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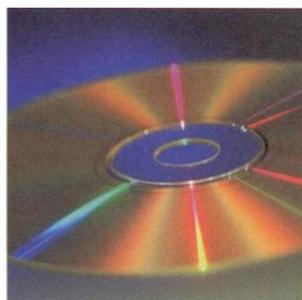
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Evaluation of the Kent & Medway One Care Pilot

Professor Jenny Billings
Gregory White
Dr Rasa Mikelyte

Centre for Health Services Studies
University of Kent
February 2018

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Kate Ludlow
Administrator
Centre for Health Services Studies
Rutherford Annex
University of Kent Canterbury
Kent
CT2 7NX

Tel: 01227 824057

E-mail: k.ludlow@kent.ac.uk

www.kent.ac.uk/chss

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1. Executive Summary

Introduction and Context

This report details an evaluation of the One Care pilot project, which delivered a unique model of health and social care in West Kent, based primarily on the Buurtzorg model of self-managed teams and led by Kent Community Health NHS Foundation Trust (KCHFT). The pilot ran from the period of May to November in 2017, and patients were referred from one GP practice in Maidstone.

Evaluation Methods

Our study aimed to investigate local implementation of the One Care pilot on two main outcomes:

Outcome 1: Implementation of a new model that will improve the patient experience of care;

Outcome 2: Improved staff engagement and retention.

A qualitative approach of individual semi-structured interviews and focus groups was adopted, and the evaluation sought opinions from seven service users, five members of the One Care self-managed team, as well as the One Care coach, two Kent County Council (KCC) managers, three managers from KCHFT and an external consultant associated with the pilot. Reflections from the Test and Learn steering group regarding the findings and suggestions for recommendations were also collected.

Key Findings

Outcome 1: Implementation of a new model that will improve the patient experience of care.

- Overall the picture is positive and interviews clearly demonstrate that patients have benefitted from the pilot in terms of wellbeing and support:
 - Patients felt that their health and social care needs were met in a holistic way and to a very high standard during the pilot, and expressed disappointment that the trial is finishing;
 - Patients also reported gaining a skill to plan for future health needs and more confidence in managing their own care as a result of the approach from the team;

- Interviewed patients also felt that One Care involvement also reduced the strain on GP services and the number of times the patients would have had to seek assistance from the GP surgery.
- All participants were pleased with care and support delivered by nursing team:
 - Patients praised the team's professionalised and personable approach and commitment to care;
 - Interviewed patients also felt that the One Care team offered support that exceeded their expectations; especially in relation to providing social care and support;
 - Patients did however express disappointment about the pilot closing and returning to traditional nursing
- Patients reported being treated with dignity and respect, and at a pace suitable to the patient. Frontline staff also felt able to deliver a positive patient experience and provide '*truly*' person-centred care, with many reflections mirroring those of the patients'
 - The One Care team reported that having more time to engage with patients allowed the staff to encourage patients to self-manage their care and plan for the future and develop more knowledge of their health conditions and needs
 - The ability to build strong rapport with the patients and work at their own pace was seen as crucial for achieving desired patient outcomes

Staff felt that they would have been able to take more complex cases if the integration of domiciliary care staff into the One Care team had been possible
- With respect to the team themselves, continuous care to promote patient independence had the perceived effect of building the team's own self-esteem, and helped with identifying and developing their own strengths, resources and confidence to become self-managed, although concerns were expressed about discontinuation of the project

Outcome 2: Improved staff engagement and retention

- The One Care team were highly positive about their involvement in the pilot and reported high morale during the pilot period
 - Staff were also largely positive about the support they received from managers on the steering group.
- The One Care team reported satisfaction about delivering care and working in

self-managed fashion

- Particular aspects that improved staff morale were: equal responsibilities for operations within the team, shared workloads, less time-pressure and limits on patient engagement, more direct contact with patients, and a finite caseload proportionate to team size;
 - However, staff also mentioned that the hierarchical structure of the host organisation at times impeded their ability to self-manage the team (e.g. by seeking permissions from team managers, which the One Care team did not have).
- Staff felt the pilot was an overall success but indicated that they did have significant obstacles that challenged service delivery (e.g. low GP engagement, delays setting up digital and physical infrastructure, data sharing across organisations, inability to recruit a domiciliary carer and lower staffing numbers than expected),
 - However, staff also reported proactively solving arising obstacles, including a proactive approach to finding suitable referrals when GPs could not provide these.
- Staff wished to be consulted about their experience implementing the One Care approach for any further applications of the Buurtzorg model and reported high interest in working in the Buurtzorg way again in the future.
 - However they reported anxieties about going back to the traditional way of working (e.g. more time pressures, larger, non-capped caseloads, inability to self-manage).
- Managers were highly complementary about the One Care team's engagement and performance.
- Managers felt that high staff engagement and greater likelihood to retain staff within teams like One Care resulted from the small size of the team, workloads adjusted to capacity/staffing, and team autonomy
- Discussions within the steering group have also demonstrated that even greater staff engagement and retention could have been achieved by improving health and social care within the team, improving GP engagement and suitability of referrals, as well as basing the teams more centrally within the communities they support.

Recommendations

Continue to explore and implement self-managed teams

- Develop clearer criteria for entry to the service with stakeholders.
- Enable teams to manage their own budget and set them with outcome criteria in order to promote greater throughput of the 'right kind' of patient and accountability for ensuring high caseload levels.
- Base teams more centrally within neighbourhoods so that house calls will be done at more convenient times for the patient and reduce travel time and costs for staff.
- Use practice as a base for continual development of skills and knowledge.

Integrate health and social care professionals within a self-managing team, moving away from separate health and social care tasks

- Align goals and responsibilities for shared health and social care approach to person-centred care within the self-management person-centred ethos.
- Create clear role definitions and agreed pathways to ensure continuity of care from referral to discharge.
- Develop strategies with all agencies involved to overcome barriers related to governance, resource allocation and data sharing.

Ensure favourable environment from the start of new projects

- Set up core infrastructure together with frontline team and before the patients are seen.
- Ensure the skills are in place and identify the necessary training.
- Set up data sharing agreements and data recording processes before the commencement of the project.
- Find ways of developing a closer relationship with referrers, especially GPs (involvement in set up, improving understanding and knowledge).
- Make more information about the team available to other services as early as possible in the process.
- Plan for a longer pilot period for projects of this nature

2. Introduction & Context

This report sets out the methodological approach, findings and recommendations of a seven-month evaluation of the pilot of the new One Care model of care within West Kent, which took place between May and November 2017.

The One Care is a model of care that is centred on the Buurtzorg model, founded in the Netherlands by Jos de Blok in 2006. The literal translation of Buurtzorg is 'neighbourhood care'. The core principles of this model are that the nursing teams are autonomous and self-managing. Buurtzorg teams are intentionally small with each team having a maximum of 12 nurses and the work with a smaller number of patients than the average district nursing caseload. This model has expanded over the globe with teams forming in Sweden, Japan and the USA.

