Aberdeen City Health & Social Care Partnership
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Integrated Neighbourhood Care Aberdeen (INCA) Test of Change

Evaluation Report

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ABERDEEN CITY COUNCIL

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Background

Given increasing demographic and economic challenges, there is a need to develop and test new models of delivering health and social care. One model gaining international attention is the Dutch model Buurtzorg, characterised by self-managing nursing teams providing person-centred care and founded on principles of empowerment and relationship-based practice. The model has shown promise elsewhere, and locally the decision was taken to apply and adapt the principles of this model to test their congruence within the Scottish context.

This report evaluates a new model of integrated care delivered by community-based, self-managing teams in Aberdeen.

Methods

The Integrated Neighbourhood Care Aberdeen (INCA) service went live in February 2018. A key difference between the INCA model and the Buurtzorg model was the use of integrated teams locally, as opposed to purely nursing that exists within the latter. The INCA model consisted of two teams comprised of three support workers and three nurses in each, working in two sites across Aberdeen (one team co-located within a GP practice, the other located in a non-partnership building with no health and social care staff on site). Teams had full autonomy over service operation, such as: care planning; care delivery; referral management; assessment; team rostering and work commitments (within an agreed framework).

The evaluation framework for this project was co-created over two workshops with the INCA team. Service data collected included number of referrals, days on caseload, type of care provided and reasons for discharge. Patient outcome data collected included quality of life (QOL), self-rated health and mental wellbeing assessments. Patient experience and satisfaction was measured through semi-structured interviews. Staff outcomes, including feelings of autonomy, value and overall satisfaction were measured at baseline and three months, with staff experience being collected through semi-structured interviews. A variety of stakeholders were also interviewed to understand their experiences of working with the INCA teams.

Results

Due to challenges in staff retention, results were collated between go live (26/2/18) and the final day of operating of the Cove team (29/6/18). There were 43 referrals into the service with a discharge rate of 49%. District nursing (DN) teams (46.5%) were the highest referrers

into both sites and large palliative caseloads resulted in a majority (38.1%) of discharges being due to patients dying.

Patients were very satisfied with the support they received (mean satisfaction score 4.9/5). Interviews with nine patients highlighted high-quality staffing and a strong emphasis on collaboration in the design and delivery of support. Pre-post outcome data collected from eight patients demonstrated improved scores in QOL and self-rated health in half of the sample. The remaining patients had not been on the caseload long enough to administer follow-up questionnaires, or were inappropriate to collect data from (such as if they were palliative).

Staff acceptability was mixed, with the INCA teams decreasing from 12 to six staff members by the beginning of June 2018. Interview analysis highlighted challenges regarding self-management, resolving conflict and a predominantly social-care heavy caseload. However, staff felt autonomy over frequency and duration of service delivery led to improvements in patient-centred care. Co-located staff appeared to respond more positively about their experiences. Stakeholders working with the INCA teams (such as General Practitioners (GPs) and existing community teams) commented on the support the service provided by allowing rapid access to care provision, however also acknowledged communication challenges, particularly with accepting referrals.

Discussion and recommendations

This service appeared to provide high-quality support to patients, particularly due to staff having control over frequency and duration of visits according to individual needs. Self-management should be situated within a clear operational framework and requires sufficient training and facilitation to succeed. Teams delivering new models of care need to establish and maintain communication links with existing teams to embed delivery into the wider system. Improving and implementing fit for purpose IT systems will enhance the quality of data that can be extracted and utilised to determine factors including capacity, patient-facing time and cost effectiveness.

Key points

- The INCA service appears to be highly acceptable to patients receiving the service.
- Perceived high-quality patient care was attributed to teams having autonomy to adjust frequency and duration of care, in addition to care continuity.
- High staff turnover was associated with nurses feeling de-skilled, leading to an undesirable work/life balance.
- The INCA model provided rapid access to social care, facilitated by being located within traditionally hard-to-reach geographical areas and the team having responsibility for both assessment and delivery of care.
- Co-locating an INCA team with existing primary and community care teams appeared to improve collaboration and job satisfaction.
- Integrated teams are not necessarily a prerequisite for integrated working.
- The Caseload Management Tool is not fit for purpose regarding data collection and extraction.
- For self-management to operate effectively, it requires a clear framework outlining which elements of service operation staff are accountable for.

1. Introduction

Health and social care services are likely to face increasing demand, with a 59% predicted rise in the number of individuals aged over 65 years in next 20 years[1]. This demand is complicated by a probable decrease in financial resources. In 2016-2017, NHS boards had to make savings at unprecedented levels of £390m, despite the continual growth of operating costs[2]. Therefore, there is a need to reconfigure how services are delivered, with wide acknowledgement that doing more of the same will not be effective towards coping with this demand. At both local[3] and national[4] levels, it is hoped that these challenges can be met through the integration of health and social care and that this may also result in enhanced service delivery and promotion of population wellbeing. To achieve this, innovation is championed and testing new models of delivering integrated care is required.

One such model gaining international attention is the Dutch Buurtzorg model[5]. This model is characterised by, self-managing, community-based nursing teams, consisting of no more than 12 individuals with an approximate caseload of 50-60 patients. Coaches are utilised, as opposed to managers, to facilitate team cohesion and communication, as opposed to providing clinical input. The model is founded on the onion care model, which places the individual at the centre of their care and utilises an enablement ethos, in addition to harnessing informal networks as support structures[6]. The Buurtzorg team have characterising principles including autonomy (providing nurses with the ability to make decisions and act upon them to support professional and holistic nursing care); collaboration (developing strong links with community connections and professional partners to ensure well-coordinated cross-system support); trust (providing a basis for shared leadership and autonomy within teams) and creativity (joint decision-making processes between patients, their networks and professionals to develop novel solutions)[7]. Reported results are predominantly positive. For example, Buurtzorg has

[1] Scottish Government (2016). A national clinical strategy for Scotland. Edinburgh: Scottish Government.
[2] Audit Scotland (2017). NHS in Scotland 2017. Edinburgh: Audit Scotland.
[3] Aberdeen City Health & Social Care Partnership. (2016). Aberdeen City Health and Social Care Partnership Strategic Plan 2016-19. Available from: https://www.aberdeencityhscp.scot/globalassets/strategic-plan.pdf [accessed 25/07/18].
[4] Scottish Government (2014). Public bodies (joint working) (Scotland) act 2014. Edinburgh: TSO.
[5] Kreitzer, M. et al. (2015). Buurtzorg Nederland: a global model of social innovation, change, and whole-systems healing. *Glob Adv Health Med*, 4(1), 40-44.
[6] Drennan, V. M. et al. (2017). The Guy's and St Thomas' NHS Foundation Trust Neighbourhood Nursing Team Test and Learn project of an adapted Buurtzorg model: an early view. Centre for Health & Social Care Research Joint Faculty of Kingston University & St. George's University of London
[7] Monsen, K. & de Blok, J. (2013). Buurtzorg: nurse-led community care. Creative Nursing, 19(3), 122-127.

the highest reported satisfaction rates of clients from all home-care organisations, in addition to reduced sickness absence rates (2.5%) compared with the Dutch average (6.3%)[8]. Therefore, aligning the key principles of self-managed, autonomous teams with the integration of health and social care has the potential to be a novel yet effective model to deliver efficient and effective person-centred care. However, this was untested in a Scottish context.

This report describes the evaluation of a new model of delivering integrated health and social care through self-managing, autonomous teams in Aberdeen City.

[8] Alders, P. (2015). Self-managed care teams to improve community care for frail older adults in the Netherlands. *Int J Care Coord*. 18(2-3), 57-61.

2. Context of implementation

In 2016, the Scottish Director of Health and Social Care Integration and Chief Nursing Officer invited Integration Joint Boards, health boards and local councils to engage in testing the principles of Buurtzorg in Scotland. In June 2016, representatives from Aberdeen City Health and Social Care Partnership (ACHSCP) attended a national event to learn about the principles, and were invited to become a test site to examine how these principles could work in the Scottish context.

Supported by Health Improvement Scotland's Living Well in Communities team and Public World, a series of local workshops were conducted in October 2016 which were attended by a number of stakeholders, including senior managers, community nurses, allied health professionals and commissioned care providers. It was agreed that change was necessary, with stakeholders agreeing that whilst the principles should be tested, they required adaptation to the local context.

A key difference identified was to test an integrated model (as opposed to a purely nursing model typical to Buurtzorg) and that care at home support workers should be core members of the team(s), working as equal partners with community nursing staff. The Buurtzorg "onion model"[9] closely aligned with ACHSCP's values, with staff striving to deliver person-centred care, drawing and building on informal as well as formal networks, and enabling service users to be as independent as possible. However, the way care was structured, with social care and nursing staff assessing and delivering care separately, as well as the nursing delivery model being made up of practice attached, direct delivery and out of hours teams, meant that there could be multiple different staff visiting each service user, and a coordinated, enabling approach difficult to achieve in reality. It was felt that testing the Buurtzorg principles in an integrated team would overcome these barriers and be congruent with the local agenda for change.

A project team was formed to begin planning implementation, and it was agreed that support workers would be employed through Bon Accord Care, Aberdeen City Council's local authority

[9] Drennan, V. M. et al. (2017). The Guy's and St Thomas' NHS Foundation Trust Neighbourhood Nursing Team Test and Learn project of an adapted Buurtzorg model: an early view. Centre for Health & Social Care Research Joint Faculty of Kingston University & St. George's University of London

trading company. Living Well in Communities and Public World supported a study visit to Almere in the Netherlands in June 2017 and by the end of October 2017, the 12 team members had been recruited.

3. Rapid scoping of the literature summary

A rapid scoping review was conducted to understand key findings from previous similar projects. The rationale of this exercise was not to provide a meticulous account of all published material, rather to provide a breadth of understanding from which to develop a bespoke evaluation framework for this project (described Section 3.2.1). Literature was identified using a combination of databases (e.g. PubMed and Medline), published reports and reference lists. The scoping process was limited by the majority of Buurtzorg literature being published in Dutch. Below, beneficial outcomes from Buurtzorg models are identified to provide examples of work undertaken previously, however this is not an exhaustive list. These are structured relative to locally-developed outcome groups of interest: patient outcomes; staff outcomes; resource/service outcomes; and unpaid carer outcomes.

3.1 Patient outcomes

A sample of identified patient outcomes are visible in Table 1. Buurtzorg models show high satisfaction rates amongst patients, particularly in staff quality. Some reports have also cited that due to enhanced patient outcomes, the average number of home care hours delivered are half of equivalent services.

Table 1. Example patient outcomes identified from scoping review

Outcome	Score	Source
Overall satisfaction	91%	Monsen & de Blok (2013)[10]
Perceived staff quality and participation	Ranked 3rd – 6th / 360 organisations	Alders (2015)[11]
Average number of home care hours delivered per patient year	50% reduction (due to patient improvement)	de Blok & Kimball (2013)[12]

3.2 Staff outcomes

A sample of identified staff outcomes are visible in Table 2. Overall staff satisfaction for this way of working is high, with other proxy measures (e.g. staff turnover and staff sickness) also comparing favourably to the industry average.

Table 2. Example staff outcomes identified from scoping review

Outcome	Score	Source
Satisfaction	95% for involvement 89% for overall satisfaction	Nandram (2015)[13]
Staff turnover	10% (15% industry average)	Gray et al. (2015)[14]
Staff sickness	3-4% (6-7% industry average)	de Blok (2013)[15]

[10] Monsen, K. & de Blok, J. (2013a) Buurtzorg Nederland: A nurse-led model of care has revolutionized home care in the Netherlands. *J Am Nurse*, 113(8): 55–59

[11] Alders, P. (2015) Self-managed care teams to improve community care for frail older adults in the Netherlands. *Int J Care Coord*, 18(2–3): 57–61

[12] de Blok, J. & Kimball, M. (2013) Buurtzorg Nederland: Nurses Leading the Way! [online] AARP The Journal, Spring 2013 Available at: http://journal.aarpinternational.org/a/b/2013/06/buurtzorgnederland- nurses-leading-the-way [Accessed on 27 July 2017]

[13] Nandram, S. S. (2015) Organizational Innovation by Integrating Simplification: Learning from Buurtzorg Nederland. Cham: Springer

[14] Gray, B. H. et al. (2015) Home Care by Self-governing Nursing Teams. [online] The Commonwealth Fund. Available at: http://www.commonwealthfund.org/publications/casestudies/ 2015/may/home-care-nursing-teams-netherlands [Accessed 28 July 2017]

[15] de Blok, J. (2013). Buurtzorg: better care for lower cost. [online] Presentation at King's Fund. Available at: http://www.kingsfund.org.uk/sites/files/kf/media/jos-de-blokbuurtzorg-home-healthcare-nov13.pdf [Accessed 28 July 2017]

3.3 Resource / service outcomes

A sample of identified resource / service outcomes are visible in Table 3. Promisingly, Ministerial Strategic Group (MSG) Integration Indicators[16] such as emergency admissions have shown positive results through Buurtzorg models, in addition to demonstrating positive financial performance.

Table 3. Example resource/service outcomes identified from scoping review

Outcome	Score	Source
Emergency admissions	1/3 of similar organisations	Laloux (2014)[17]
Average hospital length of stay	Lower than similar organisations	Ernst & Young (2009)[18]
Average non-adjusted cost for home care per patient annually	1749 Euro less	Gray et al. (2015)[19]

3.4 Unpaid carer outcomes

A sample of identified unpaid carer outcomes are visible in Table 4. Family members are reported to be satisfied with the Buurtzorg model, particularly citing improvements in practice compared with previous experiences with traditional community nursing teams.

[16] Scottish Government. (2017). Measuring performance under integration. Available from: http://www.improvementservice.org.uk/documents/OEPB/board-papers-aug2017/oepb-31aug17-item4a-letter.pdf [accessed 26 July 2018]

[17] Laloux, F. (2014) Reinventing organisations: a guide to creating organisations inspired by the next stage of human consciousness. Brussels: Nelson Parker

[18] Ernst & Young (2009). Maatschappelijke Business Case Buurtzorg Nederland. Report by Ernest & Young. http://www.transitiepraktijk.nl/files/maatschappelijke%20business%20case%20buurt zorg.pdf [Accessed: 1 Aug 2018]

[19] Gray, B. H. et al. (2015) Home Care by Self-governing Nursing Teams. [online] The Commonwealth Fund. Available at: http://www.commonwealthfund.org/publications/casestudies/2015/may/home-care-nursing-teams-netherlands [Accessed 29 July 2017]

Table 4. Example unpaid carer outcomes identified from scoping review

Outcome	Score	Source
Acceptability	Reported positive change in nursing practice vs. community nursing teams	Drennan et al. (2017)[20]
Satisfaction	Not reported	Kreitzer et al. (2015)[21]

[20] Drennan, V. M. et al. (2017). The Guy's and St Thomas' NHS Foundation Trust Neighbourhood Nursing Team Test and Learn project of an adapted Buurtzorg model: an early view. Centre for Health & Social Care Research Joint Faculty of Kingston University & St. George's University of London

[21] Kreitzer, M. J. et al. (2015). Buurtzorg Nederland: A Global Model of Social Innovation, Change, and Whole-Systems Healing. *Glob Adv Health Med*, 4(1), 40-44.

4. Method

4.1 Design

The Integrated Neighbourhood Care Aberdeen (INCA) project began taking referrals in February 2018 as part of ACHSCP's transformation programme to redesign service delivery locally. Two teams consisting of three care at home support workers (SW) and three nurses each were recruited and based within two separate locations to inform implementation – one within a General Practice (Peterculter; West locality) and another in a corporate office (Cove; South locality). Similar to the Dutch Buurtzorg model, a coach was accessible to the teams, however they were sourced externally from another provider (Cornerstone) who were implementing Buurtzorg principles, rather than being employed in-house. The function of the coach was to support the team with anything they required, for example self-management and team working. Teams received both nursing and social care referrals and managed their own caseload, completing a full holistic assessment of both nursing and social care needs, in addition to planning care provision and rotas. The framework that guided service operation is available as Appendix 1. Inclusion criteria for patients were: living in the correct postcode area and not currently in receipt of nursing or social care. Exclusion criteria were patients living outside relevant postcode area and already in receipt of nursing or social care support. Pre-existing community nursing teams in Cove and Peterculter continued to provide nursing care to local residents who were already on their caseload before the project started, and referrals for nursing care were filtered by these teams to ensure that only those with a new need were picked up by the INCA teams. Similarly, social care referrals were sent to social work via pre-existing channels, and those that fitted the INCA criteria were forwarded onwards to the teams. Residents of Cove and Peterculter who were already receiving social care prior to the start of the INCA project continued to receive this from their existing provider. The full referral process is available in Appendix 2.

