

The Guy's and St Thomas' NHS Foundation Trust Neighbourhood Nursing Team Test and Learn project of an adapted Buurtzorg model: An early view

Executive summary

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The full report

The full report is available at [Kingston University Research Repository](#)

The evaluation team

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Fiona Ross is professor of primary care, having been a district nurse as well as an educator of health and social care professionals. Her many leadership roles have included Executive Dean, Director of Research at the Leadership Foundation for Higher Education as well as Board membership of a Community Health NHS Trust and a Hospice. She is currently chair of the Board of the Prince Alice Hospice, London. She has extensive experience of mixed methods and research within the NHS.

Mary Saunders is an experienced senior district nurse, educator and manager. With Quest consulting colleagues she has undertaken reviews of district nursing in several parts of England. She has also led national work for the Queens Nursing Institute in London on voluntary standards of education and practice for district nurse courses.

Peter West is a very experienced health economist who has worked as a consultant and academic on a wide range of projects and problems in health services. He has worked in or for agencies across the NHS, Ireland, Australia and the USA. In the public sector, as well as board membership of two NHS trusts, Peter led the value for money work of the Healthcare Commission from 2005 to 2008. He is currently on the clinical strategy group at a hospice in Surrey.

The team also acknowledges the input to this review of Melania Calestani, qualitative researcher, Robert Grant statistician, and Katerina Belogianni who has assisted with data management.

This report provides the executive summary of an early view evaluation of a Test and Learn pilot of an adapted Buurtzorg model undertaken in Guy's and St. Thomas' NHS Foundation Trust (GSTT) adult community services. The full report is available at [Kingston University Research Repository](#).

Background

In response to both increasing demand for district nursing services and also significant and enduring problems in recruitment and retention of nurses in the district nursing service, Guy's and St Thomas' Adult Community services decided to test a new model of care for community nursing based on the Dutch Buurtzorg model¹.

The Dutch Buurtzorg Model

The Buurtzorg ("care in the neighbourhood") model of community nursing is based on small self-managing teams of community nurses (c12) working in a defined geographical areas supported by a small national administrative team known as "back office" and coaches. A review concluded that "Buurtzorg has earned high patient and employee ratings and appears to provide high-quality home care at lower cost than other organizations"² (p1 6).

The GSTT Test and Learn Pilot

GSTT adult community nursing services implemented a Test and Learn pilot in 2016. An electoral ward in inner London was identified as the 'neighbourhood' which allowed the nurses to walk to all parts within 20 minutes of their base office. Three general practices had patients resident in the neighbourhood. Three nurses, the Neighbourhood Nursing (NN) team and their sessional coach were in post, taking patient referrals, by November 2016. Sessional dedicated 'back office' administrative support was established in late February 2017. The team grew monthly in new personnel until June 2017, when the team split to establish a second team in a different neighbourhood. Not all of the initially recruited nurses had had previous experience in community nursing, as is often the case for registered nurses recruited into district nursing teams. The NN team used the Buurtzorg methods of solution focused meetings to manage themselves, with collective decision making undertaken by vote in weekly meetings. All decisions on the way they organised themselves and practised nursing were recorded in their 'book of rules'.

The adapted Buurtzorg model therefore required the implementation of two interacting innovations:

- A renewed focus on patient centred care,
- Self-managing team of nursing staff.

The evaluation

The early view evaluation was designed to offer formative insights as well as evaluative methods for a second period of a scaling up to a second team. The formative evaluation addressed questions about the organisational experience of implementation, about potential impact on nursing practice changes,

¹ Monsen, K. & de Blok, J. (2013) Buurtzorg Nederland: A nurse-led model of care has revolutionized home care in the Netherlands. *Journal of American Nursing*, 113(8): 55–59

https://www.researchgate.net/profile/Karen_Monsen/publication/259628825_Buurtzorg_Nurse-Led_Community_Care/links/5751ab2508ae17e65ec32ff0/Buurtzorg-Nurse-Led-Community-Care.pdf

² Gray, B. H., Sarnak, D. O. & Burgers, J. S. (2015) Home Care by Self-governing Nursing Teams. [online] The Commonwealth Fund. Last accessed 8-8-2017 at : <http://www.commonwealthfund.org/publications/case-studies/2015/may/home-care-nursing-teams-netherlands>

patient and carer satisfaction and outcomes as well as questions as to the types and availability of patient level data required to consider cost effectiveness.