The Buurtzorg nurses aim to spend at least 60% of their time with patients, working closely with relatives, informal carers and local voluntary agencies to ensure that communication is good and that care is delivered by the most appropriate person.

Based on this model, a pilot of One Care was trialled between May and November 2017, running from one GP practice in Maidstone – College Road – and led by Kent Community Health NHS Foundation Trust (KCHFT). The pilot was intended to consist primarily of a small self-managing nursing team of four nurses with social care and home care services staff (n=6) who together will be responsible for a caseload of adult patients. Due to reasons explained later in the report, the team consisted of three nurses, one health care assistant (who was away due to injury for the majority of the pilot) and a personalisation development officer who initially worked on the pilot two days a week, which was later dropped to one day a week. A domiciliary carer from a private care agency could not be recruited into the team. During the majority of the time the pilot took place, it was staffed by three nurses only. Referrals into the team were accepted from hospital, GPs, social care or other nursing teams. The team had a dedicated coach supporting their development and training, which included visits to the Netherlands sites. The overarching aims of the pilot were to:

- To increase patient experience of care in their homes
- To increase self-management of and engagement in their health pathways
- To improve the holistic assessment of the patient
- To prevent deterioration or complications related to their condition

It was anticipated that One Care would create the opportunity to set the course for a robust service development and anticipated roll out across the area.

Evaluation of this pilot was required to investigate two main outcomes:

Outcome 1: Implementation of a new model that will improve the patient experience of care

Outcome 2: Improved staff engagement and retention

The aims of this evaluation were:

- a) Develop a co-designed evaluation framework for evaluating the pilot;
- b) Undertake a formative evaluation regarding: (i) the implementation of the new model of care through patient/informal carer experiences/impacts and staff perceptions (outcome area 1) and (ii) an assessment of the extent to which staff engagement and retention has improved through staff experiences (outcome area 2)
- c) Identify 'active ingredients', success, and areas for improvement
- d) Develop recommendations for practice

All data reported in this document are based upon the perceptions and experiences of participants and do not reflect KCHFT as a whole.

3. Methodology

3.1. Co-design of the evaluation framework

As the One Care pilot was in itself in development, it was vital to approach the evaluation in a flexible and responsive manner, and in co-design and partnership with stakeholders who were managing and delivering the service. This included agreeing an initial evaluation framework, the method of evaluation and associated tools.

In terms of a design, it was agreed that the research would adopt a formative approach, using qualitative methods as the primary source of data collection. The target groups were to include patients, informal carers, staff delivering the service, the One Care coach, managers, commissioners and other key informants associated with the College Road GP practice. There were to be individual semi-structured interviews with patients and staff, and a focus group with the One Care Team. The research team provided drafts of data collection instruments and these were developed and agreed with the Test and Learn Group, and the One Care team. It is to be noted that, despite attempts, no informal carers were available for interview during the evaluation period.

3.2. Patient interviews

Initially, our evaluation intended to collect interview data from 15-20 patients of differing ages, backgrounds and conditions. However, due to a number of issues relating to the roll out of the service and recruitment for the evaluation, which will be outlined in due course, an actual sample of seven patients was purposefully selected.

The inclusion criteria were:

- the participant is cognitively able to participate,
- the participant is able to understand and converse in fluent English
- he/she has had at least four contacts with the team to be able to fully inform on the service experience.
- the participant is based at home (their own home, in extra care facilities, or sheltered housing)

Semi-structured interviews were used as a primary source of data collection in order to explore aspects such as the overall experience of care, the extent to which needs were identified and met in an holistic way, participation in care and care planning, the quality of care and how co-ordinated it was, effects on health and wellbeing, comparisons with any previous service contacts, effects on self-care and maintaining independence at home, and exploration of crisis avoidance and illness prevention

(*Appendix A for interview schedule*). The interview was recorded and took no longer than 45 minutes to avoid fatigue.

With respect to recruitment, potential participants were approached by a member of staff on discharge or after at least four contacts and informed of the evaluation. If they agreed to take part, the staff member completed an expression of interest form and the details were given to the researcher (see *Appendix B*), who then contacted the participant to arrange a suitable time for an interview.

3.3. Staff focus group and interviews

As for data collection with staff members, a total population sample of the self-managed team (n=5) was set for participation in a focus group. The first part of the focus group explored issues related to service delivery, with the second part focussing on staff engagement and retention. In addition, it aimed to investigate team working, co-ordination and collaboration, assessing needs and care planning, information sharing, quality of care, and perceived impacts on patients. The second part aimed to gain impressions of roles and relationships inside and outside of the immediate team, impressions of self-management, motivation and satisfaction levels, impacts on retention, experiences of the coach, and wider management, cost effectiveness and accountability issues (*Appendix C for focus group schedule*). Due to staff availability only the nurses (n=3) participated in the focus group. A health care assistant who had since left for a different position, and the personalisation development officer have been interviewed separately. A total of five frontline staff took part.

Further individual interviews were conducted with the One Care coach, two Kent County Council (KCC) managers, three managers from KCHFT and an external consultant associated with the pilot (n=7). With respect to the individual interviews, the subject matter mirrors the focus group discussion areas for continuity, although is tuned to the informant's perspective (*Appendix D for interview schedule*). The focus group and interviews were no more than an hour duration and were recorded with permission.

Despite numerous attempts to recruit GPs, no general practitioners referring to the One Care team agreed to take part in the interviews.

With respect to recruitment, staff were approached directly by research staff and provided with an information sheet if they expressed an interest in taking part. Individual arrangements for interviews and focus groups were made with researchers at the staff's convenience.

4. Analysis

All qualitative data was transcribed and subjected to content analysis using Flick's (1998)¹ approach. This required bringing a predetermined template to the data usually fashioned from the instruments (in this case the interview and focus group schedules). Transcribed data and quotes were sorted into the predetermined categories and coded according to the origin of the quotes. Each category was then analysed into themes using the quotes to justify interpretation. Data that did not easily fit into the predetermined categories was set aside and separately thematically analysed, so that all data was optimised. To ensure a credible and unbiased analysis, a second researcher checked the analysis trail.

4.1. Ethical procedures

As the evaluation did not intend to recruit participants that were cognitively impaired, ethical approval was gained from the University Research Ethics Committee within the School of Sociology, Social Policy and Social Research in June 2017.

High ethical standards were maintained. All data were rendered anonymous through a coding system that only one researcher had access to, and participant confidentiality was maintained. All participants were informed about what taking part would entail and reassured about the right to withdraw (see: *Appendices E, F, and G for patient, frontline staff and manager information sheets respectively*).