Whilst this was scheduled to be a two year pilot project, this evaluation presents findings over the first four months of implementation. This is due to staff retention challenges, meaning that the INCA team based in Cove ceased care provision as of 29/6/18.

4.2 Data collection and analysis

4.2.1 Evaluation framework development

This evaluation framework was developed through two co-creation workshops, based on theory described in detail elsewhere[22]. Workshops were facilitated by a Research & Evaluation Manager and a Public Health Researcher and held with the INCA team and lasted between 3-4 hours. In workshop 1, co-creators discussed what key outcomes they wanted the project to achieve and which components were crucial to measure in order to determine project success. The evaluation was split into two types: 1) process evaluation (thinking about the implementation of the project) and outcome evaluation (understanding the impact on citizens and patients; unpaid carers; staff; and resources and services). The scoping review (Tables 1-4) was used as a starting point for considering most appropriate measures. Co-creators were shown examples of the literature for each target population group to stimulate their thinking. In smaller groups, co-creators discussed which outcomes were most important to measure. Each smaller group then fed back their ideas to the wider group. Facilitators then supported the co-creators to collectively decide and prioritise what the key desired components to measure would be.

The purpose of workshop 2 was to confirm agreement of desired components to measure (decided in workshop 1) and to explore the practicalities of demonstrating the desired outcomes (e.g. when, how and who would collect the relevant data). Possible indicators and approaches to data collection (e.g. interviews, focus groups, and questionnaires) were discussed in three smaller groups, fed back to the larger group and collectively agreed with all co-creators. The two facilitators used the information collected in both workshops to develop the final evaluation framework.

The developed framework was utilised as a "best case scenario" guide, as given the complex system in which this service is being trialled, it would be necessary to ensure the framework was agile and adapted to changing circumstances and needs. Therefore, it was acknowledged and agreed by the group that the co-created framework developed initially may not be exactly reproduced after a period of service implementation.

[22] Leask C F. et al. Principles and recommendations for utilising participatory methodologies in the co-creation and evaluation of public health interventions. *RIAE* (Submitted)

4.2.2 Service level data

A variety of service-level data were collected, including caseload characteristics, referral source, days on caseload, along with number and reasons for patient discharge. The Microsoft Excel based Caseload Management Tool (used by community nursing teams across Aberdeen City), was the system used to collate information. However, this system is not optimal for data extraction, with numerous challenges apparent when attempting to quantify certain elements of care, such as care duration.

4.2.3 Patient measures

4.2.3.1 Patient outcomes

Patient outcomes measured were QOL; self-rated health; emotional wellbeing; social support; physical activity; diet; alcohol consumption and smoking. Outcomes were measured using a co-created questionnaire that was administered to patients on initial assessment and again after three months. For pragmatic purposes, constructs were predominantly assessed using uniscales (i.e. single-item assessments)(Appendix 3).

4.2.3.2 Patient experience

Interviews were based on a semi-structured topic guide. Discussions were based on a series of exploratory questions regarding patients' experience of being supported by the INCA teams. Example questions included: *"Tell me about the support you get from the INCA team?"* and *"Have you noticed any changes to your health and wellbeing as a result of seeing the INCA team?"* (Appendix 4). Interviews lasted no more than 60 minutes and were audio recorded. Field notes were also taken during discussions and used as a reference point during analysis.

Audio recordings were transcribed verbatim and analysed thematically. Thematic analysis is useful towards understanding patterns occurring in the data in order to improve understanding on a particular topic[23], such as the experience of being cared for by a self-managing, integrated health and social care team. Analysis followed the six step framework previously described by Braun and Clarke[24], including: 1) familiarisation with the data; 2) developing initial codes; 3) searching for themes; 4) reviewing themes; 5) theme definition and 6) write up of results. The data were analysed independently by two researchers and then findings compared and adapted if required.

[23] Maguire, M & Delahunt, B. (2017). Doing a thematic analysis: a practical, step-by-step guide for learning and teaching scholars. *AISHE-J*; 9(3).
[24] Braun, V. & Clarke, V. (2006). Using thematic analysis in psychology. *Qual Res Psych*, 3(2), 77-101.

Satisfaction questionnaires were also distributed to patients, focusing on constructs of prevention, choice and overall satisfaction that were agreed during the co-creation workshops (Appendix 5).

4.2.4 INCA Staff measures

4.2.4.1 INCA Staff experience

Individual interviews were conducted with eight staff members once the Cove site completed operation. Interviews followed a semi-structured topic guide and discussions were based on a series of exploratory questions regarding their experience of working in this model. Example questions that were asked included: "*How did you find working in a self-managing way?*" and "*Was there anything that helped to make this new way of working successful?*" (Appendix 6). Interviews lasted approximately 60 minutes, with discussions being audio recorded. Field notes were taken during interviews to be used as a reference point when conducting analysis. These interviews were supplemented with exit interviews carried out with staff who decided to leave their post throughout the duration of the project (staff retention rates are visible in Figure 7).

Audio recordings from each interview were transcribed verbatim and analysed thematically (as described previously).

4.2.4.2 INCA Staff outcomes

The INCA team involved in the co-creation of this evaluation described three top outcomes they wanted from this job: 1) feeling valued for the work they do; 2) autonomy and 3) belonging (as part of a team). A questionnaire was co-created from which numerous detailed components were aggregated to ascertain to what extent the above were achieved (Appendix 7). Outcomes were assessed at baseline and at three months.

4.2.5 Partners' experience

Nine interviews were conducted with a variety of partners who engaged with the INCA team, including the project leads (PM) (n=3); GPs referring into the service (n=2); members of community nursing teams referring into the service (n=2) and social care referrers (n=2). Interviews lasted approximately 60 minutes and explored Partners' experience of working with the INCA team (Appendix 8). All discussions were audio recorded and transcribed verbatim. Analysis followed the same process described previously.

5. Results

5.1 Evaluation framework development

5.1.1 Evaluation framework co-creation workshops

The attendees of the co-creation workshops are described in Table 5.

Table 5. Co-creation workshop attendees

Workshop 1	Workshop 2
Research Manager x 1	Research Manager x 1
Public Health Researcher x 1	Public Health Researcher x 1
INCA Support Worker x 6	INCA Support Worker x 6
INCA Nurse x 6	INCA Nurse x 6
Nursing Service Manager x 1	Nursing Service Manager x 1
Strategic Advisor for Person Centred Care x 1	Transformation Programme Manager x 1
Transformation Programme Manager x 1	

5.1.2 Feedback on co-creation process

At the end of the process, feedback forms were distributed to the members. These included components around perceived skill / knowledge development, overall satisfaction and ownership in the process. Results are displayed in Table 6. Overall, the findings were predominantly positive, with constructs around organisation, enjoyment and knowledgeable facilitators scoring highest.

The following sections describe the data collected and analysed for this project.

Table 6. Responses from co-creation workshop 1 evaluation

Question	Dimension	Strongly disagree	Disagree	Neither	Agree	Strongly Agree	% agree
The purpose of the workshop was clearly described	Clear purpose	8%	8%	8%	23%	54%	77%
I gained new knowledge/skills from the workshop	Knowledge/skill development	8%	15%	15%	23%	38%	61%
I enjoyed participating in the workshop	Satisfaction	15%	0%	0%	38%	46%	84%
The facilitator was a good communicator	Facilitator good communicator	15%	0%	0%	15%	69%	84%
The material was presented in an organised manner	Organised workshop	15%	0%	0%	15%	69%	84%
The facilitator was knowledgeable on the topic	Knowledgeable facilitator	15%	0%	0%	8%	77%	85%
I made a valuable contribution towards the success of this workshop	Empowerment	8%	8%	8%	46%	31%	77%
I would be interested in attending similar workshops in the future, should they be relevant to me	Commitment	8%	8%	0%	31%	54%	85%
For this project, co-creating an evaluation framework is better than individually developing one.	Co-creation better?	15%	0%	0%	15%	69%	84%

To provide consistency, the results below are presented between the dates that both teams went live (26/2/18) and the final day of operating of the Cove team (29/6/18), unless otherwise stated.

5.2 Service overview

5.2.1 Caseload characteristics

The characteristics of the INCA caseloads are visible in Table 7. There were slightly more female patients, the majority of whom were an older cohort. However, large variability in the age and number of days on the caseload were apparent, with approximately half of the patients being discharged since the service's inception.

Table 7. Characteristics of INCA caseload (up until 29/6/18)

Characteristic	Overall	Cove	Peterculter
Caseload, N	43	19	24
Female, N (%)	23 (58)	11 (58)	12 (50)
Age, mean (range)	78 (26-95)	76 (26-95)	80 (52-93)
Caseload days, mean (range)	61 (5-123)	57 (5-109)	64 (11-123)
Discharged, N (%)	21 (49)	9 (47)	12 (50)

5.2.2 Referrals

Figure 1 shows referrals by month across teams and overall. March saw the highest number of referrals for both teams, with a subsequent decrease in referrals monthly thereafter.

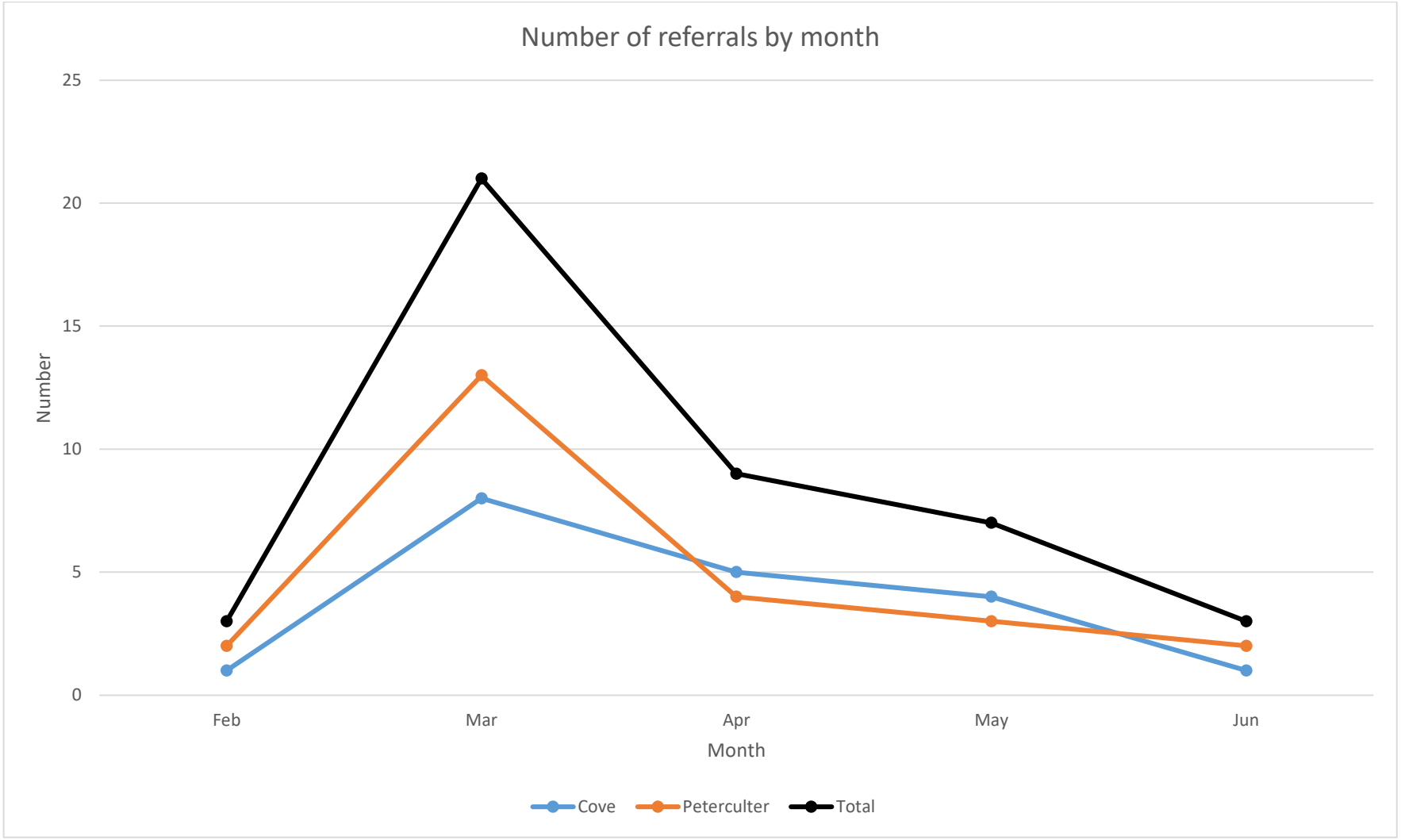

Figure 5. INCA monthly referral rates

Figure 2 shows the source of referrals overall and per team. Community nursing teams (46.5%) were the highest referrers both overall and for each team. The majority of the total remaining referrals came from Care Management (18.6%) and GP (16.3%) respectively. It was interesting to note, however, that there were also instances of self-referrals and family members referring into the service across teams.

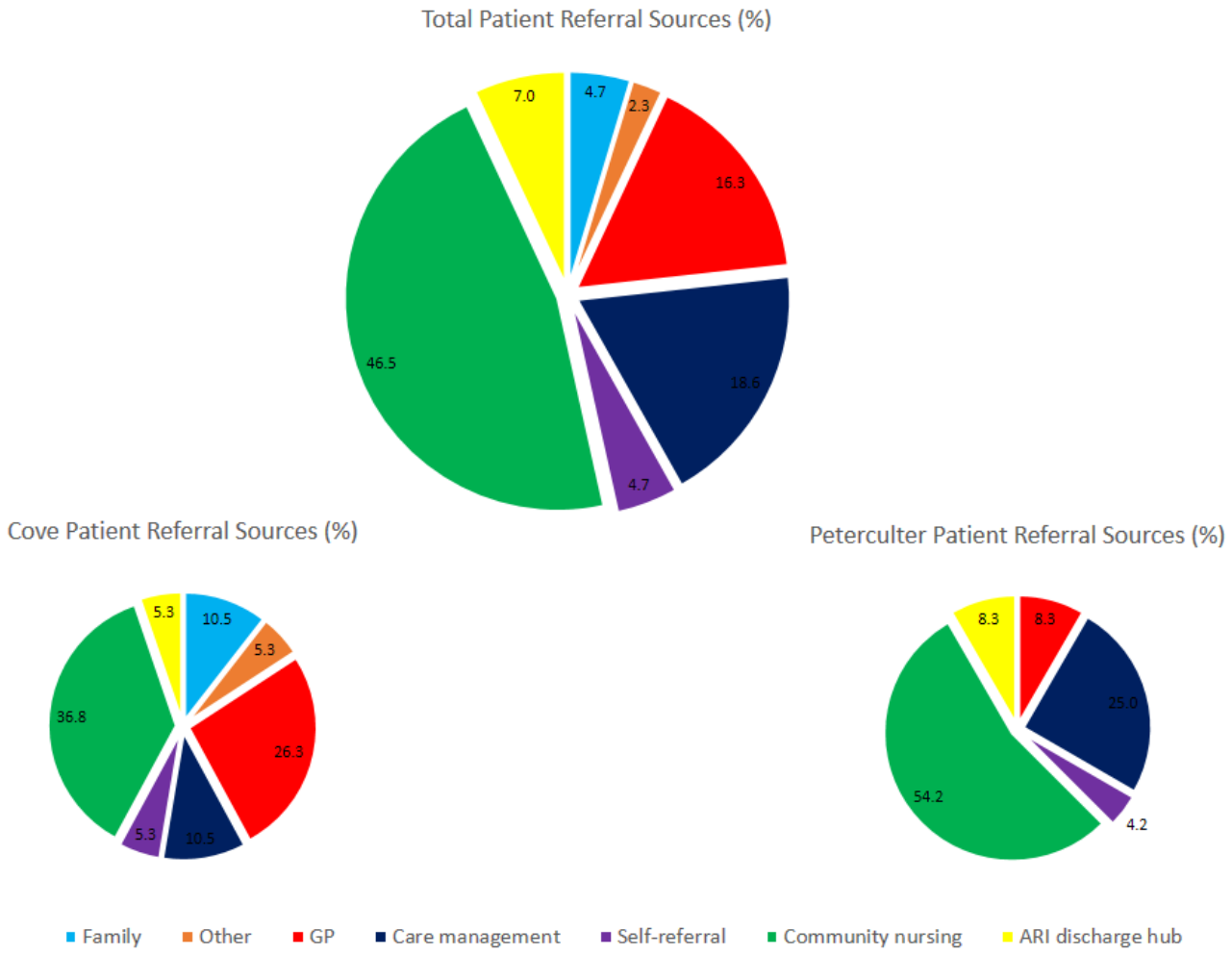

Figure 6. INCA referral sources

The primary diagnosis for patients being referred to INCA teams is presented as bar charts in Figure 3. Overall, there were a variety of primary diagnoses, with cancer (14%), Chronic Obstructive Pulmonary Disease (COPD; 11.6%) and Type 2 Diabetes (9.3%) the most commonly reported.

