the FNCT were fully bought into the approach as they had been able to apply to work in this way. One opportunity going forward related to engaging the wider MDT and integrating the previous Leanchoil staff into the FNCT and its philosophy. However, these cultural changes will take time:

> You've got people that are very up in a social model and then you've got people that, you know, still very much follow a medical model and certainly we saw that in some of the staff, that when Leanchoil transferred over into the Forres neighbourhood team, which has been part of all of this as well, which is really quite interesting, is just to see how they adapt to the principles and a completely different way of working. So, I would say that would be some of the challenges that we've faced to date. But I don't think they're unsurmountable. I think that we will get there with

> it. It's just going to take time. It's not something… You know, it's okay putting processes and procedures in place but we're speaking about kind of cultures and behaviours and that's the areas that take a lot longer to turn around [B01].

From the acute side, it was also suggested that greater understanding of what the Varis Court site offers and how it compares to a traditional community hospital setting would help change mind sets around patient discharge plans/pathways:

> We should really be doing a little bit more promoting Varis Court, if you like, doing sessions with staff, because they are very quick to, we don't know anything about Varis Court, it's a different option that we've not really been involved in any of the discussions around and... So, you know, I have had that said back to me. You know, if we phone and speak to […], we're not really sure if it's appropriate, an appropriate referral. So, I think there's a bit of learning there [D02].

As noted above, throughout the interviews there was a real sense that communication could be improved to ensure that everyone knows what the different parts of the service aim to provide. Bringing together the different strands of care and setting out clear boundaries by managing expectations of what the different elements can and cannot do and how they can work together will be important. Linked to this was the sense that any evaluation has to take a holistic approach and appreciate the person-centred goals of the FNCT initiative:

> My personal opinion about what nursing is, is that I think nursing is about everything… Look after every aspect of their nutrition, their cleanliness… I think that they realised … that they couldn't really just shut Leanchoil Hospital without something being in Forres … [sending] elderly people all across Moray, it's not going to work, and I think there would be an absolute outcry from the people of Forres if there was nothing in place. So, I think it's all been very coordinated [A02].

> In my mind good care is where we are able to take into consideration the needs of the patient and their family or service user, that we can look at their outcomes, to be able to meet those outcomes in an environment that's conducive to them either recovering and rehabbing or, if it is end of life, that they're in a setting that's more homely, that allows them still, obviously, dignity and respect while they're still with them, and I think that's really important for any family members that are around them as well so they experience that as well … I think good care looks... where people have got control and a bit of autonomy over how their care is shaped around them and I think that's why I think Forres neighbourhood team has kind of got that right in the fact that we promote independence when people are either within the units or they're in their own homes … [but] it has to be meaningful to the area … Forres is unique in the fact that we did have a building that was no longer fit to be a community hospital … you need to obviously decommission something to be able to free up finances, resources to commission something else [B02].

7.0 Analysis

In general, there is understanding of the principles of health and social care integration and the associated political agenda. Moreover, there is a great deal of investment from stakeholders, with most expressing a desire to see this project work, especially given the closure of Leanchoil. Nevertheless, the interviews reflect different professional logics, career knowledge and how 'close' they were to the project (e.g. sequential models v. integrated models of care; direct involvement v more peripheral involvement; early v late involvement; and 'winners' v 'losers' from the change).

The pilot project was generally thought to be working [relatively) well in that it provided a much-needed step-up and step-down facility for local service users and patients. The FNCT are engaged and working effectively across the community. Most interviewees agreed that patient care and safety as well as the wider patient experience were key measures of success. However, there was some uncertainty around what good outcomes 'look like' with some suggesting that outcomes [such as hospital admission rates) can be interpreted in many ways. To date, the benefits appear to be largely providing extended social care at the margins, beyond what is already provided. However, with the closure of Leanchoil, it is expected that the Varis Court accommodation and FNCT could potentially provide a more central care role within community care going forward.

The new arrangements/co-location had been extremely beneficial in integrating social care and raising their profile and voice. We suggest that this cohort may be more positive. There was, however, a feeling that AHPs could be better integrated into the operational planning. There are also resource constraints here as these professionals are often stretched across wider community care and sometimes acute care.

More broadly, it was suggested that greater collaboration and coordination with the district nursing team and wider care team would enhance the project going forward. This was observed in the interim report. Over the last six months Health and Social Care Moray have been working to establish a single team culture, especially between the district nursing team and FNCT. Moreover, they have sought to engage the wider multi-professional team in the values and objectives of the project. This second phase of the test of change is focused on the Buurtzorg principles [3) Continuity of care and [4) Building trusting relationships.