The evaluation drew on:

- Interviews with patients and families, neighbourhood nurses, general practitioners (GPs), community nurses, managers and district nurses,
- Observations of members of the neighbourhood nurses and district nursing team providing care and during their day,
- Analysis of anonymised patient records,
- Analysis of reports and documents internal to GSTT.

The Test and Learn pilot had iterations as the Neighbourhood Nurse (NN) team and the parent organisation have tried ideas and learnt throughout the period (November 2016-June 2017). The early view evaluation therefore offered insights and also raised questions to be considered by the NN teams and GSTT going forward.

The Findings

We now provide a summary of our findings from the patient and carer perspective, from observation of the nursing practice, from the patient records, from the nurses' and, finally, managers' experience.

A different way of working from the patient and carer perspective

Patients and carers reported high levels of satisfaction with the NN team.

"The care the neighbourhood [nurses] giving is first class" Patient 9

"That's my kingpin [the nurse], because she's like you [the interviewer], she sits down and listens and she doesn't...., you start a sentence, she let me finish like you do". Patient 3

Patients and carers were able to report a positive change in the nursing practice they experienced compared to previous experience of district nursing. Individual patients could describe how this change had resulted in direct improved clinical outcomes.

"I think the neighbourhood nurses are the best solution so far to trying to keep people monitored who are not in hospital that have got conditions and giving them the support they need to keep them out of hospital." Carer 10

While some patients had had positive experiences with the district nursing service they could also report key problematic areas which they did not experience with the NN team. These were:

- A lack of continuity in nurses attending them and its impact on their care,
- Brief visits with a concomitant lack of attention to any problem beyond that the nurse had attended for,
- Lack of follow-up to initial visits or subsequent care,
- Difficulties in contacting the nurses.

"And now we have the neighbourhood nurses ...the new system is so different, it's like cheese and chalk." Patient 7

Observing the care

Observation of the nursing practice confirmed that the NN team nursing practice was very different from the District Nurse (DN) team practices but noted the NN team had a small patient caseload in comparison to the DN team.

It was clear to the observer that the NN team had a different approach to care. All nurses seemed to have a very personal relationship with their clients. They were often hugged and kissed by the client. Many clients gave unsolicited praise for their nurses citing how much they appreciated the continuity of care and the relationship they had with the nurse. Many patients were telephoned before the visit and often a time for the visit was negotiated. For almost every patient, each NN team nurse asked if they could get them anything to eat or drink and were quite happy to do this for the patients on some occasions. During the visit the NN nurses placed much more focus on the total care of the patients than most of visits observed of the DN nurses. They also spent time offering health promotion and preventative advice. For the patients seen with the NN nurses the communication with the social carers seemed to be fuller and more inclusive than that observed with the DN team for example explaining how best to help the patient to mobilise more.

Inefficiencies in recording of care and duplication between home visiting nursing services were observed in the DN team. The NN team had changed their practices to be as efficient as possible and ensure continuity in nurses, avoiding duplication with other services. This raised questions as to whether there was learning from the NN team's ways of working that could be adopted by other DN teams.

Perceptions of the wider health care team

Positive care outcomes were reported by General Practitioners (GPs) as well as positive feedback they had received from patients and family. They described a period of learning to work together with the new team but noted some differences in that the NN team came to them with patient problems and identified solutions rather than just problems. They could see the potential for the NN team to be more proactive in chronic disease management with housebound patients. Likewise, other health professionals reported positive patient clinical outcomes which they attributed to the NN team way of working, although there was some surprise expressed at some team members' need for training in what were considered common community nursing situations. GPs and other health professionals pointed out the inefficiencies created by the lack of shared patient records, a situation experienced across community nursing services.

Recording care and outcomes

Examination of anonymised patient records demonstrated the NN team had small numbers of patients in comparison to the staffing, although the early view period was a time when many new staff were recruited and being inducted. The analysis showed some very different patterns of nursing staff contact, such as high levels of telephone consultations, compared to the DN service. The NN team also provided short term personal care and meal preparation activities for some patients in contrast to the DN service. However, without accurate descriptions of patient case mix and acuity this was hard to interpret. The absence of outcomes or process outcomes further added to the difficulties in gauging effectiveness and costs. These are elements to investigate over a longer period of time and with more patients than in the Test and Learn pilot. The evaluation team provided a detailed discussion of the issues and potential methods.