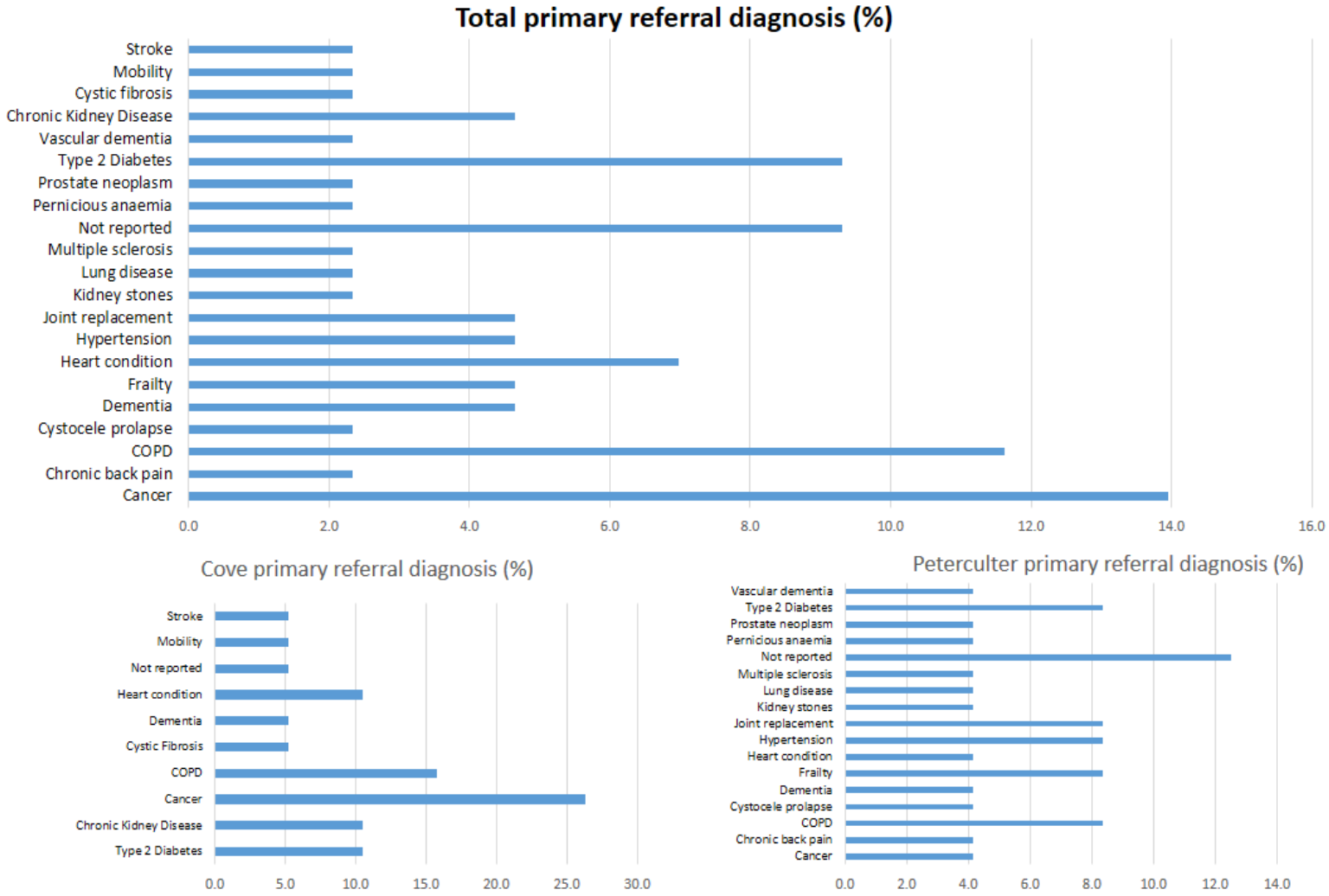

Figure 7. INCA primary referral diagnosis

5.2.3 Patient discharge

As aforementioned, Cove and Peterculter discharged 47% and 50% of patients respectively up until 29th June 2018. Figure 4 details the reasons that patients were discharged. Both sites had a caseload of numerous palliative patients, resulting in 38.1% of total discharges due to patients dying. Of all discharges, 23.8% were due to input no longer being required from the INCA team.

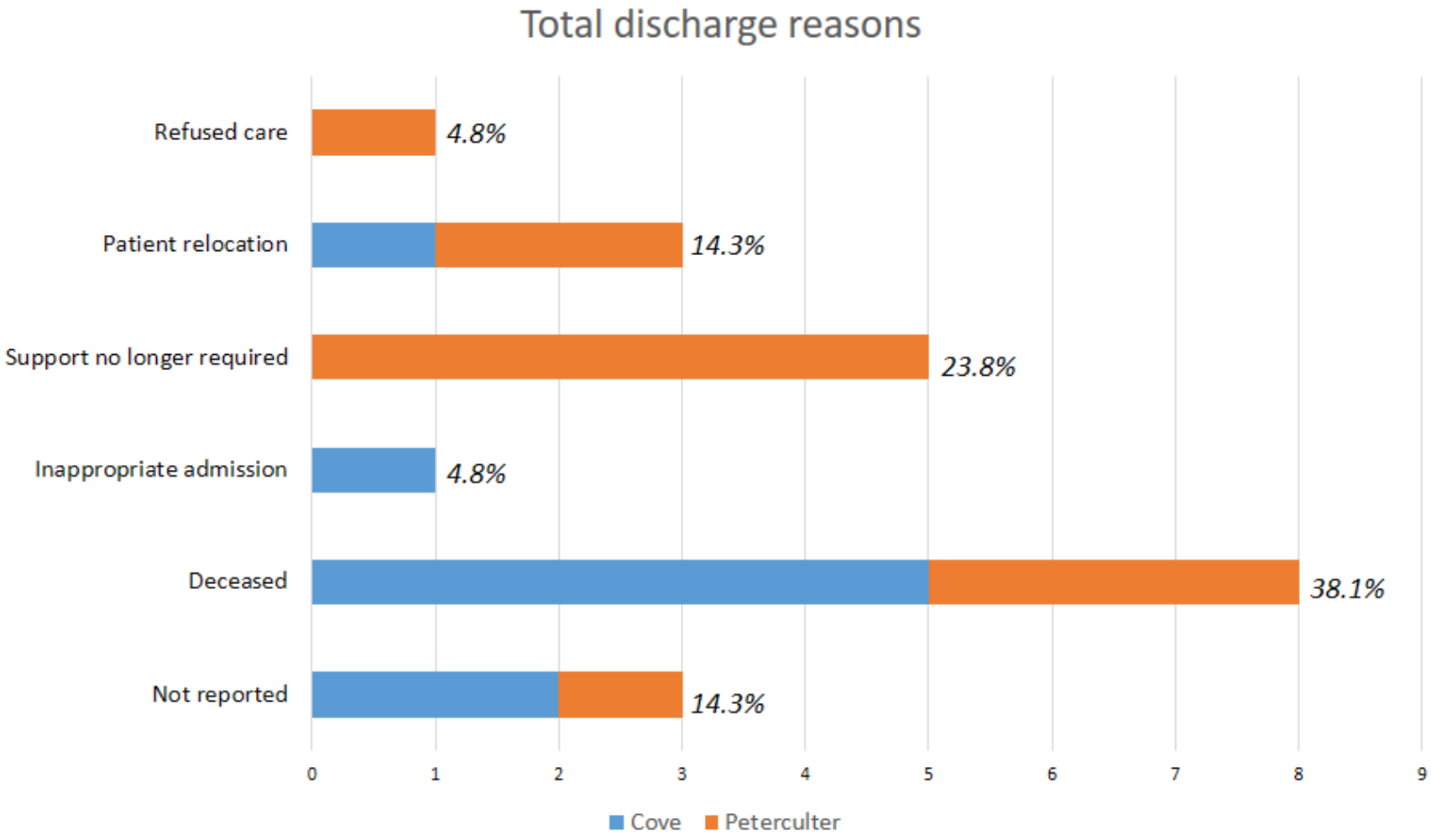

Figure 8. INCA discharge reasons

5.2.4 Interventions

Regarding data such as the number of visits and time spent with patients, the caseload management tool was not optimal for data extraction. Interventions are scheduled individually and may often be carried out at the same visit, but the Caseload Management Tool does not make this clear. Staff using the Caseload Management Tool have no ability to input the start and end time of visits. As such, to provide an indicative idea of the number and types of interventions, the month of May 2018 was selected to provide an overview of activity.

Table 8 shows the number of recorded interventions by time of day. Both teams totalled a similar number of total interventions, with the majority of interventions occurring in the morning. When accounting for the number of days for which data was available, the average number of interventions per day were 16.6 (Cove) and 21.6 (Peterculter).

Table 8. Number of interventions recorded in May 2018

Team	Number of Interventions			Total
	AM	PM	Unavailable data	
Cove	206	170	8	384
Peterculter	226	150	13	389
Grand Total	432	320	21	773

Figure 5 shows the number of interventions per day across both sites. The highest and lowest interventions per day for Peterculter were 23 and seven, with the same values from Cove being 17 and nine respectively.

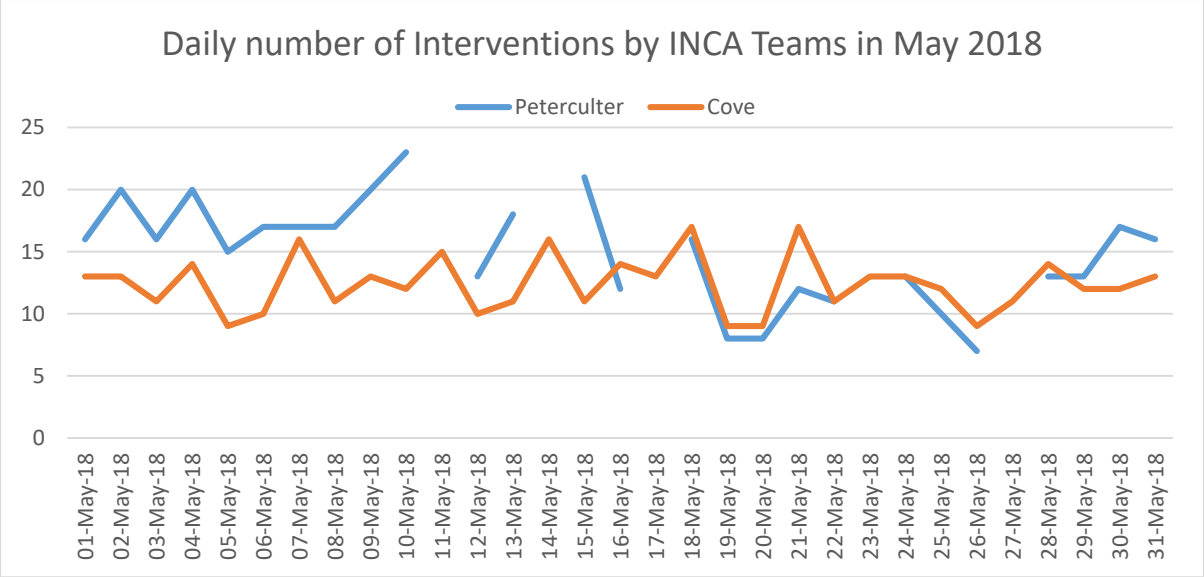

Figure 5. Daily number of interventions by INCA teams. NB: breaks in the Peterculter line indicate days where no daily plan was available to extract data from.

Figure 6 shows the type of interventions that both sites were delivering. The majority of interventions required social care input, for example personal care and meal support, whilst nursing activities were a smaller percentage of workload. As aforementioned, challenges with data entry using caseload management tool meant that, unless specifically stated, it was not possible to distinguish between phone calls and face-to-face visits.

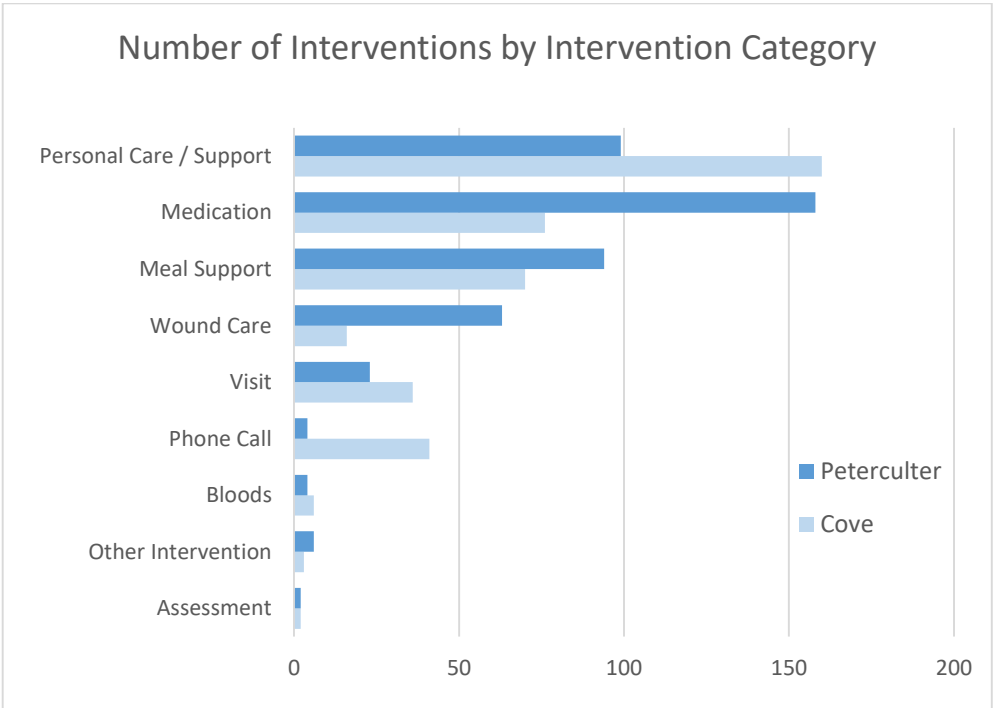

Figure 6. Number of interventions by intervention category

5.3 Patient results

5.3.1 Patient experience

Table 9 outlines the characteristics of patients who were interviewed in Cove (C) and Peterculter (P). The number and sex of interviewees was consistent across both sites, with one man and three women from each participating. The cohort were predominantly older (mean age = 83 years) and were referred onto the caseload with a variety of initial diagnoses associated with ageing.

Table 9. Interviewed patients demographic information

Participant ID	Age (yrs)	Sex (M/F)	Referral reason/diagnoses	Referral source
C1	95	F	Mobility	Social care management
C2	93	M	Mobility	Family
C3	91	F	Heart failure	GP
C4	84	F	T2D	Family
P1	86	F	Cancer	GP
P2	85	F	Frailty	Community nursing team
P3	64	F	Multiple sclerosis	Hospital discharge team
P4	66	M	Lung disease	Social care management

NB: GP = General Practitioner; T2D = Type 2 Diabetes

4.3.1.1 Themes

Table 10 outlines the four themes that emerged from thematic analysis: 1) Service Operation; 2) Staff Qualities; 3) Acceptability & Assets; 4) Confounding Factors. Each of these themes had a number of identified sub-themes that are described below. Due to the small sample of individuals interviewed, ascribing quotations to specific patients has been removed.

Table 10. Themes and sub-themes derived from patient interviews

Theme	**Sub-theme**
Service Operation	Care content
	Collaboration
	Delivery mechanisms
	External support
Staff Qualities	Caring

	Concern for safety
	Encouragement
	High quality staff
	Respectful
	Staff helpful
	Supportive
Acceptability & Assets	Patient characteristics
	Patient outcomes
Confounding Factors	Care discontinuation
	Consequences of ageing

4.3.1.1.1 Service Operation

Care content –There were numerous examples described by patients of the care that they received, unique to their individual needs. For example, the INCA teams were able to support patients with aspects of personal care: *"They come to help you with the showers and that"*, as well as providing clinical care to those who required it: *"The support I need at the moment is for my ears and eyes also my foot"*.

As the INCA model did not restrict patients to pre-designated times and days of care delivery, staff had the autonomy to arrange home visits at a time that was mutually beneficial: *"Initially it was first thing in the morning to get me up and then at bedtime to get me back into bed"*. Managing their own time also meant that staff could be flexible, with patients providing examples of longer or shorter periods of support as required: "*There has been one or two changes of course but there are four of them coming in here at different times"*. Over time, as patients became more independent, the number of visits they received reduced accordingly: "*In five months they got me from three times a day to be independent enough to have them just coming in once in a while, just a courtesy visit*".