In this report, efforts have been made to ensure as much as possible through coding that data are not traceable to individual participants. Although the One Care nursing team may be identifiable as it was unique in the local area, individuals will not be identifiable within the reported data. The team has been made aware of this aspect and it is included on the consent form (*Appendix I*). There is also the potential for those taking part in individual interviews (managers, GPs, the coach and the commissioner) to be identified. However, the professional origin of the participant will not be reported, instead a coded collective term such as 'interviewee 1' will be used descriptively or attached to quotes when reporting the findings.

Data have been stored on a single password protected computer and will not be transferred between parties. As well as information sheets mentioned earlier, the researcher gained consent to participate at the point of data collection to ensure complete understanding of procedure (see: *Appendices H, I and J for consent forms for patients, frontline staff and managers respectively*). It was stressed to patients and

¹ Flick U (1998) *An Introduction to Qualitative Research*. Sage Publications: Thousand Oaks CA.

informal carers that either taking part or not will not affect their care, and to all participants that participation is voluntary and that they could withdraw at any time.

5. Findings

This section of the report presents findings from interviews. To maintain balance of perspective, patient, frontline staff and management staff contributions are presented separately.

5.1. Patients

As has been outlined, despite the initial intentions of the study to recruit between 20 and 25 patients, an actual sample of seven patients was achieved. Whilst the number recruited fell short of our expectations, there are several rich testimonies from participants outlining experiences with the One Care team.

The data collected strongly indicates that patients had a positive experience with the One Care team, and further, have reaped improvements to their health – especially in terms of self-management. As will be discussed, participants emphasised that the care and support received from the nursing team was both professional and personal. The findings will be grouped within three main themes, namely experience with receiving the service, effects on health and wellbeing, and care received through the pilot.

Theme 1: Experience with receiving the service

Overall, patients responded positively to the first set of questions regarding experiences of the One Care pilot. The positive experiences of patients are reflected in all of the interviews conducted, with comments ranging from professionalism to attention to detail from the team. Those patients receiving the service reported to us that they felt the team had treated them with dignity, and, further, had offered a level of personal treatment they had not experienced previously.

In terms of receipt of care, one patient commented that the service offered had been over and above personal expectations:

“The [One Care team] are marvellous; more than I ever expected... Much nicer than having just the district nurses come; all different ones all the time. To have the same nurses all the time is marvellous... and they’re so helpful.” (Patient AB)

Some of our participants went into greater detail regarding the service received by the One Care team. Comments focused on social matters, such as the team offering their time, above what might be expected, to provide care:

“The One Care team were just friendly, they’re nice and they’ve got time, so I think that’s fairly important... They’re not there to just do something medical, they go further.” (Patient CD)

Theme 2: Effects on health and wellbeing

The second part of our patient questionnaire dealt with participants’ perceived impacts on personal health and wellbeing, as a result of the interventions of the One Care team. Overall, participants noticed a general improvement of their wellbeing. The majority of comments focused on the provision of holistic care and support. In addition, participants were very positive in terms of how they might plan for future health needs, as a result of the approach from the team.

These quotes illustrate the interpretation above:

“[The team] gave me encouragement, and I could ask them questions as to what I can do.” (Patient EF)

“They’ve been very good in the sense of they’ve come, tried to guide me in the sense of you must eat this, try and eat this but they’ve been very good... in giving future plans and trying to help with anything that god forbid could go wrong.” (Patient GH)

“When they first started looking after me I couldn’t draw up my syringes with water, you know, so they were having to come twice a day and I can’t even remember if it was three times a day. It was definitely twice a day. And now they only come once a day so, they’ve helped me. My hands have got a little bit more strength to be able to pull up the syringes and fill the syringes. I could always press it down but I couldn’t pull it up but then they came up with an idea. They did a lot of research and they put a lot of effort in to finding different ways so eventually they found a way where I could [do it] myself and do my own flushes by connecting the syringe to my peg without the plunger in it, filling it with water and letting gravity do the rest which...” (Patient KL)

Theme 3: Care received throughout the pilot

In terms of care received by patients through the One Care pilot, participants have been broadly positive. Specifically, patients were pleased with the personable attitude of the team, and commented on their commitment to care. The responses demonstrated that patients received care with the utmost professionalism from the team.

“It’s great because if you’ve got little things... You know, when you’re ill, like I am, little changes happen to your body and you think oh my god, what’s that? You can mention it to them and they can say, “Oh don’t worry about that, it’s

this and that and the other.” You don’t have to feel you’re running to the GP all the time.” (Patient IJ)

“I’ve got no complaints at all with any of the nurses that come to re-dress me, they’re all very friendly and all very helpful.” (Patient KL)

Theme 4: Improving the care

To conclude our analysis on patient responses, the following focuses on participant’s comments on how care could be improved in future, in light of their experiences during the pilot. There are a few general points that have been made by participants: firstly patients were clear that the approach in the pilot would help reduce strain on GP services:

“If they continue what they did with me the first six weeks I don’t think they could [improve] on it... I think the One Care would be marvellous for practices, because it would alleviate a lot of pressure off them and also off the nursing staff they’ve got as well.” (Patient MN)

Secondly, on being asked for their reflections on the pilot as a whole, participants made it clear that they had anxieties about the project coming to an end. Several patients expressed regret that the pilot would be coming to an end.

“Very soon I’m going to have to be seen by someone else and that’s going to be difficult. So, from that point of view I’m not impressed but everything else about it perfect.” (Patient OP)

5.2. Frontline Staff

Five themes were extracted from frontline staff focus group and individual interviews. The themes revolved around the experience of providing a service, coordination and impacts on patients, sustainability of the approach, its benefits, general workforce issues, as well as staff engagement and retention. Each theme had further subthemes indicated in bold, which are presented below with accompanying quotes from participants.

Theme 1: Experience with Implementation of the Pilot

Frontline **staff were very positive** about the Buurtzorg approach. Having sufficient time to get to know the patients and the full complexity of their health, as well as social

care needs was seen as particularly important, as was the opportunity to discuss with the patient what type of assistance/help is a priority to them and what their goals are.

“We’ve had the time and the freedom to build up good relationships with our patients whereas... as a community nurse, we just do not have that time factor, do we, in our normal roles which is very sad but we don’t. So I have really enjoyed having a much more in-depth relationship with the patients that we’ve had” (Interviewee F01)

The self-managing aspect of the Buurtzorg model was also seen as a particular strength, although staff spoke about some difficulties with autonomous teams. The new, traditionally managerial tasks were initially difficult (although staff regarded this as a welcome challenge). Managers from the steering group were praised for allowing frontline staff to make decisions

“I do think that the management have actually stepped back and let us run [the team] the way we feel we’d like to run it and that has been really, really nice” (Interviewee F03)

Setting up the infrastructure of the project was seen as particularly difficult, and the interviewees reported a sense of lack of support. While the team were positive about self-management and the new challenges this entailed, the staff felt that some tasks were outside their initial capabilities and authority and they should have been better prepared at the beginning of the pilot.

