Aberdeen City Health & Social Care Partnership
A caring partnership

Integration Joint Board

Report Title	Buurtzorg Model of Community Care
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1: Purpose of the Report

The purpose of this report is to provide information to the Integration Joint Board on progress towards utilising Buurtzorg principles to develop new integrated community nursing and care at home teams.

This report also seeks agreement for a cross sector team to visit the Netherlands to learn more about the approach in order to inform developments in Aberdeen.

2: Summary of Key Information

2.1 About Buurtzorg

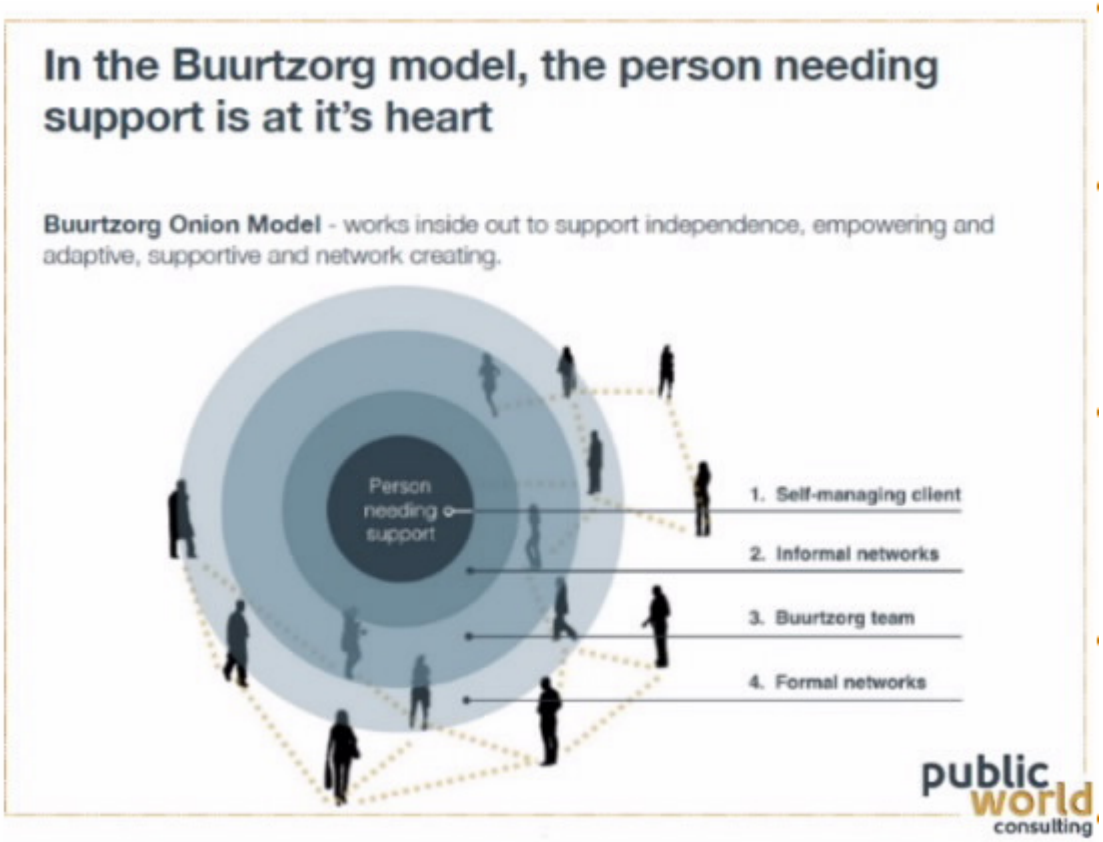
Buurtzorg Netherlands was created in 2006 as a new model of patient centred care focussed on facilitating and maintaining independence and autonomy for the individual for as long as possible.

The model is a powerful integrator at the point of care and has demonstrated results in high quality person-centred support and care, and high levels of staff engagement and job satisfaction. The key characteristics of the model include:

- Strong focus on the person, their strengths, formal and informal networks and promoting independence.
- Unhurried visits, mostly from registered nurses working in locality based teams of no more than 12 staff.
- Highly autonomous self-organising teams (intermittently supported by a

coach) who develop a flexible range of solutions to meet people's needs.