Collaboration – Patients described forming a working partnership with staff and having active input regarding what care they received, for example: "*We talk about it and I have suggested about changing my going to bed time could be a bit earlier.... is an opportunity if there is something I want to say or something I need help with"*. Patients also commented how the

INCA team ensured their unpaid carers were involved in decisions around the support they received. This resulted in feelings of ownership in the care process and an associated open dialogue between families and staff: "*So say they came in and X (patient's daughter) phoned me then the Nurse would have a word with her and I will say 'do you want to tell X anything?' it gives X confidence because she'll say 'are you sure you are alright mum, you're not just saying that?'. No, I'm not. So they know and they try to involve people, but in a nice way*".

Good communication with staff was not only seen to encourage patients to take control of their own health, but led patients to express feelings of empowerment: "*I mean I like to do little things for myself and they will leave me to do it. You know, so I said 'don't fuss over me, if I need you I'll shout', so they have all just rallied round. That's about all I can say really. They respect your wishes"*. Patients felt that the strong alliances that they had with staff directly contributed towards the re-ablement process: "*we agreed between us they would come in twice a day and then eventually as I was recovering and getting better through physiotherapy"*.

Delivery mechanisms – Patients unanimously agreed that the care delivered to them was positively received. Aspects that they specifically commented on included the availability of the team: "*If I need them, I phone them and they will be down"*, the stability of care provided: "*I don't feel abandoned, I feel supported"* and the overall reliability of staff: "*They are always here about the time they say they will be"*.

Patients were conscious of staff having to attend others on their caseload with varying needs, signalling their appreciation for the amount of input they received: "*I am aware that there is certainly more than me around and I don't know how health conditions are for people without the area"*. One patient did remark that they felt staff had excessive paperwork to complete and was unwieldy to store within their home: "*I have got stuff lying through there, on that dresser and they are writing in that writing books, I wonder if they are writing a book about me, it's taking up a lot of space and I have to keep that space for them, will just throw it in the bin because that's what's going to happen to it*".

External support - Patients described the INCA team working with their family/friends where possible to enhance external support structures that facilitated patient mobility out with their home. The assistance provided by family members in turn aided staff by contributing towards

patient re-ablement: "*I cannot get out by myself but then I don't need them to take me out because my son's .... I know if I phoned them, any of them, they would be here. I know they would"*. Family and friend involvement in patient care ensured that, where possible, patients continued with everyday activities and experienced social inclusion: *"I have my cousin who stays about 2 minutes from here and we go shopping on a Tuesday... Maureen and I meet every week and we do it together, she is very helpful".*

Regarding their network of support, patients reported being signposted to relevant community groups, such as tea dances or Men's Shed: "*Well they asked me if I would like to go [to a community group]"*. However, patients did identify barriers to attending these services, such as no wheelchair access: "*I am on 2 crutches and then when I do go out I need a wheelchair and getting into places, sometimes there is no access for wheelchairs".* Others did not perceive barriers to attending community assets, however felt them unnecessary given the strong family connections they had locally: "*Yes, they did [signpost], but I think meantime I've got my daughter and granddaughter"*.

Recognition was given to the INCA staffs' ability to engage with other professionals to provide additional support when required by patients. For example, the team were able to quickly gain patients access to further services that they otherwise had found challenging to receive: "*If we wanted to ask about some other service or something, they might be able to put in their outlines. I had said to the clinic that I hadn't seen a Physiotherapist since I had come home and then they saw about this for me ... if we are wondering about something, some other help or something, they would try and find out for you"*.

4.3.1.1.2 Staff Qualities

Patients reported positively of their experiences with all the staff members and several traits were frequently highlighted. Examples of these include: responsible staff; "*I think they do a good job. We are very fortunate here to have them and they never fail to come in so that's good"*, respectfulness; "*I mean there's nothing that she wouldn't do for you... she takes time to have a chat with you... you can speak to them. You know they would take time and listen to you"*, supportive; *"if I ask them to move anything, they would do it, just no hardship at all. They are very willing and a very nice group of people"* and caring: "*I don't remember much at the start, because I really wasn't well then..... then I came home and the ladies have been there since. I mean they were so helpful, even just speaking to them, you know and then it*

slowly got better and better and better". These qualities resulted in patients having strong feelings of trust: "*I can depend on somebody to do something about it … I needn't feel I'm alone"* and that staff were providing a person-centred service: *"The girls have been helpful, they have come in and if I want anything done then they will do it"*.

Patients expressed a genuine concern from staff regarding their safety and wellbeing. For example, one individual described a recommendation from a staff member to have alarm systems installed in case of an emergency, for when team members may not be there to assist: "*They have been concerned about my safety since day one.... they will not let me get myself into any dangerous situation. If they felt it was not appropriate for me to do something, they wouldn't let me do it... INCA suggested that I get a panic button... and I thought brilliant"*. These feelings extended to ensuring disability aids in the home were used correctly and safely: *"we go upstairs on my ... I've got a lift, so they see that I am on my lift right and see that I am strapped in"*, in addition to staff providing supportive supervision when patients were trying new aids/equipment to support their recovery: " *When I got the walker for a start, I was able to go out, somebody took me sometimes.... so we just walked around the corner and back again which was very kind of them"*.

Although staff ensured that patients were not attempting to unsafely escalate the re-ablement process, it appeared that patients gained motivation from the team to aid their recovery, for example by discouraging sedentary behaviour: "*they were super in encouraging me to not just sit about. They got me going and encouraged me to get up to go to the bathroom and back and ... because they were encouraging me so much to get me going"*.

4.3.1.1.3 Acceptability & Assets

Patient characteristics – Patients described a desire not to become dependent on the care that they were being provided with and instead, discussed a shift towards self-managing elements of their health: *"I am trying to be self-sufficient as much as possible. I do what I can"*. Even though service provision was free and tailored to the individual, it was evident that patient's felt retention of control and continuing to complete tasks of everyday living they were capable of doing was important: "*there are a few things that I can do myself and I keep saying to them 'no, don't make me redundant all the time"*.

Patient outcomes – Interviewees were agreed in detailing the positive impact the INCA team had on their wellbeing. For some, simply receiving a telephone call to alert them of an up-coming visit had a positive effect on self-assurance: *"really helps my confidence as I know someone is coming and that is a big thing for me anyway knowing that someone will be along"*. This model of care and support appeared to build on patient's self-efficacy, with patients more likely to attempt to do more by themselves, knowing that support was at hand: *"As long as they are here when I am showering, I have no confidence to go in the shower myself, but they sit here and if I need them I shout"*. Furthermore, patients spoke of the learning experience that existed through detailed interactions and building relationships with the staff and provided examples whereby they had made positive changes to lifestyle behaviours over time: "*I am learning more and more as the time goes by and just watching my diet more than anything else"*.

For some patients who had reduced mobility and were socially isolated, the companionship that the staff provided resulted in improved mental wellbeing, such as reduced feelings of loneliness: *"I know they are coming and I am grateful for them to come in just to speak to because there is nobody else ... I like their company when they come in....I have made friends"*. In addition to personal outcomes however, patients described the relationships that they formed with staff over time that went beyond simply providing care, but into friendship: "*I just used to look forward to her visits and hear about her grandchildren and she heard about mine and that was just the highlight of my day"*.

4.3.1.1.4 Confounding Factors

During the time of interviewing, challenges with staff retention resulted in care being discontinued in one site. This had a direct impact on patients' experience, all of whom reported disappointment in their support coming to an end: "*I'm getting them moulded into my way and you are taking them away and putting them someplace else"*. There was reference from a number of patients who appreciated the low staffing numbers in each team and this was identified as a possible consequence to staff moving on: "*there is often one Carer on alone to do the whole thing. That is hard going for one person... but they are especially busy in the morning"*.

Despite the high-quality of support described, some patients acknowledged that simply the process of living into old age had a deleterious effect on their health: "*I could do a lot more*

before". However, these feelings of ill-health did not relate to the care received, but to patients' capabilities pre-referral to the team: *"I am not managing so well now"*.

5.3.2 Patient outcomes

Pre-post outcome measurements were available for eight patients across the two sites (Table 11). There were numerous reasons for this low number, but primarily because patients had not been on the caseload for a long enough duration to administer follow-up measurements. In addition, palliative patients and those who were inappropriate referrals also did not have these measurements taken. Half of patients noted positive changes in QOL, self-rated health and diet over 3 months. Four patients noted a two-point increase in self-rated health, the equivalent of moving from "poor" to "good", or "fair" to "excellent". Due to the small sample size, statistical analyses were not performed on this data.

Table 11. Patient characteristics and changes in pre-post patient outcome measures

Patient	Sex	Age (yrs)	QOL	SRH	Feelings	Alcohol frequency	Diet	Physical activity	Social support	Group membership
Cove										
1	M	94	-	2	-	-1	-1	-	-	-
2	M	72	1	-	-	-	1	1	-	-
3	F	95	2	2	-	-	1	-1	-	-
4	F	66	-	2	-1	-3	3	-1	-	-
Peterculter										
1	M	72	1	-	2	-	-1	-	-	-
2	F	84	-1	-2	-	1	-	-	-	-
3	M	80	2	-	-	-	1	-	-	-
4	F	85	-	2	1	3	-	-1	4	-
Average		*81*	*.6*	*.8*	*.3*	*0*	*.5*	*-.3*	*.5*	*0*

NB: M = male; F = female; QOL = quality of life; SRH = self-rated health; "-" indicates no change in score

5.3.3 Patient service satisfaction

Responses to the service satisfaction questionnaire are visible in Table 12. The questionnaire was comprised of three components: 1) Prevention (examining perceived support to live independently; reducing medical symptoms; information needed to treat; and care explained in an understandable way); 2) Choice (having a say in provided support; teams taking account of things that matter to the patient; being encouraged to have their say; and increasing choices available); and 3) Overall satisfaction (satisfied with support; recommend support to others; confidence in the INCA teams; well-coordinated care). Overall, satisfaction appeared to be very high, with all responders having confidence in the teams and feeling encouraged to input into the support they received. Two open-ended responders described the support and staff as "excellent", with a third writing:

"I could never have made the progress I have without the help and encouragement of the INCA team."

Table 12. Satisfaction questionnaire scores (N=13)

Questionnaire components	Cove Average Score	Peterculter Average Score	Total Average score
Prevention			
Independent living	4.8	4.6	4.7
Reduce symptoms	4.2	4.2	4.2
Well-informed	5	4.7	4.8
Care well-explained	5	4.5	4.8
Choice			
Input of support	4.8	4.7	4.8
Things that matter	4.8	4.4	4.6
Encouraged to input	5	4.7	4.8
Increase available choices	3.8	3.6	3.7
Overall satisfaction			
Satisfied with support	5	4.9	4.9
Recommend support	5	4.9	4.9
Confidence in teams	5	4.9	4.9
Well-coordinated care	4.7	4.6	4.6

NB: Scores based on Likert-scale responses, ranging from 1 (strongly disagree) to 5 (strongly agree). % agreement classed as responders who either responded “agree” or “strongly agree”

5.4 INCA staff results

It should be noted that main contributing factor towards the amalgamation of the two INCA teams was due to the high turnover of staff. The service began in February 2018 with a cohort of 12, however by June 2018 this has decreased to six. Figure 7 shows the turnover of staff in line with the timeline of the project.

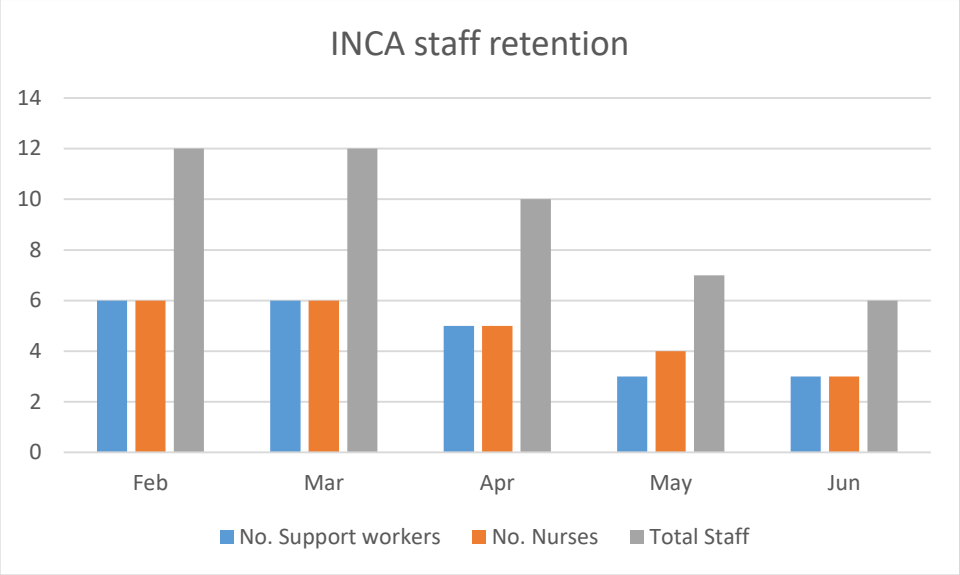

Figure 7. INCA staff retention rates

With the above in mind, the INCA staff outcome data are presented first to represent the feelings of staff three months into the project, whilst the interviews conducted with staff after the discontinuation of delivering care in Cove are described thereafter to highlight the changes that occurred over time.

5.4.1 INCA Staff outcomes

Twelve staff responded to baseline questionnaires, with nine providing responses at a three month follow up.

5.4.1.1 Staff value

Figure 8 shows the average change in score between constructs of feeling valued between baseline and three months. Aspects such as whether staff felt they made a difference and improved teamwork improved between assessments, however using relevant skills and developing their expertise appeared to decrease.

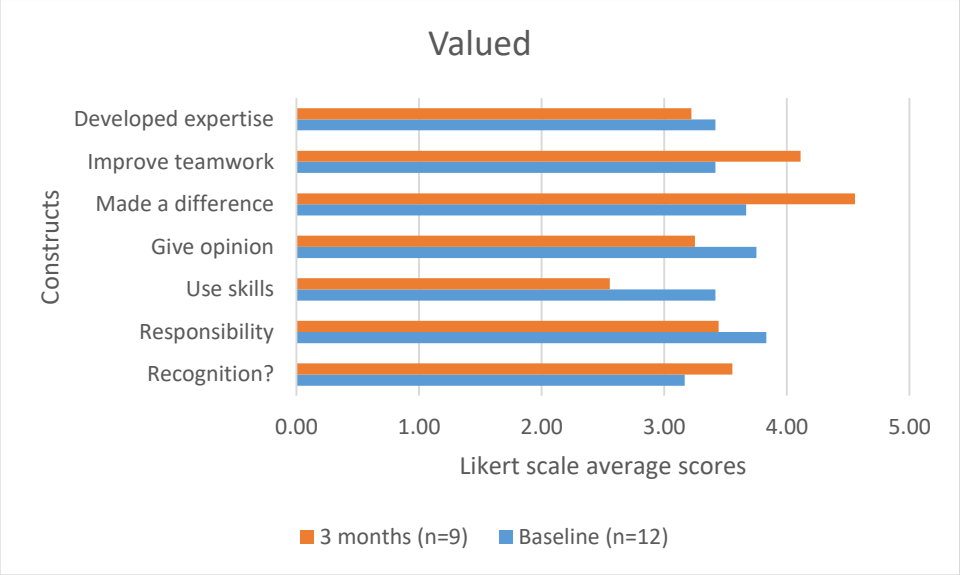

Figure 8. Pre-post changes in constructs of value

5.4.1.2 Staff autonomy

Figure 9 shows the average change in score between constructs of autonomy between baseline and three months. Staff reported a better work/life balance in their current role and reported more involvement in decisions around the rota. Staff marginally reported feeling less trusted in their current role.