A big challenge facing the Varis Court model is around communication with Hospital Medics around understanding the model, what is provided and what care the units can safely provide. Some caution was expressed around feeling confident to refer patients into this model. There was also a sense that the Varis Court initiative had changed the way GPs worked and that this had initially been challenging, especially when the Varis Court provision was operating

alongside Leanchoil hospital. However, the GPs interviewed noted that, with the decline and ultimate closure of Leanchoil, the Varis Court ACU apartments and the FNCT provided useful service that allowed them to still look after patients locally.

There was also a suggestion by some that the model has not been tested to the full as it has until recently worked alongside Leanchoil and has been operating on a smaller scale and with a smaller number of trained nurses that was originally envisioned. Yet, others made a case for Varis Court to be no longer a 'pilot' study and for it to become fully embedded in the wider community care provision as this would provide more certainty in terms of long-term planning and, of note, in helping with recruiting and maintaining their nurse cohort.
The proposal the Varis Court model could be applied at multiple sites received mixed responses and was a concern for some participants with regard to the implications in terms of nurse resourcing and the workload planning of GPs and AHPs.

The sustainability of financing beds and supporting patients with appropriately trained staff was raised by several interviewees. This suggests that there is perhaps a need for a more holistic approach to costing for the initiative that takes into account both the economic and social costs and benefits provided.

8.0 Recommendations

For some professionals, the new way of working is a natural extension of best practice. However, for others it can represent a new set of demands to work in different and sometimes unknown ways. Therefore, change needs to be managed in a multi-dimensional way which includes learning time for professionals to adapt skills to the new requirements. This learning may also need training support.

Working in multi-disciplinary teams is central to the project. However, in the perceptions of some respondents the teams are not always in the right balance with some professional groups being over-represented and others under. There is a need to carefully assess the appropriate skill mix and encourage applications from the appropriate professional groups. This could include part-time and flexible modes of working depending on overall demand levels. To this end, we believe the use of relational coordination theory and practice, which we discussed in our introduction, has much to offer in helping teams improve the quality, accuracy and timeliness of communications and the levels of mutual respect and trust necessary to deal with the identity issues associated with effective inter-professional working.

A distinct benefit of the new approach could be better quality of engagement with carers and families. It would be advisable to ensure that feedback from carers is captured and included in evaluations. On a related point, there are opportunities to enhance training and support for carers so that return home can be easier and more sustainable. Follow-up evaluations after

three months could provide qualitative data alongside other information such as re-admissions data.

Evaluation needs to take account of length of stay by benchmarks so that there is clarity on whether or not patients are staying for "longer than necessary".

Learning about how to work effectively as a multi-disciplinary team is occurring at the moment, but it is not clear that this learning is being systematically captured such that best practice can be embedded in the system more generally. This could be achieved by periodic learning reviews and recording cases and protocols on the website.

Given the pace of change, there is also scope for a more longitudinal study to be completed that focuses on the evolution of the project over time. In particular, it would be useful to examine the progression of phase two of the test of change, which is focused on creating trust and engaging the district nurses and wider multidisciplinary team in the Buurtzorg philosophy. It would be useful for future research on Buurtzorg adapted models of care to: (a) consider the challenges surrounding implementing such culture change; (b) explore how to build in trust into the system, while moving away from top down control; and (c) examine how those involved can ensure that initiatives stay focused on integrated care and relationships rather systems and structures.

So, in summary, we suggest:

- More extensive involvement and engagement with medics and senior managers from Dr Gray's hospital.
- Inter: develop further team working between all stakeholders (focusing on identity issues and inter-professional working).
- Intra: further development of Buurtzorg and understanding if this less-medicalised model may enable a quicker flow through the integration of health and social care.
- Further thought will be required on next stage research — clarity will be required on operational objectives of this new approach and establishing what metrics are indicators of change.
- In terms of the health and social care system in Moray, this learning could then be beneficial in terms of continuous learning and the future redesign of services.

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Annex A: Interview Guide

1. Can you give me a little background on your role in relation the Varis Court Extra Care initiative?
2. What is your understanding of the initiative? and how the Forres Neighbour Care Team works?
3. How does this approach compare with traditional care models?
4. What in your mind does good care look like?
5. Who in your mind are the key stakeholders of the initiative?
6. How is the initiative going? * What if anything do you think has changed since the Extra Care initiative began at Varis Court?
7. What have been the most beneficial outcomes for service users and their families following the introduction of this initiative?
8. How has the initiative impacted on staff in the Forres Neighbour Care Team (FNT) and staff in the Multi-Disciplinary Team (MDT)?
9. Do you have any concerns with the initiative? If so, what are they and why?
10. If this initiative was to be rolled out across Moray is there anything you think should change?
11. What, in your mind, would be a good outcome from this trial initiative?

Annex B: Word Cluster Analysis