“I think the idea of us being a self-managing team meant that we were kind of like ‘right, you’ve been to Holland, you’ve seen how it’s done, off you go’ and there was no support from the management right at that beginning phase when we didn’t even know almost like what we didn’t know. We didn’t know what codes were needed, how to order, how to roster, how to use the systems so some initial input from the management at the start to get us all up to speed I think would have been really helpful because it just takes longer when you’re scrabbling about trying to work it out for yourselves or trying to find someone and that’s not the right person so try this person, try that person.” (Interviewee F02)

Another sub-theme regarding the experience of providing the service concerned **issues with recording patient data**. This was found particularly difficult because IT access was delayed at the outset of the project and the staff were not set up as a single team. An added issue was monitoring team’s performance.

“A lot of that data is going to be lost because we weren’t able to put it down as One Care so unless they go through every single patient contact that we’ve had, only then you’re going to get that” (Interviewee F03)

“We’re still not set up properly in CIS as a group” (Interviewee F02)

Aside from accessing patient records within the Kent Community Health Trust (KCHT), **data sharing** between KCHT and KCC (Kent County Council) did not progress because there was not felt to be a need as the domiciliary service was not going to join the pilot. This did cause some barriers as there were still some non NHS workers in the pilot.

“It’s very hard to have integrated care if we don’t have integrated systems” (Interviewee F02)

“And also not being able to document the social care side of things because it was health and social care so it’s all gone into the adult record of care and, again, you know, it’s quite in-depth and if you’re seeing that patient every single day of the week there’s a lot of data there that you’ve got to read through and nobody’s going to take the time out to [extract social care data]. So a lot of the data will be lost, you know, from what we’re trying to capture. (Interviewee F03)

Due to the delays with digital and physical infrastructure and the amount of frontline staff’s time this consumed, the interviewees reported **feeling rushed to see patients**. The staff attributed this to the relatively short (6 month) duration of the pilot, which meant that to meet the intended outcomes patients had to sign up to the pilot rapidly after its commencement. Staff also expressed feeling that managers did not fully appreciate the amount of set-up and familiarisation required from the frontline staff.

“I felt that we were rushed into seeing patients maybe a week before we were quite ready. [...] it may not have been meant like that [but a] conference call that we had was very difficult [...] but it did feel like we were rushed” (Interviewee F03)

Lack of General Practitioner engagement with the pilot was also a prominent sub-theme. When the pilot was being planned the Clinical Commissioning Group identified the GP practice and sought their agreement to be part of the pilot, however the GPs involved seemed to know little about the pilot, the Buurtzorg model and the role they had in this. Frontline staff reflected that lack of GP buy-in resulted in a lack of referrals to the one care team. However, the staff could not suggest a reason for such lack of engagement.

“The GPs [...] had no understanding, they weren’t informed, they were just told that they were going to be part of this project. We’ve never really got to the bottom of it but they have not been engaged with us” (Interviewee F01)

“We haven’t developed a close working relationship with the GPs at all in any way” (Interviewee F02)

“Not through our fault, not through want of us trying. We tried” (Interviewee F01)

“Despite all the promotion that we done, they just weren’t interested” (Interviewee F03)

As well as struggling to receive a sufficient number of referrals, the staff also felt that referrals made by the GPs were not always suitable. In particular, the One Care team mentioned receiving referrals for the most complex and time-consuming cases from the GP practice. Some frontline staff speculated that the GPs may have been given an incorrect impression on the impact One Care team would have on service use (e.g. out of hours calls) and that they were not sufficiently aware of the scope of the pilot (e.g. no night-time staff availability).

“Before we’d come as a team, they’d already devised a list full of patients’ names but they were... all of them were their difficult patients...” (Interviewee F03)

“GPs were hoping for a massive reduction in out of hours calls, but then to put in a team of four people who cannot possibly cover 24 hours a day, I don’t think they were sold a realistic vision of what we could achieve in a six month pilot, small project” (Interviewee F02)

In relation to the above, frontline staff spoke about dealing with lack of suitable referrals from GPs by being proactive and “finding [their] own referrals”. This was achieved by utilizing existing links with district nurses and working closely with other professionals within the GP surgery (e.g. the paramedic).

“We found our own referrals by working in partnership with the district nurses really [...] We got about three referrals from the GPs and unfortunately none of those were appropriate for our service and then they have the paramedic there and we got a lot of referrals from him [...] we had to chase for all of our patients and we did that by working... We looked at who had been referred to the district nurses and after talking to them, whether they thought we could go in and assess them and that worked okay. (Interviewee F02)

Overall, Theme 1 demonstrated that staff found working on the pilot positive overall, although setting up digital and physical infrastructure resulted in considerable delays and other difficulties. Working with GPs was also problematic, with insufficient and at times unsuitable referrals, however, the team proactively obtained appropriate referrals via other routes.

Theme 2: Coordination & Impacts on Patient

The second theme revolved around coordination of service provision along with intended patient impacts and how/if these were achieved.

Ability to provide *'truly' person-centred care* was a strong sub-theme, with frontline staff attributing this ability to having more time to get to know the patients and their own wishes, as well as building rapport over frequent and non-time-limited visits.

"The extra psychological support that our patients have been getting because we have been in there with time to care and to do extra bits. I think that has worked really well and I think it's worked because we were allowed to start with a small caseload and find our feet" (Interviewee F01)

"[Patient needs are now] looked at in a much more holistic way than they would be in a normal [sic.] nursing or even social care setting" (Interviewee F01)

According to the frontline team, more time engaging with patients allowed them to encourage self-management of care, which then resulted in increased patient confidence and independence. At the same time, however, staff mentioned that some patients set unrealistic or unachievable goals, which complicated their approach and negatively affected patients' perceived success of input. While positive about personal goals and self-management of care, the frontline team questioned how working with patients who set unrealistic goals could be improved.

"A gentleman who doesn't get out of the house, doesn't really get out of bed very much, eats very little, goes from bed to chair downstairs and that's it and trying to set some goals, person-centred goals for him, and he wanted to play cricket again. Not watch cricket, he wasn't interested in just going out and seeing a match of cricket, but playing cricket" (Interviewee F02)

"He hasn't even been into his back garden for the last – what? – four years or something?" (Interviewee F01)

"Basically when we were asking people to set some goals, none of those goals were health related. Even people with leg ulcers... their goal was not to heal the ulcer, not to improve it in any way and I think that's really interesting" (Interviewee F02)

Despite the difficulties with setting realistic goals, frontline staff offered several recollections of encouraging confidence and independence, which then resulted in improvement of the patient's health:

“One particular patient [...] had a heart attack and she didn't necessarily need any nursing care but her name was put forward to us because she had lost confidence in everything. “I'm scared to have a shower just in case something happens. I'm scared to walk down the road just in case something happens.” (Interviewee F01)

So we went round. She was absolutely fine in the shower but knowing that there was a nurse there to give her that element of support she was completely independent, you know, with her hygiene needs and then to try and build up a level of exercise tolerance up again we were walking down the end of the road with her and walking back with her again. [I]t could have easily gone the opposite way [...] she might have become one of those patients who would have ended up isolated [...] (Interviewee F03)

Aside from spending more time with patients *per se*, **continuity of care** (i.e. being visited by the same, relatively small, team of professionals) and building strong professional and therapeutic relationships with the patients was seen as crucial for positive patient outcomes.