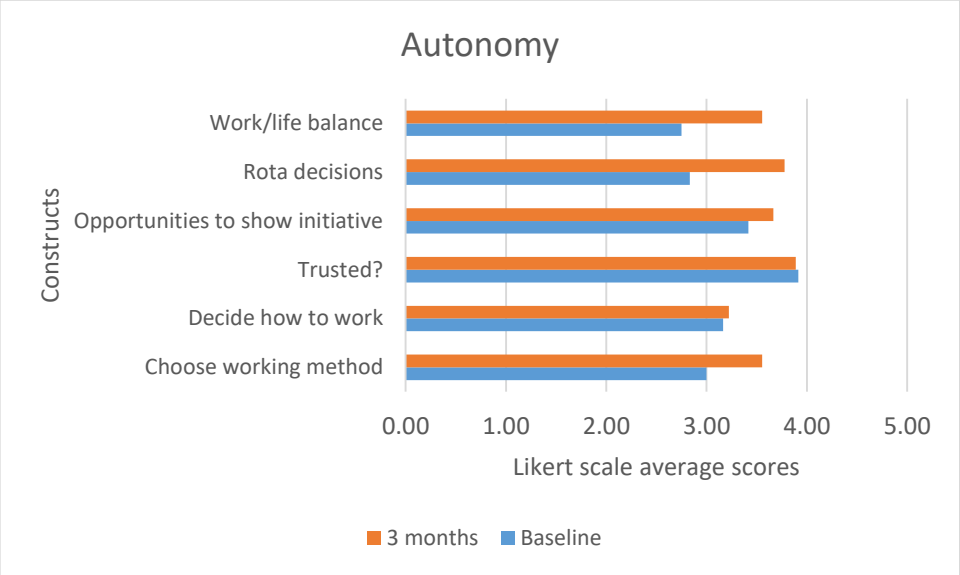

Figure 9. Pre-post changes in constructs of autonomy

5.4.1.3 Staff belonging

Figure 10 shows the average change in score between constructs of belonging between baseline and three months. Staff reported improvements in feeling respected and supported by

other colleagues, however there was a large decrease in knowledge of their work responsibilities.

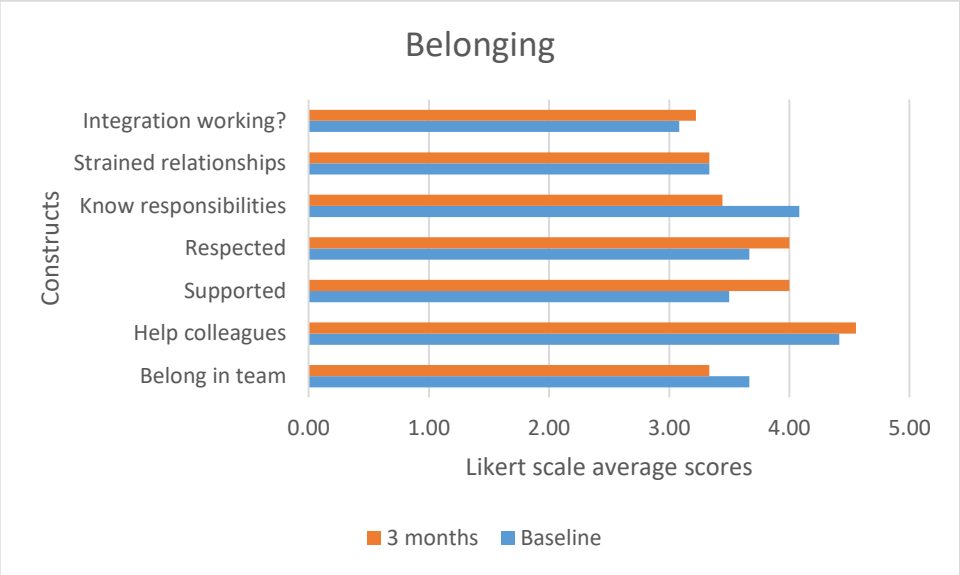

Figure 10. Pre-post changes in constructs of belonging

5.4.1.4 Overall staff satisfaction

Figure 11 shows the average change in score between constructs of overall satisfaction between baseline and three months. Overall, staff reported improved satisfaction in the care they provided to patients and more enthusiastic than previously about their job.

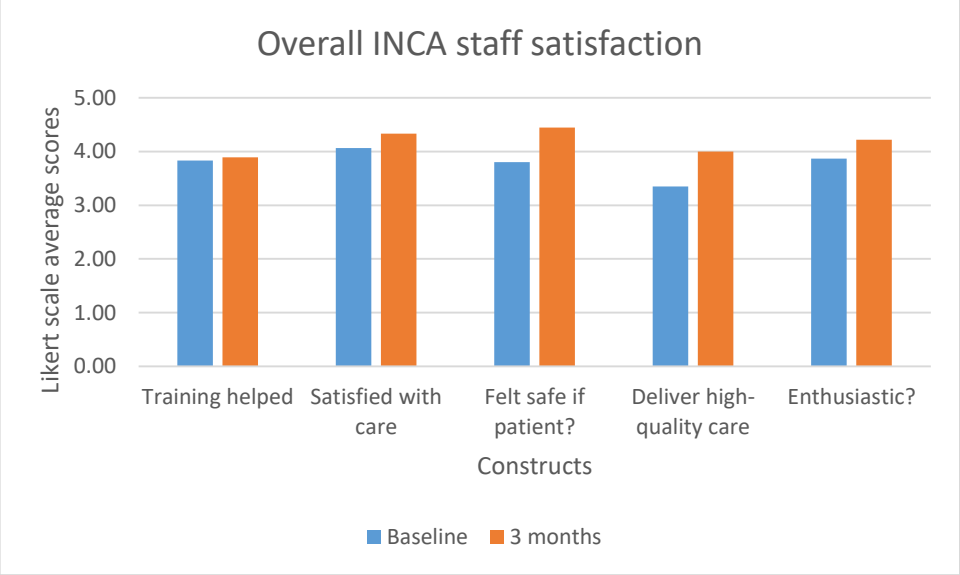

Figure 11. Pre-post changes in constructs of satisfaction

5.4.2 INCA staff experience

Nine team members were interviewed during the summer of 2018, four from Cove (C) and five from Peterculter (P). Their characteristics are shown in Table 13.

Table 13. Characteristics of interviewed INCA staff

Participant ID	Age (yrs)	Sex (M/F)	Experience (yrs.)	Role
C2	64	F	>10	Support worker
C4	34	F	6-10	Nurse
C5	30	F	>10	Nurse
C6	26	F	2-5	Nurse
P1	40	M	>10	Support worker
P2	-	F	6-10	Nurse
P3	43	F	>10	Nurse
P4	55	F	>10	Nurse
P6	54	F	>10	Support worker

5.4.2.1 Themes

Four key themes emerged from the analysis: 1) Service Development; 2) Service Operation; 3) Inter/intra Team Collaboration; and 4) Personal Attributes and Outcomes. These, along with the relevant sub-themes, are visible in Table 14. Again, attributing quotations directly to INCA staff has been removed for anonymity.

Table 14. Themes and sub-themes derived from INCA team interview analysis

Theme	Sub-theme
Service Development	Recruitment and retention
	Induction and training
Service Operation	Caseload
	Patient interactions
	Service characteristics
	Team structure and composition
	External barriers

Inter/intra Team Collaboration	Team relationships
	Team working
	Partnership working
Personal Attributes and Outcomes	Necessary personal qualities
	Positive job aspects

Service Development

Recruitment and retention **-** From the outset of the project, recruitment was a challenge. Participants raised concerns about the suitability of those recruited: *"I don't think we were experienced enough or had the right skills to go into these types of teams" "I wasn't the right person for that job, I don't have the experience, I don't have the knowledge".* There was some feeling that experienced nurses were reluctant to join the team "*because they couldn't see it working"* or because the local medical practice "*wanted to keep them".* One experienced community nurse resigned after two months, leaving the remaining nurses with limited community experience or training. Once staff started to leave, the same recruitment issues recurred: *"When we had no staff they were like well OK what are you going to do about it? Well we can't recruit, there's nobody wanting to recruit so that was a massive thing as well, nobody wanted to be a part of the team".*

There were a variety of reasons why it was difficult to retain staff. The most consistently reported issue for the nurses was feeling de-skilled with the suggestion they were being: *"paid an awful lot to heat up a meal or give someone a wash",* whilst others commented that: *"I didn't get to use any of my skills, I actually felt de-skilled hugely".* There was also a perception that one of the community nurse teams had a negative influence on the retention of staff: "*it was quite clear …when it came towards the end of people handing in their notices that it was heavily influenced by the existing community team".* Some staff described previous employers offering them their old jobs back, providing them with an alternative if they chose to take it: "*my previous manager, was a boss in [X organisation] before, so kept inviting me to resume my post full-time, but I told X I would continue here*".

Further challenges reported included an unsatisfactory work-life balance, with a need to come *"into work most days for meetings etc."* and *"even on our days off we were getting …phoned in to ask things about work. We were never getting away from it".* As a result, staff

morale was low, with several people reporting that the work was stressful, tiring and different to their expectations: *"I don't regret coming into the INCA team but overall it wasn't a good experience"*. Several mentioned having been attracted by the Buurtzorg ethos, but the experience deteriorated and became more unpredictable as more people left: "*because nobody knows who will leave next".*

Induction and training **-** Feedback on the induction process was mixed. A lot of information and orientation was covered, which was challenging, but did have benefits for some: *"It was useful at the time … some days were longer than others on the induction but …I'd be lying if I said I didn't come away …each day thinking '… I've learned something new today' so it was beneficial".* However, others felt that there was not enough input on aspects of the role that were fundamental to the project, such as self-management: *"I think the two weeks we had at the start would have been much better spent actually having a coach or somebody who does this kind of stuff to come in and …teach us how to be self-managing because we only got that very brief part from one of the Buurtzorg nurses"*. Once the work had started, ongoing training was not provided, with one noting there were: *"… no clear guidelines about when we were self-managing and when we weren't".*

Other areas where participants felt the induction had not met their needs included: *"input from care managers"* and *"dealing with bereavement (for support workers)".* There was one comment on the hurried nature of the process: "*I feel everything was really rushed at the start. You know we were kind of oh we don't have anywhere to put you so we're just going to chuck you here … even stuff like cabinets to put our paperwork in…it all felt like it was just being pushed through really quickly".*

Service Operation

Caseload – The caseload in both teams was characterised by heavy social care demand and limited need for nursing input (further to that provided by the community nursing team). It was generally acknowledged that this caseload weighting towards social care had been difficult for the nurses: "*I think the nurses, their self-worth went down which … ended up with a wee bit of friction … because their skills were not needed so much"; "I can only speak for myself and X just because we've spoken about it a lot but for us it was like we weren't even getting to do any nursing at all. It was all care and if I still wanted to be a carer I would have never done my nursing training".*

Workload was inconsistent and often at quite low levels: *"There was a lag to get the caseload … when you are in a care setting, you are always on the go, and so there was a time when we remained in the office and were not being with the clients. Yes, we are doing team working and study, but the main part is being here and being with the client."* There was a feeling that the community nursing teams hadn't always passed on clients to INCA: "*I think we would have got more but I think it was being filtered from the [X] DNs because if they were quiet they weren't going to give us the work that they were getting, they were going to take that".*

Patient interactions **-** Staff spoke about going beyond the traditional professional/patient relationship into something more meaningful: *"Last week when I went in, one girl was really upset, she just wasn't herself, but by the time I left we were laughing and joking. I asked: 'have I cheered you up?' 'Oh yes' she said, 'You certainly have, you always cheer me up', and to me that's a positive thing"; "we could only help their social and enhance their life and to a lot of them that was really really positive".*

The time that staff were able to have with patients meant there were success stories of enabling patients: *"One particular person we were told they wouldn't have long [to live], but 5½ months down the time this person is very happy. She was very fulfilled and really just took a new lease of life."*

There were also accounts of positive relationships with patients' families: "*If people have been unpaid carers they're so appreciative of us taking over some of their job to free up time with them but they totally get it because in the end we as a team and them as a relative or friend, whoever it is, only have one thing really in common and that is we're there for the patient, to keep them at home, that's what we want to achieve together".*

Service characteristics **–** Participants articulated that their service was able to reduce the waiting times for patients to receive care: "*If you got a referral we would see that person and do the assessment and if the person is eligible [they were] prescribed the right care from the next day … when the full team was on. Prescribing care from the next morning or evening, so fruitful and fantastic. With the conventional system it goes six to eight weeks and then a different level of Managers sanction what to pass on, so compared to that we are effective and benefiting for the community".* Although, there were exceptions to this, with one participant giving an example of a client waiting a fortnight for the INCA team to see her: *"we'd had*

a lady who'd waited, I've no idea how this happened, but had waited two weeks for us to come … and then we had to let her down and she was absolutely devastated".

Functioning in small and integrated teams meant that staff were able to provide continuity of care for patients accounting for changes in their needs: "*maybe their medical issues had moved on but they had social issues so we were carrying through".* Staff autonomy also allowed for this care continuity as staff felt they had been: "... *better able to enable patients in that model because [we] had more time, getting to know the patient better than when carers [are only] undertaking some elements of care.".*

The time staff were able to spend with patients was highly valued by staff and, as staff could choose the length of visits, they noted how they were less constrained than community colleagues working in traditional structures: "*The guys that are out in the community just now are brilliant but they are actually timed at how long they can spend and people are very aware of this that they have got 15 minutes … whereas with us, we went in sat down, we didn't make it feel as if we was clock watching and ... to me, that was as good a tonic as any tablet to them".* The team also had full control over the frequency and timing of patient visits, and for some participants this had been a very positive factor: *"It wasn't until I was working in this team and in this environment that I realised when you actually work in an environment that controls everything, what you're delivering isn't actually patient-centred, there's too many restraints on what you're doing. But, working in this environment, in their home, as a self-managed [team] with nobody on top of you saying 'you've got 15 minutes for that and 15 minutes for that bang, bang, bang' … you get so much more out of the individual you can give them more and you build up that relationship."*

Team structure and composition **-** There were conflicting opinions about whether nurses and support workers had been able to function effectively in the same team. Advantages highlighted were *"more concordance with care in this system"* and potential for greater continuity of care, whereas those who opposed the idea: *"disagreed with the recommendation which is nurses belong in the model … it was a social health care model."* Although it was acknowledged that this view had been influenced by caseload bias towards need for support rather than nursing care. One argument in favour of separate teams was: "*it's not so much the carers getting bogged down with our stuff because, you know, they can't do our job because they*

don't have that training but we can do their job and I feel that we'll get bogged down with them and that's why I think we both need to be in separate teams".

The small team numbers combined with working rotations meant that staff had often felt isolated from their colleagues: *"… quite a lot of shifts I have been on my own doing 8-8 because we do not have enough to have two on … the luxury of having three on, oh I'm … in my element!".* There was also conflict regarding the flat structure of the team, with even those who championed the concept commenting that some form of leadership role would be advantageous: *"… even saying that we are all equal, we need somebody to lead and sort of drive forward".*

External barriers **-** Many of the challenges the teams encountered had been out with their direct control. For example, it had taken a long time for the support workers to get access to a crucial caseload management tool: *"from day one the nurses were in control because they had access to all the log ins, they could get onto whatever so when we started getting clients the three nurses could go on and check what was happening with clients but if you were there yourself, … you couldn't go on to check nothing".*

Location had also proved to be an issue: "*The fact that we weren't in a health setting was a huge disadvantage to us...because we weren't part of a health setting we couldn't get our bloods picked up, we didn't have a label printer, everything was going back and forth to [X] which was fine in the start but as our caseload got busier it was so hard to find time to go and do the stuff you needed to do".* Problems had also arisen with the teams providing cover for each other, despite being located in opposite sides of the city.

Other challenges related to: not being involved in the decision to terminate the INCA service in one area: *"… self-managing took a whole new meaning that day they came and told us. That was quite a kick in the stomach so we are either all self-managing or we are not";* the perceived negative influence of the community nursing team from one of the areas and the coach not having a health background.

Inter/intra Team Collaboration

Team relationships **–** Tension had existed between and within teams from an early stage, with perception of roles and responsibilities being different: "*I think the damage had already been done and it was already too far gone and the fraughtness and the frustration, we were*

taking it out on each other and I think that would have been hard to come back from because you didn't want to fall out with anybody because you had to work with these people".

Communication seemed to have broken down within the team and between teams, potentially due to competition and defensiveness: *"In some ways it was really good, in terms of information/updates being cascaded to us, but communication between the INCA teams was really poor – there seemed to be a competitive element that shouldn't have been there"; "there was a divide between nurses and support workers but nae nothing that could not be mended with a wee bit of a sit down a conversation".* Among a small working team, personality clashes had arisen: *"I knew x was going to be a bit of a negative person because she was, and why have you even come to this job because "'I don't want to do this and I don't want to do that shift' and I thought ... Why even put yourself forward, you don't want to work weekends, why did you apply for the job really".* Whilst there had been tension in the team, it was also recognised that initial team building had been somewhat rushed and this may have contributed to working difficulties later.