When compared to current models of community care (similar to those in Scotland) this model has resulted in better outcomes for people helping them to stay independent at home for longer, and when they do require hospital care, length of stay has been reduced. Compared with their former model, which involved numerous time limited visits from care workers focused on allotted tasks (or artificial boundaries between personal care and healthcare), this model has consistently produced more effective results with improved efficiency across the board.



2.1.1 National Support

There has been considerable interest from Scotland and elsewhere in the Buurtzorg model of neighbourhood care developed, and now widely adopted, in the Netherlands.

The Scottish Government is supporting the Buurtzorg principle

of neighbourhood care in Scotland, using the learning to accelerate progress with integration as well as the development of the health and social care workforce. A number of areas have expressed an interest in participating in nationally supported tests. Because Scotland is operating in a different context, the tests will need to reflect local circumstances and developments, including integration. To date three potential tests have emerged and are progressing with work to take these forward in their areas. These include Aberdeen City Health and Social Care Partnership, Borders Health and Social Care Partnership, and Cornerstone. There are a number of other areas which are at an earlier stage.

The test sites are being supported by the Living Well in Communities team in the iHub at Healthcare Improvement Scotland in partnership with Buurtzorg's UK agent Public World. There have been a number of visits to potential test sites to support them to develop their plans and there have also been three national meetings of a learning network. A national evaluation framework and guidance is being developed to support local learning and evaluation, and also to provide key insights to inform national policy going forward.

2.2 Development of Principles in Aberdeen

To ensure broad understanding of the approach and how it may differ from the existing models of nursing and community care in Aberdeen, a number of workshops took place at various times on 5th and 6th October 2016. These workshops, which were attended by almost 200 colleagues including Community Nursing, AHPs, Care Management, Third and Independent Sectors, provided an opportunity to find out about Buurtzorg including hearing from a Buurtzorg Netherlands Nurse. The workshops allowed questions to be asked and provided a space for considering how the application of the principles of Buurtzorg may be relevant to nursing and care at home activities in Aberdeen. These workshops were very well received, with those present reporting that they were excited and enthusiastic about what this approach might bring.

The Buurtzorg "neighbourhood care" principles that we are seeking to test in Aberdeen include:

- Person at the centre
- Autonomy of professionals and self-organising teams (within agreed framework)
- Prevention of admission/ supporting discharge from hospital
- Collaboration and co-production (developing solutions locally together)
- Developing local improvement capacity and capability
- Building social value

- Encouraging innovation
- Reduced fragmentation of care: delivery of holistic care
- Simplification of health and social care system

To "test and learn" in Aberdeen, it is proposed to develop two community teams including both nursing staff and care at home staff.

2.3 Key Considerations

To support the development and delivery of this new way of working, two groups have been established: an Operational Group whose members include frontline nursing staff from across the city (will also include care at home staff in due course), and a Governance Group whose members include senior staff from across the Health & Social Care Partnership and its Partners (including IT, HR and OD). Both groups are being supported by Public World Consulting with financial backing from the Scottish Government through Health Improvement Scotland.

Some of the key activities that are and will be developed include:

Developing the operational model – rules and framework within which integrated community teams will operate

- Team structure
- Capacity of team
- Care processes
- Culture
- Interfaces
- Team roles and tasks
- Team processes
- Team budget – team development, training and supplies
- Coach role
- Back office role

Human Resources/ Organisational Development considerations

- Process for starting up – selecting the site, selecting/ recruiting the team
- Recruitment process
- Peer supervision
- Sickness procedures
- Career progression
- Team development
- Training and support
- Selecting and training a coach

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Goals and indicators of success

- Aligned to the triple aim of the Aberdeen City Health and Social Care Partnership Strategic Plan: Improved health and wellbeing; improved experiences; reduced wastage and duplication
- Links to partnership's Integration and Transformation Evaluation Framework and benefits realisation
- Aligned with values of partnership: Caring; Person Centred; Enabling