“We've had the time and the freedom to build up good relationships with our patients [...] So I have really enjoyed having a much more in-depth relationship with the patients that we've had. (Interviewee F01)

“[Patient needs are now] looked at in a much more holistic way than they would be in a normal [sic.] nursing or even social care setting” (Interviewee F01)

However, there were difficulties with **integrating social care into the team**. Staff felt that inability to add social care staff to the team, and the limited presence of the personalisation development officer due to a change in circumstance had a negative impact on their ability to achieve intended patient outcomes, accept a wider range of referrals and provide integrated care. As the personalisation officer was not a funded role it was not possible to replace her role in the team. The majority of patient contact was with healthcare professionals, with a lack of social-care professionals' perspectives and input. Importantly, while the team was set up as a self-managing one, they felt these changes to have been out of their control and reach.

“I've wondered how different our service would have ended up if we'd had the carer from the start because obviously we are three nurses and a healthcare assistant, we all come from a health perspective and I wonder how much

different [our work would have been] and maybe we would have taken on some different patients” (Interviewee F02)

Theme 3: Sustainability

In terms of **continuing with the Buurtzorg approach** within the services, frontline staff reported having been told that the project would be extended, others – that it would be replicated in another locality,

“I was under the understanding that [...] they were going to roll the project] out for a year. [W]e found out half way through that, no, six months, that’s it and so we had a lot of optimism in the beginning, didn’t we?” (Interviewee F02)

At the time of the interviews and focus group, frontline staff were aware that KCHFT had recently been successful in a joint partnership bid for a large research project to implement the Buurtzorg model in four counties in Europe (TICC project). It had been agreed that the model would be established in a different area of west Kent to ensure there would not be bias through previous work. This reflects the views of the One Care team who attributed the success and quick adoption of a new way of working within the current pilot to recruiting staff into the team; new recruits had an interest in the Buurtzorg approach and ‘*decided*’ to apply for the project. The staff questioned if the model would be adopted as successfully if it was imposed on an existing team.

I think the active ingredients are we all volunteered, we all applied for the job because we had an interest in it and I think that at first that is what you need. You need people who have got an interest with it rather than it being imposed on a team” (Interviewee F02)

Despite some concern about their future involvement, the One Care staff hoped to be consulted in the future and felt they had valuable insights on the practical applications of the model within health and social care contexts in the UK (and more specifically KCHFT and KCC).

“I think they are under the impression that we will be part of this TICC project when it’s rolled out because we do have the experience and we have made it successful and I think the management are quite shocked at what we have achieved so I think their ideas are still to have us on board” (Interviewee F03)

One Care staff reflected on **organisational factors** that influenced implementation of the Buurtzorg approach and would remain important in future applications. Staff reflected that in some respects the hierarchical nature of health and social care organisations in the UK were not ready or able to embrace and support the self-

managing aspect of the team. Instead, the organisation perpetuated hierarchies both within the team and the way the team was treated as part of the NHS trust. Organisational culture change was therefore seen as necessary to enable and sustain the implementation of the Buurtzorg approach.

“There isn’t a banding within the team and it didn’t appear to me that there was ever any banding issues within the team but because it is the Trust, they entrust to the higher band the higher powers so things like authorisations... banding came into that. But that came from management, that didn’t come from us because if it was us as a team, we would have sat and discussed right, somebody needs to do this, who’s going to do it? But it wasn’t like that because we weren’t completely working autonomously. (Interviewee F04)

“Managers if you like, will address everything to the Band 6 rather than the team rather than all of us jointly, that has been, yeah that has been a slight issue but again it’s understandable because everyone’s learning a new way of working and that includes our Managers who are used to working in a hierarchy” (Interviewee F01)

Overall, Theme 3 demonstrated that careful consideration and organisation change is necessary to sustain teams applying the Buurtzorg approach.

Theme 4: Benefits of the One Care Approach

Theme 4 revolved around the perceived benefits of the new way of working within the pilot for its staff.

Staff were overwhelmingly **positive about the project**. Frontline staff also expressed a desire for more health and social care practitioners to experience working within the Buurtzorg approach.

“The relaxation of being able to hand something over and knowing that it will be done because I trust my co-workers... and because they have the time to do it” (Interviewee F01)

“We all feel responsible... and there aren’t really delays in our team” (Interviewee F03)

“It has been a positive challenge [...] I enjoyed coming to work every single day” (Interviewee F02)

“It would be really nice for other teams to experience this way of working” (Interviewee F03)

When asked to comment about specific **beneficial aspects** within the pilot that contributed to their positive experiences, staff mentioned the following aspects:

- Equal responsibility over patients and other aspects of work
- Shared workloads, which enabled successful handovers between team members and enabled shared decision-making
- Self-managing of the team that allowed setting priorities and problem solving in the way that fit the particular set-up of the team. Self-managing also avoided delays in taking action or dealing with arising issues
- Less time-pressure and limits regarding seeing clients, which meant that visits could be extended when necessary and go beyond team's working hours in unusual circumstances (the latter was purported to have resulted in avoided admissions on several occasions)
- More direct contact with patients within workloads was, according to the frontline team, not only related to better patient outcomes and higher patient satisfaction, but also improved staff morale and motivation
- A finite caseload enabled the team to adjust the caseload for the size of the team and not compromise on intensity and frequency of care provision to the patients on the caseload

The quotes below illustrate some of the aforementioned benefits of the Buurtzorg approach:

"I think the reason why it's worked really well in this team is because we've all taken responsibility and we're all aware that we're all responsible" (Interviewee F03)

"We have a caseload, and I think that that works better because just knowing that when you're full you're full, that that means that you can always give the amount of time and care that you want" (Interviewee F02)

However, the teams were unable to **integrate Health and Social Care** within the One Care pilot. The One Care team was nearly entirely staffed by healthcare professionals (three nurses and one health care assistant). While the healthcare team felt they had integrated social care tasks into their practice, they questioned how different the team's performance would have been with a more substantial representation from social care professionals. When both social and healthcare professionals did work together within One Care, the staff noted a separation within the team and some lack of knowledge of remits, capabilities and roles between healthcare and social care. Nurses in particular were not sure what social care employees could offer and saw social care potential within One Care predominantly as domestic and personal care provision. While, as pointed out in the sections above, the One Care team felt they could have taken more and different referrals if KCC involvement in frontline service delivery was greater, they were not sure how the case mix would have differed or what exactly could have been added to the team's remit.