The nurses' experience

The nursing staff described their experience in very positive terms "*I enjoy everyday – everyday is a pleasure*". They reported their satisfaction in their work came from positive patient feedback, from positive feedback from GPs and other health professionals and from working together collectively to provide the service. The NN *team* worked as just that – a team providing care for patients – which those who had worked in DN services were able to pinpoint the difference. The DN team experience had been that each staff member had their list of patients for the shift and the responsibility was theirs alone. There had been no sense of collectively problem solving or helping each other to complete the necessary work in that shift. The NN team also paid attention to their work-life balance, for example, so individuals, with the agreement of the team in the weekly team meeting, took time back in lieu for extra hours worked. Many of the working practices the NN team adopted addressed the issues that the DN nursing staff raised with the evaluation team as aspects they disliked about their jobs.

The NN team members also reported the experience was very challenging. Challenges came both from learning to work as a self-managing team but also from the extent the wider GSTT organisation recognised the concept of a self-managing team. The NN team stressed how important a role the coach was in supporting them to be a self-managing team and also being a "*buffer*" between the team

and the wider organisation. The lack of information technology systems to support mobile working (a current project in GSTT) and nursing practice was particularly irksome to the NN team especially when compared to that on offer within the Dutch Buurtzorg service.

The NN team staff offered advice for nurses who were setting up such teams and also organisations that were considering implementing such teams. The advice covered both organisational matters but more importantly the need to really commit to the philosophies of patient centred care and self-managing teams. The NN team staff and the managers in GSTT were unanimous that ‘*back office*’ support should be in place before a nursing team commenced.

The managers’ perspective

There was strong commitment from the leaders and managers in adult community services to testing and championing this model. At the same time there was curiosity and questioning as to the value and impact of an adapted Buurtzorg model in an inner London setting. Some interviewees reflected on the readiness of the wider management cadre and administrative and support departments to embrace the concept of self-managing teams. One point of learning has been trying to understand the optimum mix of experience and skills needed for an effective self-managing nursing team. The first group of nurses had limited experience of community nursing, which changed in subsequent recruitment. This raised the question as to whether some of the ‘learning’ in the initial phase was of learning to work in the community rather than specifically learning to work in the Buurtzorg model.

Some nurses applied for NN team jobs and then declined job offers following interview and others took up posts and subsequently left. This suggested that self-managing teams are not necessarily a model that all are comfortable with. One aspect raised for consideration is how the NN team staff experienced ‘flat’ structures with salaries fixed on their previous employment and as yet no clarity on career and financial progression.

This early view evaluation was not able to address questions of cost for a number of reasons not least the evolving team, practice and administrative support. Investigation of impact on issues such as staff retention also requires longer periods than the early view. A full evaluation of NN in GSTT would require a longer period of time to accumulate data and much more detailed data than is currently available. A KPMG report identified lower monthly costs per patient, shorter duration of care, higher hourly costs but overall lower median costs over the total episode of care than other home nursing services³. To identify whether the NN team in GSTT is achieving these outcomes would require a long-term study with a large number of patients to give statistical confidence in the results. We have offered insights in the full report into how this could be undertaken in the future and some of the challenges within that.

³ KPMG (Jan 2015) The Added Value of Buurtzorg Relative to Other Providers of Home Care: A Quantitative Analysis of Home Care in the Netherlands in 2013 [in Dutch] / KPMG-Plexus. De toegevoegde waarde van Buurtzorg t.o.v. andere aanbieders van thuiszorg. Een kwantitatieve analyse van thuiszorg in Nederland anno 2013. 2015]

Concluding comments

The adapted Buurtzorg model of community nursing holds potential for addressing the issues of patients, carers and staff. From the patients' and carers' perspective issues in relation to lack of continuity in care provision, lack of support in attending to interacting multiple long terms conditions (physical, mental and social), and lack of proactive care navigation. From the nurses' and managers' perspective these were issues in relation to the quality of nursing care, low nurse job satisfaction and consequent unattractiveness of community nursing.

The two interacting innovations (a renewal on a patient and carer centred care focus and the self-managing team), were implemented in this pilot in ways that patients, carers, other health professionals and nurses could identify the difference it made to both the nursing care and also the nurses working lives.

With the 'settling' in period over and the establishment of two NN teams there is opportunity to evaluate this adapted model over a longer period of time.

Suggested citation

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