Team working – Self-management of the team was one of the most frequently reported challenges of this way of working. In particular, understanding of what was meant by self-management and how it practically functioned seemed to be unclear: *"In the way we were self-managing – nobody made decisions – too scared to do so or it would be perceived that you've taken over."* Interviewees mentioned that they would have liked more time spent early in the project exploring the concept and clarity regarding which elements of their role should be autonomous. The role of the coach in supporting the team appeared to have insufficient prominence and as the project continued and staff number dwindled, the team had less time to get together for open discussion.

Conflicting opinions were evident, particularly around the care delivered to patients: *"I would say there was maybe a lot of… struggles with who want to be a leader, different opinions, things like that. Different opinions on what the whole project is, really, that caused a lot of conflict".* Whilst such decisions would have been a matter of professional opinion: *"it always felt like it was …us and them, … the nurses and the carers, it was like two sides and …we just felt like we couldn't be open and honest because we just felt like we would be kind of dismissed".*

It was also thought that greater openness in drawing on the experience and support of colleagues would have been beneficial "... *at the end of the day sometimes the carers were going into things that were totally outwith their depth and then it was well …, are you able to come back to me and say actually I don't know what I'm doing here and I felt that that wasn't always the case".*

***Partnership working* –** There was a lot of tension highlighted, particularly with senior management across health and social care: *"I feel there were a great number of managers and other senior staff inputting into the INCA team frequently without communication with each other, leading to confusion and miscommunication within the team".* While meetings had been held and attendance expected, examining identified problems and finding solutions was less likely: *"... 'oh you're just being negative' but no we have legitimate issues that we need to address"* and there was a sense of frustration at not having been listened to.

The referral pathway had not always been followed and referral of patients on to the INCA team had been variable: *"We seemed to get ones they [existing teams] didn't want to go out and do".* However, this appeared to be less prevalent in the co-located team, who were able to provide examples of closer collaboration with colleagues: "*Occupational Therapists, very good, excellent communication, I work quite a lot with her, very collaborative, and very easy to approach and that is the outstanding person from my experience, the OT. We have had a lot of contact as we have to seek her advice and help sometimes with implementing equipment and providing wheelchairs or chairs or whatever".*

The majority of participants cited situations where they had signposted patients to local community assets as a mechanism to re-affirm their social networks. However, a further challenge was persuading patients to attend these, with issues highlighted including the logistics of attending such groups: *"I think in X we tried to … use those third sectors as much as possible but we were more restricted in X in terms of …transport … and persuading people to do it".*

Some staff members also acknowledged good practice existing elsewhere in the system and questioned whether service benefits were unique to this service: *"... the girls in the X team have really good relationships with their patients anyway so everything that was good wasn't anything new, I would say. It was stuff I'd done… in previous teams, … had good relationships, good palliative care, good holistic assessment, meeting families. That's all the stuff that I*

would have done in a normal team". However, staff did suggest that their own awareness of other (particularly 3rd sector) opportunities that they could signpost patients to had improved.

Personal Attributes and Outcomes

Necessary personal qualities – Several traits were consistently highlighted regarding the requirements to work in this model. Firstly, commitment was identified, with the majority of the remaining team members believing INCA was a good way to move forward and were determined to make it a success: *"I do not want INCA to fail and I think we have to make it work … we have all came through so much since we started and where we are now, we are in a better place with what we have got".*

Further qualities that were identified included patience, particularly due to the implementation issues of being a pilot project: *"You've got to have patience in this team, 100%*; and mutual respect with other professional colleagues: *"you are a very important part, I am a very important part too and as two important parts we can work together".*

Positive job aspects – Several participants discussed having enjoyed the experience of working in an INCA team, despite the difficulties encountered. Being 'patient focused' was seen as rewarding and in line with staff's own values. Another positive aspect highlighted was the potential to upskill staff in this model, particularly among support workers: *"I thought it was wonderful as I can learn or see and gain experience … I can see and learn more about catheter care; … clinical experience at an informal level, so that increases your care skills".* Others mentioned being able to see opportunities for training colleagues and improving the team's skills.

Working in this way was seen as a learning experience that enhanced their ability to perform a professional role in the future: *"I've learnt so much from being in the INCA team. I've come away from it with a total different outlook on my job … a totally different experience of how I will handle situations in the future".* One of the team felt very positively about the job *"in a sense being like a student nurse again"* in learning a new recording system used by a different practice.

5.5 Partners' experience of service

Three themes emerged from analysis: 1) Service Development; 2) Service Operation; 3) Collaboration. The themes and relevant sub-themes are visible in Table 15. Given the small sample interviewed, all responses are anonymised.

Table 15. Themes and sub-themes derived from INCA Partners' interview analysis

Theme	Sub-theme
Service development	Induction and training
	Referral considerations
	Learning experience
	Leadership
	Barriers
Service operation	Care need
	Service delivery
	Team workload
	Perceptions of team
Collaboration	Communication
	Relationships

Service development

Induction and training – There was a wide variety of content during the teams' induction, with both clinical and team-building activities incorporated into the programme: *"it was a mix of trying to help them come together as a team, but also get some of the stuff that they needed to know if they were coming into community new, so it was a bit of a mix". (PM)*. Although self-management was an underlying principle of service delivery, those designing / planning the induction found the concept challenging to define, making it even more difficult to teach: "*… it's so difficult to quantify what self-management is because what I consider self-management and maybe [PM] considers self-management is two different things*" *(PM).*

There was no on-going training provided, as the INCA teams were expected to self-manage and identify their training needs themselves. However, existing community teams interacting with them felt more could have been done to help, particularly as they were: *"Very experienced professionals in their own setting but new to community so I think there needed to be a lot more training and support available" (Nurse Referrer).*

Referral considerations – More clarity was required regarding the referral criteria, as Partners were unsure who to refer into the service: *"The other aspect I would say is that perhaps there wasn't total clarity of what would be most appropriate for the community nursing team and what would be most appropriate for the INCA team and within that maybe a bit of confusion"* (GP).

Interestingly, some interviewees felt that existing teams were potentially withholding referrals into the INCA team, although were unsure of the reasons why: "*I do think from the nursing side of it there has been a little bit of the other teams holding on to these patients and not actually referring in, for what …reason … I don't know*." *(PM)*. Whilst referrers indicated that they did not block referrals into the service, they did admit that this was being considered due to quality challenges: "*No, but we were nearly getting to that stage just because service provision from them was not as good as we'd hoped, but no I would have referred*" *(Social Referrer).*

Learning experience – From a project management perspective, there was a lot of knowledge gained from the development process. Primarily, the time required to implement a functioning, newly-formed, integrated health and social care team: *"I think it shows that integrated working can happen it just takes a lot longer than people are imagining to happen. It's not a quick fix and when you think we were out in Holland in June last year and there was an expectation this would be up and running in December and it wasn't as if anywhere else had actually brought support workers in I think we were somewhat unrealistic that this would go ahead with no issues. It shows it works but there's an awful lot of background stuff that's got to happen." (PM).* However, it was acknowledged that in applying broad principles from a different healthcare system and adapting it locally, educated approximations had to be taken on many factors, including team composition*: "Would I start with more than 6 people? If I was starting exactly the same, starting with zero caseload, I think it would be hard to justify, so maybe I would put in more additional Support Workers or something, but again I didn't envisage that it would always be so skewed towards social care. I think that was just where we started, but we haven't been able to get beyond that because of everything that has occurred" (PM).*

Despite the numerous challenges, learning was not just gained regarding the refinement of this model, but also used to inform other new models being trialled that were in their development phases: *"Although a lot of it is like 'oh no this hasn't worked and this hasn't worked', … we have learned a huge amount from the partnership, which has already been shared with other projects, lessons learned with Link Workers and Hospital at Home, so that has been invaluable and … it is very very early stages. We have only been live since March." (PM).*

Leadership – There was scepticism from partners whether a fully self-managed team could function optimally and consideration should be given to viewing self-management as a spectrum: "*I have my doubts whether that could be totally self-managed but what I do agree with is the principle of a lighter touch management than has been traditionally the case. The principle should be break down the barriers that stop you from being able to do things as much as possible within safety and governance*" *(GP)*. One consequence of implementing a self-managing team was a knock-on redefinition of the function of traditional service managers, something they also found challenging: "t*hey [INCA team] came to us at various times. They came to us about risk assessments and stuff that was going on, so we did all struggle with what they were meant to be managing, what they needed help with, what's the difference between being a Manager and being a heat shield and all that kind of stuff, which I think we are still probably working through to be honest." (PM).* Three managers performed various aspects of a project management role in developing and implementing this project and, with hindsight, it was agreed that a team leader style role would be beneficial to streamline the process: "*But to have somebody in that coordination role that was operational could have helped it, but then that wouldn't have been the ethos of self-management, but on moving forward and scaling up, would that be something that we would want to consider, yes I think so*" *(PM).*

Barriers – Some partners perceived cultural resistance to change for colleagues, potentially due to the publicity the project received: "I*t's been touted as … the answer to everybody's prayers and I don't think there was enough recognition that actually some of this has been going on under the radar and so therefore for those that have been working in a relatively integrated way it must have been an absolute kick in the teeth because they've been working but … this lot come in and they've been away to Holland and they're getting nice offices in the oil and they're getting iPads, they're getting everything thrown at them but what about us. There is that, you could see … resistance to that because actually we're working that way*"

(PM). Partners interacting with the team also felt that this collaboration resulted in increased workload for them: "*we have to rely on a phone call and them getting in touch, so that is a little bit of extra work and when you add that on to the number of referrals that come through to us, you know these extra 5 minutes per patient takes up quite a bit of time" (Nurse Referrer).* Respondents also described feelings of pressure to get the service operational quickly to its detriment: "*I think there was a tremendous amount of outside pressure looking in – 'get it started, get it started, get it started!'".*

Operationally, there were numerous challenges that were detrimental the project. For example, basic considerations including logging onto and accessing appropriate software were evident: "I *think there is a multitude of things. I think logistically and IT issues have been quite frustrating for them*" *(PM)*. Some partners felt that there were additional systems the team should have been able to access to improve efficiencies: "*They didn't have access to Docman which gives them all the information from hospitals or referrals from clinicians. There is a lot of information that they would need to have prior to assessing a patient." (Nurse Referrer)*. Additional barriers this individual highlighted were having staff employed through different parent organisations: "*having NHS employees and Aberdeen City Council or Bon Accord or whatever it is just having different managers, different ways of working, different policies, procedures*" *(Nurse Referrer).*

Service operation

Care need – It was widely remarked that there was a low nursing need that negatively impacted the nurses within the team: "*I know that some of the concerns from the nurses was they weren't doing an awful lot of nursing tasks*" *(PM).* Despite this, partners did provide examples where the team were able to assist existing teams by caring for palliative patients locally: "*they did actually take a patient from X [outside originally agreed postcode area] for us who had been diagnosed with a terminal illness and they kindly took him onto their caseload so that he could go home to spend his final days*" *(Nurse Referrer).*

Notwithstanding the lack of nursing need, a particular success of this model was the successful unblocking of social care delays through rapid care provision: "*when they first launched we definitely had quite a lot of unmet need that was sitting with my community colleagues, so I am aware that they filled a need there, so they took on the backlog of cases, and that*

included some of the X ones as well. So they absolutely, when they launched, took a certain amount of cases off of our backlog that had been sitting" (Social Referrer).

Service delivery – The majority of partners were in agreement that the team were providing high-quality care to patients: *"the patients stories that we hear back from the teams all the time are really inspiring and reminding you why you do your job" (PM)*. There were several reasons cited for this, particularly due to care continuity: *"they will come in when they say they are going to come in, they are working more flexibly than we could ever work here, (Social Referrer)*, and the autonomy to increase and decrease care input rapidly: *"you could hopefully be a lot more responsive to when people's needs fluctuate, whereas what happens is that they get an assessment, which is a snapshot in time, often when they are just home from hospital or something and their needs are quite high, a care package is put in and actually they do improve and they probably don't need it all," (PM).*

Service delivery appeared to be streamlined when teams were co-located with other professionals. For example, partners in one site admitted that: "*It was difficult in terms of interaction with the team because the team here was based in a remote centre rather than within the Medical Practice. That's never absolutely ideal within an integrated team. Whilst electronic communication is a good facilitator these days there's nothing that beats the corridor conversations at particular times of more intense need" (GP)*, whilst in the other, staff member suggested that: "*I think as well by having Carers onsite meant communication was improved … them being … co-located would have made a big difference" (Social Referrer).*

Despite the aforementioned benefits, partners did acknowledge that there are existing teams that are functioning in an integrated way already: "*What I do know is that we have a community nursing team that has been working very very well here and working in a very integrated way with other services where in other parts of the city my feedback is very different" (GP).* This led to the exploration of whether positive patient experience was unique to this model of delivery, or whether similar outcomes would be visible elsewhere: "*I suppose it's trying to think for me whether 'is that anything to do with INCA?', probably not really as a lot of it is about personalities and their knowledge and skills and what they bring to their job, which happens right across the board" (PM).*

Team workload – It was noted that the INCA team had a very small caseload, which appeared to disgruntle partners who regularly cited a heavy workload: "*Very few. I mean comparatively considering the amount of staff they have, whereas we've got what 90 odd*" *(Nurse Referrer).* However, this did result in referrals usually being accepted by the team: "*I think of everybody we referred, if they had the capacity, they did take on their care*." *(Social Referrer).*

The teams managed an on-call rota for a period of time and provided care seven days a week. It was felt that this delivery structure may deter future staff, particularly considering that community-based professionals do not typically work such hours: "*they are working a lot more weekends than the Community Nurses do currently and they are working into the evenings …. That will be a barrier …and honestly I don't know how that would pan out" (PM).*

Perceptions of team – It was unanimous across the board that the self-management component was challenging not just for the team, but any new professional who may have joined the service: "*I think we do need to keep going back and exploring the self-management component is (that) something that we keep or whether we take that away. It is quite hard for them. They will say that they want to self-manage, and they do, but there are other things that they don't want to self-manage around, and that's really hard for them to learn; hard for anybody, even if you have been working in the organisation for years and years*" *(PM).* The consequences of this were perceptions of disorganisation and last-minute decisions within the team: "*I have real doubts that any team can self-manage effectively, and I didn't see it in the INCA Team. I saw no evidence that they were managing themselves well. I saw evidence that they were trying to manage things, but it was very much at the 23rd hour, as I mentioned, and it seemed to be all very reactive rather than planning*" *(Nurse Referrer).*

It was noted that recruitment was particularly challenging, although not a new issue to the area. With this in mind, some partners were sceptical whether the service should have began:

"I think that if they had appointed people well enough initially they could have foretold a lot of the problems that we had. (Nurse Referrer)

But they didn't get the applicants (Nurse Referrer)

Well, if you don't get the applicants and they are not up to scratch you debate whether you start a service, especially a new service" (Nurse Referrer).

Even with these recruitment challenges, it was felt that the individuals remaining in the project had particularly enduring commitment qualities with a desire to make the service successful: "*I think they tried extremely hard here. It was quite clear how much initially they wanted to make this work. They gave it their all I think here*" *(GP).*

Collaboration

Communication – From the outset, the partners endeavoured to establish communication channels with the team to facilitate implementation: "*we tried to arrange regular meetings with the INCA team to discuss how things were going and if there was any way that we could support them further if they were having any problems and that seemed to be working okay*" *(Nurse Referrer)*. However, this seemed to break down over time, with the majority of partners reporting communication challenges with the team: "*This seemed to be one of the issues that we never knew if they had been in to the ward and done what they needed to do and then the person was discharged without feedback, certainly to the hospital team, of what package of care had been put in, so I suppose staff felt out of the loop once we handed over … from a referring point of view we never really knew what had then happened to allow us to update our systems*" *(Social Referrer).*

Indeed, it was felt that there were also difficulties communicating within the teams, meaning there was a lack of communication continuity: "*think what probably we could have been better with is the communication in teams; this wasn't that great. If you go and speak to one person and 2 days later they wouldn't pass it on and so you would be having the same conversation again with Person B, and that's frustrating not only for them but also for us*" *(PM)*. Although, it was acknowledged that these challenges were in part due to wider IT and geographical issues the teams faced: "*And likewise when they are out on home visits they can't contact the practice and they are not able to contact anybody either because they are in a black spot and there is a lot of black spots*. *(Nurse Referrer).*

Relationships – At the beginning of the process, the teams did interact with other professionals, particularly those who were not co-located, in an attempt to establish relationships: "*… they came along to a PLT meeting to introduce themselves and give an update of how things were going*" *(GP).* However, it was felt that more should have been done to build this collaboration with partners as far back as the induction weeks: "*forgive me I could be wrong, at no*

point did we arrange for them to see the community nurses they were going to be working with nor did we invite… them to come in and explain what their role was and whether that may well have eased the process" (PM).