“It did feel quite separate [between KCC & KCHT frontline staff] especially in the initial stages. I think when it came to the later stages of the project, I did feel much more part of the team [...] There didn’t seem to be much clarity on what Health [services] are putting in and what Social Care are putting in” (Interviewee F05)

In terms of the benefits of the One Care pilot, frontline staff also commented about the benefits of **more direct contact with senior management**. The benefits revolved both around being listened to regarding frontline experiences, and around developing a better understanding of the rationale behind management decisions relating to the pilot. The One Care staff reflected on feeling that management and frontline staff worked towards a common goal and not against one another as a result of increased direct contact.

“... I don’t know any of the managers. I know the odd names but I definitely don’t know what they look like, let alone to even have spoken to them so it’s been quite nice to have a little chat every now [with the managers] to find out where they’re coming from, what their views and opinions are and [now] I completely understand the reason why they make the district nurses fill in millions and millions of things” (Interviewee F02)

Overall, Theme 4 demonstrated that frontline staff saw the One Care way of working as particularly beneficial, both to the patients and the staff, and were able to comment on specific aspects that influenced this. However, some concerns were shared regarding the ability to achieve integration between health and social care.

Theme 5: General workforce issues, engagement and retention

The final theme addressed workforce engagement and retention, as well as other workforce related aspects.

The frontline staff felt **engaged and dedicated** to the one care principles.

“This is a Buurtzorg thing - we do only what needs doing. And so we are getting to know our patients and doing the assessments that are required for them, rather than spending a whole load of time asking them questions and filling out electronic forms of things that really are not necessary” (Interviewee F02)

“I think some days were really busy... as soon as we realised our staffing issues, we all agreed that we would not take on so many patients that we couldn’t deliver what the Buurtzorg model was” (Interviewee F02)

They were especially positive about **managing the team** themselves, and making the necessary changes as the issues occurred, instead of being constrained by generic (i.e. not team-specific) policies or awaiting management permissions.

“I think [a self-managing team] is part of what’s made us all work well as a team because we’re all equally invested, we’re all equally responsible and that’s nice. I’m going to find that slightly difficult actually when I go back to my old team.”
(Interviewee F02)

However, the team also felt that aspects of self-management were not enabled. Due to funding constraints the project was fixed at 6 months and for 4 funded staff members The Personalisation Officer was an additional staff member seconded from Kent County Council, and this meant the team was unable to undertake the recruitment. Not being able to recruit new staff into the team came up a number of times and was seen to particularly go against the Buurtzorg model and negatively affect both workforce morale. It was, however, not possible to ascertain if lack of self-management opportunities in these areas affected patient care or outcomes.

“Part of the project is we are supposed to be interviewing our own team members and now all of a sudden they’re going to put another member of the team in with us and we’ve just got to deal with it” (Interviewee F03)

Flexible workloads and ability to hand over patient care to other team members was also seen as enhancing workforce morale, performance and retention.

“I felt that I could breathe for these last 6 months” (Interviewee F01)

“...just the relaxation actually of being able to hand something over that I haven’t been able to do and knowing that it will be done because I trust my co-workers but also because they have the time to do it and also because we all feel responsible” (Interviewee)

All of the interviewees reported **high satisfaction** and wished to continue working within the One Care team.

“I think we just got off the ground and we just got to some kind of level and the only direction it could have gone is upwards and it could have grown so I do feel very disappointed” (Interviewee F03)

“100% satisfaction. It’s been really nice to be part of this and we have made a difference to people and their life [...] I have been satisfied throughout”
(Interviewee F03)

“Even at times when it was stressful and things weren’t clear, it has been so satisfying... I feel a bit tearful actually” (Interviewee F02)

In addition to this, frontline staff shared their concerns about going back to the traditional model of working.

“It will be hard to go back to the top down approach from management. I’ve been very worried about it. I loved having the autonomy and the freedom and responsibility” (Interviewee F01)

“It’s going back to that way of working where you can’t give the time. I think I’m going to struggle” (Interviewee F02)

Nonetheless, some of the staff mentioned that the One Care pilot has equipped them with **new skills and confidences** they could take back to the teams working in the ‘old model’

“I feel more positive now that actually I can in my mind justify not having to fill out a [Assessment form] on someone who is obese and who has come to us for weight loss problems so I feel that I can justify that as I go back to my old team, I actually feel a bit stronger from doing this that actually I am a clinician and if I can justify clinically why this should or should not be done, I feel that I will be supported. We’ll see” (Interviewee F02)

The staff also expressed **concerns** for patients who will go back to a less integrated service once the One Care pilot comes to an end.

“[The patients are] going to have a shock, the ones that we do hand back to the community nurses, because they do not have the time to invest in the patients that we have had” (Interviewee F03)

“I do feel especially with our lady in [deleted to maintain confidentiality], we had lots of tears yesterday just the thought of what am I going to do? What is she going to do in a month?” (Interviewee F02)

Overall, staff satisfaction with the pilot was particularly high and its impending discontinuation resulted in concern that the traditional model of nursing would mean there was less time to spend with each patient which will impact on both for the workforce and the patients.

5.3. Managers

A further five themes were extracted from individual interviews with KCC and KCHT managers involved in setting up and steering the pilot, along with an external consultant of the Buurtzorg model and the One Care coach working with the frontline staff. As with frontline staff, the themes from manager interviews revolved around the experience of providing a service, coordination and impacts on patients, sustainability of the approach, its benefits, general workforce issues, as well as staff engagement and retention. Each theme had further subthemes, which are presented below with accompanying quotes from participants.

Theme 1: Experience with Implementation of the Pilot

Managers were positive about being involved in steering the pilot, but mentioned needing time to familiarise themselves with their roles and there was initial uncertainty on division of tasks and responsibilities. Managers also mentioned successful recruitment. With respect firstly to the **positive aspects**:

It has been one of those projects that people wanted to be a part of from the start [...] It was probably one of our most successful recruitment processes in terms of [nurses] coming forward to be part of the project” (Interviewee M01)

Managers were also complementary about One Care team’s ability to work autonomously despite arising challenges and dedication to the pilot.

“The managers appointed absolutely great colleagues into the team so the nurses that work in that team are, they’re passionate, determined, they really wanted to make this work. They can work autonomously so I think the staff that they identified they did that very successfully so I think the fact that we’ve delivered in terms of getting the pilot up and running has been great” (Interviewee M03)

Managers were also positive about ‘buy-in’ from other steering group members and commented on good peer-support within the steering group. However, some interviewees also remarked on difficult dynamics among individuals from different organisations (i.e. health versus social care) and felt health colleagues were disappointed that adding the domiciliary care element had not been possible.