Integration across health and social care

- Identify potential issues
- Clarify linkages with roles of social work, AHPs, GPs and wider Partnership, especially Care at Home providers

Understanding and mitigating potential issues with statutory and regulatory framework

- Links to relevant health and social care legislation and regulatory framework, where it may impact on the team and the framework they work within/ processes they follow
- What key data is required, and how is it shared appropriately
- Development of risk register

Back office and systems

- Design and set up of back office function to protect the team from organisational bureaucracy so that the team can focus on providing holistic care
- Responsibilities at senior level within partnership for resolving key challenges/ blockages and protecting team from wider system
- Having the appropriate IT in place to enable the team to provide safe holistic care, while minimising paperwork

Transformation process

- Minimise impact and potential to undermine existing community nursing service during test and implementation period
- Double running resource support where required
- Development of robust business case identifying resources required, and anticipated benefits, including when and how these will be realised and identified.

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2.4 Next Steps

A key milestone will be the selection of communities that the new integrated community teams will support. Due to the challenges relating to data sharing, clients within selected communities will receive individual information about the new way of working and will be asked if they would be willing to participate and share their relevant data (health, social care and care at home) in order to support the establishment of the new teams.

It is planned that the teams will include nurses and care at home workers, and the information provided by people who receive services in the potential communities (as described above) will be used to help identify Care at Home provider partners to develop the test.

Proposed Team Visit

While much has already been learned about the Buurtzorg approach, it is also felt that it would be helpful for a small team to visit the Netherlands to see for themselves how the system works in practice, and consider what can be learned from this system as we develop our Aberdeen model.

It is suggested that this small team would include a spectrum of representatives from the development teams, to ensure learning from a range of perspectives, taking into consideration the complexities of the project, including: operational front line nurse staff member(s), senior operational nursing manager, senior operational social work manager, care at home provider, IT/ systems representative, programme manager.

It is recommended that this small team is headed up by a member of the Executive Team.

The visit will be useful for developing learning relationships, as well as gaining direct experience of the detail of how this system works: from a patient perspective; care provider perspective; communications and development perspective; and overall management perspective.

The IJB is asked to endorse this proposed learning visit.

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3:	Equalities, Financial, Workforce and Other Implications

Financial Implications

At this stage in the project, based on evidence from Buurtzorg Netherland, it would be anticipated that if fully implemented this model of care would not exceed existing allocated resources, and may generate efficiencies.

Project implementation costs are likely to include backfill costs to allow care providing staff to fully participate in the development of the Aberdeen model. In addition some double running costs may also be required during the transition period.

Project management, evaluation and benefits management would be delivered from already agreed Transformation Programme Management infrastructure.

The development of the business case would fully identify the range of financial implications.

Costs relating to the study visit are anticipated to be around £500 per head (based on £200 per return flight, £200 for 3 nights accommodation, £100 subsistence). This gives an estimated total cost of £4,000 for a team of 8 people and will be funded from the Integration & Change fund.

Equalities Implications

There are no specific equalities implications as a result of this report.

Workforce Implications

The transformation to integrated teams providing care in communities will be a significant change to the way that nursing and care at home teams currently work. The transition approach seeks to directly involve these individuals in developing and implementing the new way of working.

4:	Management of Risk

Identified risk(s):

A risk register and mitigations will be developed and worked through as part of the

project process.

Link to risk number on strategic or operational risk register:

N/A

How might the content of this report impact or mitigate the known risks:

Learning from existing practice will support greater understanding of potential issues and how these issues may be overcome.

5:	Recommendations for Action

It is recommended that the Integration Joint Board:

1. Note the progress towards testing integrated community teams, using Buurtzorg principles, in Aberdeen.

2. Approve a cross sector team to visit the Netherlands to learn more about the approach in order to inform the development of this project, at an estimated cost of £4,000, funded from the Integration & Change fund.

6:	Signatures
	Judith Proctor (Chief Officer)
	Alex Stephen (Chief Finance Officer)