It was noted that there were personality clashes within the team that deterred from successful team working: "*I found that there was barriers with regards to that too because they didn't agree on an awful lot of things" (Nurse Referrer).* However, one commonly reported reason for this tension was staffing issues, from which relationship challenges derived as a consequence: "*As soon as people started to leave it became more of a challenge for them all, because all the stuff that you were trying to do and that needed to develop and evolve over time became more and more difficult because they were covering longer shifts, they were covering their own weekends and stuff" (PM).*

6. Discussion

The purpose of this report was to present process and outcome evaluation findings for the INCA project. Specifically, the impact on patients, staff and resources were explored. This paper is crucial to inform the future direction and development of this project by understanding what worked well and areas for improvement.

Patient perspective - Overall, this service appeared to be highly acceptable to patients, with overall satisfaction scoring an average of 98%.

Components within the choice element of the satisfaction questionnaire that patients strongly agreed with were their input into the support they received (average score 4.8/5), along with the team encouraging patients to have their say (average score 4.8/5). These quantitative findings are supplemented by the collaboration sub-theme that emerged from interview analysis, with patients often referring to the team-working that occurred between the two parties. This highlights the perceived benefit to patients of having equality in the relationship with those who support them. Indeed, the National institute for Health and Care Excellence have released specific guidelines stipulating the need to ensure that patients are active participants in the care and support that they receive[25]. These guidelines are reinforced by previous evidence demonstrating that joint decision-making leads to increased adherence to treatments[26] and improved knowledge of available options[27]. Given that the Buurtzorg principles, on which this model was founded, stress the importance of placing the patient in the centre of their care needs[28], it would appear that this component of the model worked well.

One reason that may have contributed to the high patient satisfaction was the ability of the team to be agile in their care delivery. For example, patients described circumstances where their health would fluctuate and would subsequently require more or less support. The au-

[25] National institute for health and care excellence (NICE) (2012). *Patient experience in adult NHS services.* London: NICE

[26] Nunes, V et al. (2009). *Clinical guidelines and evidence review for medicines adherence*. London: National collaborating centre for primary care and royal college of general practitioners.

[27] Stacey, D et al. (2017). Decision aids for people facing health treatment or screening decisions. *Cochrane database of syst rev.*

[28] Kreitzer, M. J et al. (2015). Buurtzorg nederland: A global model of social innovation, change, and whole-systems healing. *Glob Adv Health Med, 4*(1), 40-44.

tonomy the team possessed to adjust frequency and duration of support contrasts to traditional models, principally in social care, whereby care provision is fixed and requires reassessment to increase[29]. This appears to be a particularly beneficial component of care delivery in community settings, especially considering the predominantly older cohort who received care (mean age = 83 years), a population that report large variances in their health status from day-to-day[30]. Being able to tailor care delivery to compliment the needs of patients has been attributed as one of the key components of the Buurtzorg model in improving support for frail older adults[31].

Another important principle of the model incorporated within INCA was the mobilisation of community assets and social networks to support patients towards enablement[32]. Here, participants all provided examples of signposting they received towards other forms of support locally, such as community groups and activities. Community assets have previously been championed as offering the potential to enhance quality and longevity of life by improving coping abilities and self-esteem of individuals[33]. Despite this however, there was a reticence to attend community assets, with some patients citing logistical challenges and feelings of discomfort as barriers to attend new activities. It is possible that there are other factors influencing this opinion also, such as patients already feeling adequately supported by the INCA team. Indeed, the friendship that was commonly reported by patients, whilst having a direct positive impact on wellbeing, may lead to a reliance on the service and subsequent challenges discharging individuals from the caseload. Therefore, whilst strong relationships were formed between patients and staff, further work and resource is necessary to move beyond signposting individuals to community assets, to actively establishing and maintaining those connections should the individual want to do so.

Staff & Partners' perspective - One of the key challenges within this model was the composition of care need on the caseload. There was a dearth of nursing need (leading to nurses

[29] Scottish Government. (2011). *Finding the care that is right for you*. Edinburgh: Scottish Government.
[30] Leask, C. F et al. (2016). Modifying older adults' daily sedentary behaviour using an asset-based solution: Views from older adults. *AIMS Public Health, 3*(3), 542-554.
[31] Alders, P. (2015). Self-managed care teams to improve community care for frail older adults in the Netherlands. *Int J Care Coord, 18*(2-3), 57-61.
[32] Monsen, K. A., & de Blok, J. (2013). Buurtzorg: Nurse-led community care. *Creat Nurs, 19*(3), 122-127.
[33] Glasgow centre for population health. (2011). *Asset based approaches for health improvement*. Briefing paper 9.

feeling de-skilled) and this is likely to have been heavily influenced by this service double-running in tandem with existing community nursing teams. Had this model been a redesign of traditional service delivery, it is probable that these issues would have been resolved and therefore, retention problems and subsequent challenges been, in part, avoided. However, this service did appear to fill a gap in providing rapid access to social care provision. Older adults and individuals with social care input often have complex needs that require varying degrees of input at different times[34,35]. It was therefore beneficial that the team had autonomy to vary the frequency and duration of care provided to react to the needs of patients. INCA differs from traditional social care delivery, where support is usually provided by prescribing set times and days that individuals will receive care. However, it has been acknowledged that the traditional model is not sustainable[36]. Providing front-line staff with the autonomy to decide when and how care is delivered may be one effective strategy towards delivering efficient and sustainable services.

Differences in acceptability were evident in the co-location (or lack thereof) of staff. Those based in corporate offices described feelings of isolation from other professionals, whereas staff based within the GP practice reported stronger partnership working with other colleagues. This finding is unsurprising; a recent European-wide study examining co-location in primary care reported a significant relationship between co-location of multiple professionals with inter-professional collaboration and improved secondary care coordination[37]. Whist co-location does not necessarily guarantee integrated working, it provides professionals with an opportunity for increased informal interactions that can enhance mutual decision-making and practice[38]. These networks were described clearly in Peterculter as participants were able to provide positive examples of collaborative working with other professionals, however were

[34] Audit Scotland. (2016). *Social work in Scotland*. Edinburgh: Audit Scotland.
[35] Leask, C. F et al. (2016). Modifying older adults' daily sedentary behaviour using an asset-based solution: Views from older adults. *AIMS Public Health, 3*(3), 542-554.
[36] Audit Scotland. (2016). *Social work in Scotland*. Edinburgh: Audit Scotland.
[37] Bonciani, M. et al. (2018). The benefits of co-location in primary care practices: The perspectives of general practitioners and patients in 34 countries. *BMC Health Serv Res, 18*(1), 132.
[38] Jong, J. D. (2008). *Explaining medical practice variation: Social organization and institutional mechanisms*. Utrecht: Utrecht University.

less prevalent in Cove. This is one clear distinction between the INCA model and the Buurtzorg model, whereby the latter are typically based in a stand-alone office within the neighbourhood they serve.

Despite numerous reported challenges, the participants felt they provided a high-quality service to patients and gave examples of enablement approaches they had seen prove fruitful, including for one patient deemed palliative when referred into the service. Care continuity was cited as one reason for this high-quality provision because it allowed staff to develop strong relationships with patients. Indeed, a paper by Freeman and Hughes[39] has highlighted the high value placed by both patient and clinician on continuity of care, with evidence suggesting that this may result in improved patient outcomes and staff satisfaction[40]. It appears that having a small team looking after a limited cohort of patients is a simple yet effective strategy to developing strong relationships, allowing for increased interaction and communication to occur.

The self-managing element of this model proved challenging to staff. Several reasons were cited for this, including personality clashes between team members, and a lack of clarity regarding team roles. Interestingly, the opposite has previously been reported as characteristics of successfully operating self-managing teams, for example clear task division and good team relationships[41]. However, a fundamental barrier to working in a self-managing way was the concept of operating as a self-managing team within a larger organisation, similar to previous findings[42]. Whilst these are issues that, in the Buurtzorg model, a coach would support teams to resolve[43], the team cited time and staffing challenges as barriers to accessing this resource. It appears that having these support structures embedded throughout implementation, in addition to providing a clear framework to outline tasks, are fundamental to facilitate effective manifestation of the principles of self-management within this model. This is reinforced by the input of senior managers who, although they were not directly involved in

[39] Freeman, G., & Hughes, J. (2010). Continuity of care and the patient experience. *The Kings Fund,* 1-64.
[40] Fairhurst, K., & May, C. (2006). What general practitioners find satisfying in their work: Implications for health care system reform. *Ann Fam Med, 4*(6), 500-505.
[41] Weerheim, W. et al. (2018). Successful implementation of self-managing teams. *Leadership in Health Services, [Epub ahead of print]*
[42] Drennan, V. M. et al. (2018). Tackling the workforce crisis in district nursing: Can the dutch buurtzorg model offer a solution and a better patient experience? A mixed methods case study. *BMJ Open, 8*(6), e021931.
[43] Kreitzer, M. J. et al. (2015). Buurtzorg nederland: A global model of social innovation, change, and whole-systems healing. *Glob Adv Health Med, 4*(1), 40-44.

service delivery, had power to change the structure of the model, causing conflict with the teams' perception of being self-managing.

Limiting factors - There are several limitations to consider. Firstly, due to retention issues of staff, this evaluation report has been produced several months earlier than scheduled. This has resulted in a variety of data either 1) scheduled to be gathered six months post implementation or 2) dependent on the scaling of the project, not being possible to report on. Whilst this evaluation has been agile to adapt to these challenges, it would have been more complete and robust had these retention issues not occurred.

From a patients perspective, the small sample size interviewed means these findings are not necessarily generalisable to all patients. However, data saturation did occur, whereby no new themes emerged from analysis. Further, patients stated that their health improved from seeing the INCA team, however this report has provided limited clinical evidence to reinforce that stance. Third, patients may have biased their findings in favour of staff due to being provided with free care, or for fear of reprisals if they voiced negative opinions, although they were reminded that all responses were anonymous and would not impact them in any way. It may also be considered that, whilst this model has a strong focus on re-ablement, it is possible that patients actually under-reported their levels of independence in case they got discharged from the caseload (a particularly pertinent point when considering the strong themes of relationship-building that emerged through interviews).

There was limited data gathered regarding unpaid carers' perceptions of the service and how it impacted them. This was due to logistical challenges contacting these individuals and future work should attempt to investigate this further.

There are additional limitations in the staff data collected. As stated, the staff outcome questionnaires were administered at the start of the project and at three month follow-up, whereas the majority of interviews were conducted after this point. As a result, the outcome data appears to suggest that this model of working had several benefits compared to the roles staff previously filled, however this is skewed when considering that only 75% of staff were still working in this model at follow-up. Given the cohort who remained employed in this model over time, it is reasonable to suggest that it was more acceptable to support workers than to nursing staff.

Also, factors such as patient-facing time and cost-effectiveness, although desirable, were not captured here. This was due to limitations within the electronic system used for data capture, in addition to being a test of change, therefore it was agreed that limited time and resources should be used to focus on whether the service *can* work, before determining aspects such as scale up and intricate financial testing[44].

[44] Bowen, DJ et al. (2009). How we design feasibility studies. *Am J Prev Med*. 36(5), 452-457.

7. Conclusion and recommendations

The INCA model appears to be highly acceptable to patients, who self-reported enhanced wellbeing (physically, mentally and socially) and described receiving person-centred care from trustworthy and high-quality staff. Future work should aim to ascertain whether these improvements are of clinical significance (and comparable to outcomes achieved in the traditional care model) and aim to capture the experience of unpaid carers to understand how this model impacts their wellbeing. Further, given the challenges in uptake of signposted community assets, exploring the mechanisms by which individuals can be supported to access and continue to attend these networks should be considered.

This model provided mixed acceptability to staff. Particular elements that proved successful include: 1) the autonomy to adjust care provision to the needs of the individual; 2) developing their own work roster to ensure care provision whilst also considering the preferences and circumstances of INCA staff; 3) continuity of care, allowing strong relationships to develop between staff and patients; 4) the rapid provision of social care; 5) co-location with other professionals to enhance cohesion of integrated working. However, other aspects of working, including a predominantly social care caseload, challenges resolving conflict and communication issues led to staff turnover and associated difficulties in work/life balance. Collectively therefore, the above may be considered when determining which components of self-management are likely to be positive to implement in traditional models. The self-management ethos requires a clear framework in which to operate, for example outlining the roles and responsibilities of staff, in addition to the appropriate support structures and mechanisms by which to overcome logistical, environmental and intrapersonal barriers. Future work may aim to incorporate the successful examples of self-managed working into existing service delivery to determine what improvements, if any, this makes.

The colleagues of INCA staff echoed the sentiments of high-quality care provision and rapid access to social care, however acknowledged communication challenges with the team. Future work should ensure that appropriate time is assigned to establishing and maintaining these relationships to improve the service. It is important to note that, whilst numerous challenges can be attributed to this service double-running with existing teams, this was operationalised for the purposes of testing the Buurtzorg principles locally and thus determining which aspects of working may be wider applicable across the system. Therefore, thought

should be given to how this service can be integrated with existing services, such as Acute Care @ Home and the West Visiting Service. Further, whilst it was acknowledged that not enough training and support was provided regarding the self-management element of the service, it cannot be concluded that self-managing teams are not feasible. Instead, it may be beneficial to view self-management as a spectrum, particularly when considering the above elements that proved successful. Finally, given the challenges extracting data from the IT system used, future work must ensure that systems utilised are fit for purpose.

8. Acknowledgements

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Appendix 1. INCA Framework

INCA FRAMEWORK

Principles

Person at the centre

Use of informal networks

Self-managing team

Relationships with formal networks

Enabling approach

Neighbourhood Based

EFFECTIVE USE OF RESOURCES

Anyone living in the Cove (postcode AB12 3??) or Peterculter (postcode AB14 ???) areas with a new need for nursing care, social care or both is eligible for assessment by the INCA teams.

The teams will cover 24 hours per day, 7 days per week including public holidays.

Out of hours periods where there are no scheduled visits should be covered on an on-call basis.

There will normally be no scheduled visits between 23:00 & 07:00.

We expect a minimum of one person (who could cover both teams) to be on call at all times. There will always be a qualified nurse on call.

The teams are expected to achieve 60% client related activity (either direct or indirect) within 6 months of go live date (22nd January 2018).

The remaining 40% of working hours covers annual leave, sickness, administration, training, team activities etc.

The teams have responsibility for managing their budget for stores and training.

The teams are expected to follow their host employer's personnel/HR policies and procedures & to discuss with the Project Team if there are any significant conflicts in terms of these policies.

The teams will manage absence but if a team member's absence level reaches the triggers within the host employer's Attendance Policy then this will be referred to the coach (once the ACHSCP has recruited coaching support. Until then, attendance will be managed by NHSG or BAC responsible managers)

Once the teams have reached their 60% client related activity target, if they are unable to provide the care hours required, they need to establish whether nursing or support worker hours need increased and seek support from the coach / HR regarding recruitment.

The teams should be knowledgeable about local/citywide community resources and be proactive in utilising those to achieve the best outcomes.

The teams will work out who should carry out required team tasks & whether / when to rotate them. For example:

- Rosters including accessing cover from bank/other INCA team if required
- Monitoring of hours worked & mileage
- Housekeeping
- Annual leave
- Stock orders
- Performance Monitor
- Management of student allocations and mentor issues (mentor registers, annual up-dates, triennial reviews)

SAFE, EFFECTIVE, PERSON-CENTRED CARE

Regular appraisal will be organised within the teams or with the coach.

Staff will identify their own training/learning needs with support from the coach but will also be asked to comply with some training requirements of either of the two host employers.

The teams will report incidents via relevant system.

Teams should respond to compliments and complaints through early resolution (and seek guidance from coach where this is not possible).

Teams should participate in audit / data collection to demonstrate the value of the project and influence plans for the future of service delivery across the city.

The teams should create holistic care/support plans with service users.

Team members should communicate openly and honestly with each other.