“It’s always been difficult, looking at it from the perspective of the steering group. We had some good partnerships in there, but again I think there’s a blame culture unfortunately and if things didn’t progress it did seem to fall on Social Care” (Interviewee M07)

The specific **challenges with providing the service** revolved around finding a suitable base, issues with setting up IT systems, as well as data recording and sharing, and difficulties with securing sufficient finance. As demonstrated by the quote below, however, not all interviewees agreed upon or appreciated the needs for and difficulties with data sharing agreements between health and social care organisations. ‘Buy-in’ relating to the One Care pilot from professionals outside of the steering group and frontline team (especially General Practitioners) was identified as a particular challenge

“Well we did do a data sharing agreement but in the end it wasn’t necessary because we didn’t share any information outside of the NHS” (Interviewee M03;

“The GP surgery didn’t seem to know much about the project which, you know... we couldn’t quite understand why because they were part of the bid, part of the process at the very beginning!” (Interviewee M07)

Overall, managers were positive about their own and frontline staff’s involvement in the implementation of the pilot, but mentioned inter-organisational difficulties within and outside the steering group.

Theme 2: Coordination and impacts on patients

Theme 2 revolved around manager perspectives on coordination of care by the frontline staff and impact on patients.

With respect to **roles and responsibilities**, managers felt that the One Care team were clear about their responsibilities and shared goals, but could not adopt distinct roles within their team due to shortage of staff.

“[The team] knew what the vision was for patients, the different model of working and what they wanted to achieve... and I think the current evidence that I’ve seen shows that they’re achieving those goals, they’re certainly setting goals for the patient so they don’t go in there and say ‘right, you need this, I’m going to do this to you.’” (Interviewee M01)

Managers’ opinions diverged in relation to the obstacles frontline team experienced. A particular lack of consensus was apparent around **information sharing** within the team; some managers saw it as a major, ongoing obstacle, while others believed the issues to have been overcome.

“Information sharing has not been a challenge” (Interviewee M03)

“Social Services practitioner couldn’t access her site AIS [Adult Information System] when she was physically based with the team so that would be a barrier” (Interviewee M02)

Mirroring frontline staff’s reflections (see section 4.2) on difficulties in maintaining a self-managing team due to **organisational hierarchies**, managers also said that the hierarchical structure of the organisation struggled to support an *autonomous* team. In addition to this, it was discussed that some performance management structures and organizational goals were so engrained, that One Care team members may have inadvertently followed these (despite a self-managing team not being subjected to the same pressures).

“You know, it’s a paradox, isn’t it? Part of the point of this way of working is exactly to get away from KPIs [Key Performance Indicators], but the KPIs are so embedded in the culture and nurses are so accustomed and managers, too, to being guided by them that even if it isn’t a KPI, if it looks like a KPI you can easily respond to it as if it is one.” (Interviewee M05)

Despite the aforementioned obstacles, managers unanimously commented that the One Care approach resulted in **positive outcomes for the patients**, especially in terms of seamless care and enablement to self-manage own care.

“The patients themselves become much more involved and educated in what they’re doing [...] The team were able to offer support from the position of knowing the person, and [the patients] were then able to do something about it themselves... so it was giving independence to people” (Interviewee M04)

Therefore, while some aspects of care coordination were impacted upon by a number of obstacles, managers felt that the pilot resulted in positive experiences and outcomes for the patients.

Theme 3: Sustainability

In relation to the sustainability of the Buurtzorg approach in future projects, the managers consistently remarked that a **longer planning period** prior to patient contact is necessary for future implementations. Some staff also mentioned that if the pilot was set up for a longer period of time, a roll-out/mainstreaming of the approach may have taken place.

“If it went on longer it may have had a different outcome I don’t know.” (Interviewee M01)

“We [the steering group] will be at the [new] project with that knowledge, but we’ll be able to ensure that we do things differently” (Interviewee M03)

Theme 4: General workforce issues

Theme 4 concerned general issues with the workforce.

In terms of difficulties with the workforce, some of the interviewed managers reflected on the **challenges related to social care inclusion** and inability to include domiciliary care:

“The team had difficulty accessing Social Care practitioners. I was hoping they would be able to explore an enablement worker in the team [...] to provide the team with social support and test out Health & Social Care in practice” (Interviewee M02)

The small **size of the team** was also seen as the reason the team could not reach full potential and accepted fewer complex referrals than initially intended. Despite the originally intended six professionals within the team, on most occasions (apart from the relatively short period the Health Care Assistant was working with the team and the one-day-a-week involvement of the personalisation development officer) the team consisted of three nurses.

“I don’t think we’ve seen the full potential of the team because they have been [understaffed due to illness and lack of a domiciliary carer]” (Interviewee M03)

Workloads were seen as effective however, despite the staffing issues and many of the managers positively reflected on the 60% direct face time with patients within the pilot, which meant that the One Care team got to know the patients closely. A finite number of patients within a caseload, where the team could refuse further referrals if the maximum was reached, was also noted as a positive factor, related to low levels of stress.

“They were able to follow things through, they were able to give the 60% face time as in the Buurtzorg model and I think they appeared to be really happy at the care that they were given. No one looked stressed” (Interviewee M06)

Organisational hierarchies were also seen as having a negative impact on frontline staff in decision making. In addition to the impact on self-management (discussed in Theme 2),

“[The One Care team] are not as much in the loop as they should be” (Interviewee M05)

Managers were therefore aware of issues affecting the workforce and their contributions closely mirrored those made by the frontline staff (see section 4.2)

Theme 5: Staff engagement and retention

In terms of staff engagement and retention, the managers felt that the One Care team were highly **motivated and engaged** despite difficulties with infrastructure and staffing.

“I think for the 3 nurses [the project] would definitely have an impact on them wanting to stay in the job and grow the job” (Interviewee M01)

Managers also believed **relationships** within the One Care team and between the frontline team and the managers to be positive but complex and unstable with other professionals (e.g. with GPs and district nursing teams)

“[District Nurses] are not aware of how the team works exactly and I think for them they probably think ‘well they’ve got loads of time to do and we’ve got far more patients on our caseload’ which is true” (Interviewee M06)

However, manager opinions on **retention** differed. While some interviewees believed that the One Care team are more likely to stay in their job roles and organisations after the pilot due to experiencing an integrated way of working with less time constraints, others felt that following the Buurtzorg approach and subsequently going back to the traditional way of working will reduce retention.

“I think for the 3 nurses [the project] would definitely have an impact on them wanting to stay in the job and grow the job” (Interviewee M01)

“I think that the [One Care] experience and going back [to traditional nursing] can lead to being doubly disaffected. You can see that something can be done better, and then it’s gone” (Interviewee M04)

Overall, managers were positive about staff engagement during the One Care project.