INTERACTION WITH HOST EMPLOYERS

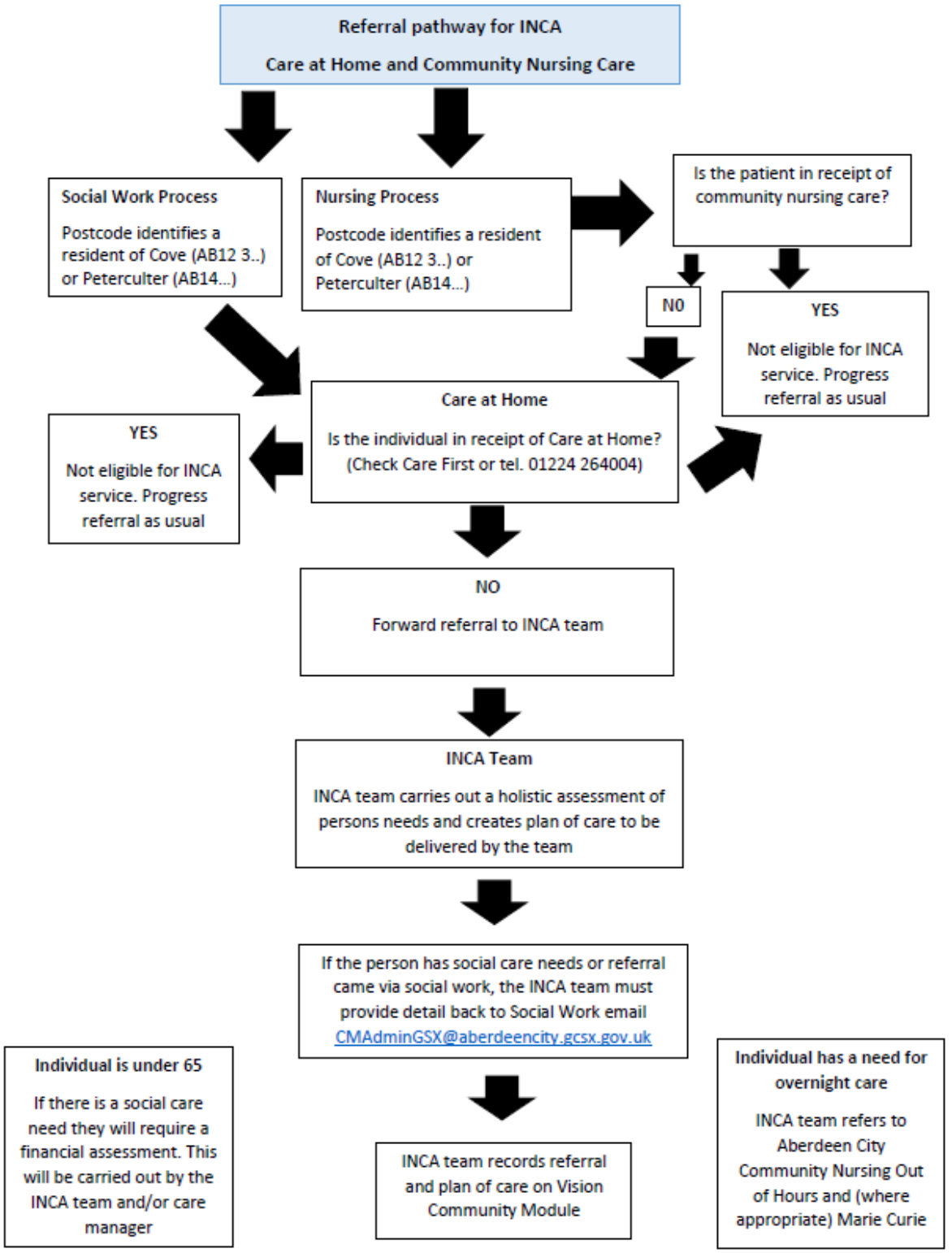
Team members should keep themselves informed of what's going on in ACHSCP / BAC via email, communication channels (eg aligned District Nurse Team Leader), also Safety Action Notices & registering body updates.

Teams should assist with the evaluation of the project and be prepared to speak/present to other colleagues about how it's progressing.

HAVE FUN AT WORK

We believe that working in this way will be fun, but if this is not the case, support from the coach and/or the Project Team should be sought to explore and try to resolve any issues.

Appendix 2. INCA Referral Process



20/03/2018 version 2.0

Appendix 3. Patient Outcome Questionnaire

Integrated Neighbourhood Care Aberdeen (INCA) Patient OUTCOMES

NHS Grampian

ID: (Research Team use only) ☐

Q1 Thinking about the good and bad things that make up your quality of life, how would you rate your quality of life as a whole? *Please tick ONE box only*

Very good ☐5	Alright / neither good or bad ☐3	Bad ☐2
Good ☐4		Very bad ☐1

Q2 In general,would you say your health is....? *Please tick ONE box only*

Excellent ☐5	Good ☐3	Poor ☐1
Very good ☐4	Fair ☐2	

Q3 During the past 4 weeks how much have you been bothered by emotional problems such as feeling anxious, depressed, irritable or downhearted and blue? *Please tick ONE box only*

Not at all ☐5	Moderately ☐3	Extremely ☐1
Slightly ☐4	Quite a bit ☐2	

Q4a How often do you have a drink containing alcohol? (if 'Never', go to Q5)
Please tick ONE box only

Never (go to Q5) ☐5	2 - 4 times a month ☐3	4 or more times a week ☐1
Monthly or less ☐4	2 - 3 times a week ☐2	

Q4b How many drinks containing alcohol do you have on a typical day when you are drinking? *Please tick ONE box only*

1 to 2 ☐5	5 to 6 ☐3	10 or more ☐1
3 to 4 ☐4	7 to 9 ☐2	

Q5 How many portions of different fruit and vegetables do you eat in a day? Remember that fruit juice only counts as 1 portion a day, regardless of how much you drink. The same applies to dried fruit. Potatoes count as starchy foods and not as vegetables. As a guide, a portion is about a handful.
Please tick ONE box only

0 ☐1	2 to 3 ☐3	5 or more ☐5
1 to 2 ☐2	3 to 4 ☐4	

Q6 In the past week, on how many days have you done a total of 30 minutes, or more, of physical activity, which was enough to raise your breathing rate? (This may include sport, exercise and brisk walking or cycling for recreation or to get to or from places BUT should not include housework or physical activity that may be part of your job)
Please tick ONE box only

0 ☐0	2 ☐2	4 ☐4	6 ☐6
1 ☐1	3 ☐3	5 ☐5	7 ☐7

Prepared by NHSG Clinical Effectiveness Team

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ProjID 4136 PatientOutcomes

Q7a Do you smoke cigarettes nowadays? *Please tick ONE box only*

Yes ☐ 1 No ☐ 2

Q7b If 'yes' to Q7a, approximately how many cigarettes do you smoke....?

i) on a weekday ..... <number>

ii) on a day at the weekend ..... <number>

Q8 During the past 4 weeks, was someone available to help you if you needed and wanted help? (For example, if you felt anxious, lonely or in a low mood, got sick and had to stay in bed, needed someone to talk to, needed help with daily chores, needed help just taking care of yourself) *Please tick ONE box only*

Yes, as much as I wanted ☐ 5
Yes, quite a bit ☐ 4
Yes, some ☐ 3
Yes, a little ☐ 2
No, not at all ☐ 1

Q9 Do you regularly participate in activities at different types of organisations? *Tick ALL that apply*

a) Church, religious group or charitable organisations ☐ 1
b) Education (e.g. art groups, music groups or evening classes) ☐ 1
c) Social Clubs (e.g. rotary club, women's institute, working men's clubs or elderly lunch clubs ☐ 1
d) Sports Groups (e.g. sports club, gym or exercise classes) ☐ 1
e) No, I do not participate in any group activities ☐ 1

Q10 If so, how many different groups do you participate in? <number>

Q11 Please use the space provided below to describe any other experiences you would like to tell us about or to write any other comments you would like to make:

Thank you for taking the time to complete this questionnaire

Appendix 4. Patient Interview Topic Guide

Experience of care

-Tell me about the support you get from the INCA team

-How has that changed from when you first met them?

(Prompt: changes to how care is delivered or who is providing the care)

-What did you value the most about the support the INCA team provided?

-How involved are you in the decisions about your support?

(Prompt: are the things that matter to you taken into account?)

-What would make the support you received better?

-Were you receiving support before the INCA team? If so, how does this compare?

Impact on wellbeing

-Have you noticed any changes to your health and wellbeing as a result of seeing the INCA team?

[IF YES] describe how these have benefitted you?

(Prompt: change in mood?; changes in mobility?; changes in your social life?).

- Are you able to do things that you couldn't before?

Referral to other services?

-Did the INCA team refer / signpost you to any activities in the community? (eg. social groups or activities)

[IF YES], what was it? [potential coffee mornings / walking groups etc.]

-Describe your experience of [name service]? How did it impact you?

Impact on unpaid carers

-Do you have a friend / family member who helps you out?

[IF YES], has the INCA team made any difference to them?

Appendix 5. Patient Satisfaction Questionnaire

Integrated Neighbourhood Care Aberdeen (INCA)
Patient Experience

NHS Grampian

ID: (Research Team use only) ☐

We are hoping to gather as many views as possible on patients' experiences of care from our INCA Team. Please take a few minutes to complete this questionnaire. All information collected is anonymous, so please be honest. Once completed, place this questionnaire into the pre-paid (no stamp required) envelope provided and post it back to us.

Q1 PREVENTION: To what extent do you agree or disagree with the following statements....?

	Strongly agree	Agree	Neither agree/ disagree	Disagree	Strongly disagree
a) The INCA Team supported me to live as independently as possible	☐	☐	☐	☐	☐
b) The INCA Team helped to reduce any medical symptoms I have	☐	☐	☐	☐	☐
c) I felt the INCA Team had all the information needed to treat me	☐	☐	☐	☐	☐
d) My care was explained to me in a way I could understand	☐	☐	☐	☐	☐

Q2 CHOICE: To what extent do you agree or disagree with the following statements....?

	Strongly agree	Agree	Neither agree/ disagree	Disagree	Strongly disagree
a) I had a say in the help, care and support that was provided	☐	☐	☐	☐	☐
b) The nurse/support worker took into account things that matter to me	☐	☐	☐	☐	☐
c) I was encouraged to have my say	☐	☐	☐	☐	☐
d) The INCA Team helped to increase the choices available to me about how I want to live my life	☐	☐	☐	☐	☐

Q3 OVERALL EXPERIENCE: To what extent do you agree or disagree with the following statements ....?

	Strongly agree	Agree	Neither agree/ disagree	Disagree	Strongly disagree
a) I am satisfied with the INCA services I have received	☐	☐	☐	☐	☐
b) I would recommend the INCA service I received to others	☐	☐	☐	☐	☐
c) I have confidence in the INCA Team members supporting me	☐	☐	☐	☐	☐
d) My care through the INCA Team was well coordinated	☐	☐	☐	☐	☐

Q4 Please use the space provided below to describe any other experiences you would like to tell us about or to write any other comments you would like to make:

Thank you for taking the time to complete this questionnaire

Appendix 6. INCA Staff Interview Topic Guide

Introductory Questions

1. Tell me about your experience of working in an INCA team?
2. How did you find working in a self-managing way?
3. How did you find having nurses and support working in one team?
4. How did you get on interacting with other organisations or departments?

Positives of working in this way/Enablers

5. What has worked well in INCA?
6. Was there anything that helped to make this new way of working successful?
7. What have you enjoyed most about this way of working?
8. Were these positives common for the other nurses / support workers?

Negatives of working in this way/Barriers

9. What have been the (biggest) challenges to this new way of working?
10. How did you try and overcome these? Was this successful?
11. Were there any barriers that stopped you overcoming these challenges?
12. Did nurses and support workers face different types of challenges?

Considerations for future INCA teams

13. If a new INCA team member started, what advice would you give them coming into this new way of working?
14. What qualities do you think would make a successful INCA team member?
15. In what way do you think the INCA way of working could be improved in Aberdeen?
16. If you were to start a new INCA team, what would you do differently?
17. Is there anything else you would like to tell me about your experience working in a INCA team?

Appendix 7. INCA Staff Outcome Questionnaire

Integrated Neighbourhood Care Aberdeen (INCA)
Staff Experience

NHS Grampian

ID: *(Research Team use only)*

Q1 **Job Title:** ☐ Support Worker ☐ Nurse

Q2 **INCA Team:** ☐ Peterculter ☐ Cove

Q3 **What is your year of birth? (yyyy)** _____ *Leave blank if you prefer not to specify*

Q4 **How many years experience do you have working in either Health or Social Care?**

☐ <2 years ☐ 2-5 years ☐ 6-10 years ☐ >10 years

Q5 **How satisfied are you with the following aspects of your previous job?**

	Very satisfied	Satisfied	Neither satisfied/ dissatisfied	Dissatisfied	Very dissatisfied
a) The recognition I got for good work	☐	☐	☐	☐	☐
b) The amount of responsibility I was given	☐	☐	☐	☐	☐
c) The opportunities I had to use my skills	☐	☐	☐	☐	☐
d) The people I worked with sought out my opinions	☐	☐	☐	☐	☐

Q6 **To what extent do you agree or disagree with the following statements regarding your previous role?**

	Strongly agree	Agree	Neither agree/ disagree	Disagree	Strongly disagree
a) I feel my previous role made a difference to patients/service users	☐	☐	☐	☐	☐
b) I was able to make suggestions to improve the work of my team	☐	☐	☐	☐	☐
c) I was encouraged to develop my own expertise	☐	☐	☐	☐	☐

Q7 **To what extent do you agree or disagree with the following statements regarding your previous role?**

	Strongly agree	Agree	Neither agree/ disagree	Disagree	Strongly disagree
a) I had the freedom to choose my own method of working	☐	☐	☐	☐	☐
b) I could decide on my own how to go about doing my work	☐	☐	☐	☐	☐
c) I was trusted to do my job	☐	☐	☐	☐	☐
d) There were frequent opportunities for me to show my initiative within my role	☐	☐	☐	☐	☐
e) My team made their own decisions about rotas	☐	☐	☐	☐	☐
f) My previous role was committed to helping staff balance their work and home life	☐	☐	☐	☐	☐

Q8 **To what extent do you agree or disagree with the following statements regarding your previous role?**

	Strongly agree	Agree	Neither agree/ disagree	Disagree	Strongly disagree
a) I felt I belonged in the team	☐	☐	☐	☐	☐
b) I tried to help colleagues in my team whenever I could	☐	☐	☐	☐	☐
c) I got support from my work colleagues	☐	☐	☐	☐	☐
d) The people I worked with treated me with respect	☐	☐	☐	☐	☐
e) I always knew what my work responsibilities were	☐	☐	☐	☐	☐
f) Relationships at work were strained	☐	☐	☐	☐	☐
g) My team worked well together	☐	☐	☐	☐	☐

Q9 **In the last 6 months, have you taken part in any of the following types of training, learning or development paid for or provided by your previous employer?**

	Yes	No
a) Taught courses (internal or external)	☐	☐
b) Supervised on the job training	☐	☐
c) Having a mentor	☐	☐
d) Shadowing someone	☐	☐
e) E-Learning / Online training	☐	☐
f) Keeping up to date with developments within your type of work (e.g. by reading books or journals or by attending workshops or seminars)	☐	☐

Q10 **To what extent do you agree or disagree with the following statements regarding your previous role?**

	Strongly agree	Agree	Neither agree/ disagree	Disagree	Strongly disagree
a) My training, learning and development has helped me to do my job better	☐	☐	☐	☐	☐
b) I was satisfied with the quality of care I gave to patients/service users	☐	☐	☐	☐	☐
c) I would have felt safe being treated there as a patient	☐	☐	☐	☐	☐
d) I was able to deliver the patient care I aspired to	☐	☐	☐	☐	☐
e) I was enthusiastic about my job	☐	☐	☐	☐	☐

Q11 **Please use the space provided below to describe any other experiences you would like to tell us about or to write any other comments you would like to make:**

Thank you for taking the time to complete this questionnaire

Appendix 8. INCA Partner Interview Topic Guide

Introductory Questions

1. How were you introduced to this new way of working – did you have enough information?
2. Tell me about your experience of working with the INCA team? How were your interactions with the team?
3. How did you find having nurses and support working in one team?
4. What are your impressions of health & social care being integrated in a self-managing team
    a. *Did it affect you/patients? Are self-managing teams the way forward?*
5. [If a referrer] What were your criteria for referral to the team?
6. [If a referrer] Did you refer all patients who were eligible? If not, describe any barriers/facilitators.

Positives of working in this way/Enablers

7. Do you feel there have been any benefits from this project?
    a. *What has worked well*? *Any advantages to patients/referrers?*
8. Was there anything that helped to make this new way of working successful?

Negatives of working in this way/Barriers

9. Have you been aware of any challenges in this new way of working?
    a. What have been the (biggest) challenges?
    b. Prompt: Challenges of the INCA project and challenges of their role (referring) within INCA.
10. How did you try and overcome these challenges? Was this successful?
11. Were there any barriers that stopped you overcoming these challenges?
12. Were you aware of nurses and support workers facing different types of challenges?
13. Do you see any disadvantages to patients/referrers?

Considerations for future INCA teams

14. In what way do you think the INCA way of working could be improved in Aberdeen?
    a. *Any differences between your views about INCA in theory and in practice)*
15. Is there anything else you would like to tell me about your experience working with the INCA team?