6. Reflections from Steering Group

A Test and Learn Steering Group was convened in December 2017 where the results were presented, with the aim of developing and agreeing recommendations. The latter are presented in section 8, and this section describes reactions and reflections from the steering group members with respect to the findings.

The Test and Learn steering groups have been operational throughout the pilot term and many of the issues raised in the evaluation had already been identified and considered in relation to how aspects can be transferred to future roll out, notably the TICC project. These learning points have been included in the recommendations, and cover aspect such as basing teams more centrally in neighbourhoods, having clearer entry criteria, and instigating weekly calls between the team and the manager.

The potential benefits of such a project were discussed. Despite the small scale of the initiative which was recognised, reflections focused on the apparent positive outcomes and effects on wellbeing for both patients and staff. The known links between improvement in wellbeing and their potential contribution to psychological and physical health were noted. For patients in particular, the support given to promote independence seemed to have a positive effect on confidence and self-esteem which could in turn potentially have an impact on service use and cost reduction in the longer term.

In addition to this, the benefit of self-managing teams were clear to the group. Comments related to the fact that this type of team could work in nursing or social care, but the goal was integrated care. The challenges related to the integration of social care raised by the evaluation however were also noted, as were the organisational and economic difficulties in providing domiciliary care within the model.

Perhaps as a result of this deficit, the issue of nurses providing 'housekeeping' services such as washing up, and laundry were discussed. While the findings indicated that this may have been viewed positively by patients and by the team, from a management or professional perspective it was not perceived to be the best use of the resource. A view was that such activities are not provided within domiciliary care, and that there may have been a misunderstanding of what is meant by domiciliary care. A counter argument was that nurses were conducting these energy-intensive tasks to enable patient activities to be focused on important self-management (washing, dressing), especially in cases where energy levels were restricted, as in frailty. This was also seen to have a potentially positive effect on mental health. A reflection was that domestic help within any intervention should be linked to the context of encouraging and enabling independence in a client, rather than allowing it to be misinterpreted or undervalued as dependence on services. Either way, it is clear that agencies would benefit from a clearer understanding of how health and social care integration can work within the Buurtzorg approach in Kent.

Reflections and discussion also focused on the issue of autonomy. It was acknowledged that there is a tension between giving the team autonomy yet recognising some knowledge and skills needed to be in place at set up (e.g. how to roster etc.). The pilot has demonstrated that a balance needs to be drawn between the two, and improved dialogue between the team and managers may be a way forward as is reflected in the learning points.

A final point concerned the managerial use of measurement of care, and from this project there was a clear need to develop ways of demonstrating the impact of self-managed teams more through the use of process indicators that can establish for example the extent of shared learning, understanding of roles and responsibilities, and client-centred care, alongside more traditional outcome metrics.

7. Summary

This section will highlight the main points of the evaluation by returning to the two evaluation outcomes. It will also provide an overview of the study limitations.

7.1. Returning to Evaluation Outcomes

Outcome 1: Implementation of a new model that will improve the patient experience of care.

- Overall the picture is positive and interviews clearly demonstrate that patients have benefitted from the pilot in terms of wellbeing and support:
 - Patients felt that their health and social care needs were met in a holistic way and to a very high standard during the pilot;
 - Patients also reported gaining a skill to plan for future health needs and more confidence in managing their own care as a result of the approach from the team;
 - Interviewed patients also felt that One Care involvement also reduced the strain on GP services and the number of times the patients would have had to seek assistance from the GP surgery.
- All participants were pleased with care and support delivered by nursing team:
 - Patients praised the team's professionalised and personable approach and commitment to care;
 - Interviewed patients also felt that the One Care team offered support that exceeded their expectations; especially in relation to providing social care and support;
 - Patients reported being treated with dignity and respect, and at a pace suitable to / desired by the patient.
- Most patients showed disappointment that trial is finishing and expressed anxieties of returning to traditional nursing care.
- Frontline staff also felt able to deliver a positive patient experience and provide 'truly' person-centred care, with many reflections mirroring those of the patients':
 - The One Care team reported that having more time to engage with patients allowed the staff to encourage patients to self-manage their care

and plan for the future;

- The ability to build strong rapport with the patients and work at their own pace was seen as crucial for achieving desired patient outcomes
 - However, staff felt that their ability to take on more (and more complex cases) was negatively impacted upon by not recruiting a domiciliary carer and reduced input from the personalisation development officer into the team – even better patient outcomes were anticipated from a bigger and more professionally diverse team.
- Staff were clear about cases where holistic, time-intensive and continuous care enabled them to promote patient independence, which had the perceived effect of building the team's own self-esteem, and helped with identifying and developing their own strengths, resources and confidence to become self-managed. Because of One Care input, it was felt that the patients developed more knowledge of their health conditions and needs. Staff also felt they had a chance to familiarize the patients with the diversity of support services available in the community and their appropriateness for patients' particular circumstance.
 - Frontline staff expressed concern about the impact discontinuation of the pilot would have on the patients who were still receiving care from the team (i.e. cases that could not be closed prior to the end of the pilot).

Outcome 2: Improved staff engagement and retention

- The One Care team were highly positive about their involvement in the pilot and reported high morale during the pilot period.
 - Staff were also largely positive about the support they received from managers on the steering group.
- The One Care team reported satisfaction about delivering care and working in self-managed fashion
 - Particular aspects that improved staff morale were: equal responsibilities for operations within the team, shared workloads, less time-pressure and limits on patient engagement, more direct contact with patients, and a finite caseload proportionate to team size;
 - However, staff also mentioned that the hierarchical structure of the host organisation at times impeded their ability to self-manage the team.
- Staff indicated that significant obstacles hampered service delivery (e.g. poor

GP engagement, delays setting up digital and physical infrastructure, data sharing across organisations, inability to incorporate domiciliary care and lower staffing numbers than expected), but overall deem the pilot a success.

- However, staff also reported proactively solving arising obstacles, including a proactive approach to finding suitable referrals when GPs could not provide these.
- Staff wished to be consulted about their experience implementing the One Care approach for any further applications of the Buurtzorg model and reported high interest in working in the Buurtzorg way again in the future.
- The One Care team unanimously expressed a desire to continue working within the One Care model and reported disappointment about going back to the traditional way of working.
- Managers were highly complementary about the One Care team's engagement and performance.
- Managers felt that high staff engagement and greater likelihood to retain staff within teams like One Care resulted from the small size of the team, workloads adjusted to capacity/staffing, and team autonomy.
- Discussions within the steering group have also demonstrated that even greater staff engagement and retention could have been achieved by improving health and social care within the team, improving GP engagement and suitability of referrals, as well as basing the teams more centrally within the communities they support.

7.2. Limitations of the study

As with any short-term study in health and social care, there are limitations to undertaking research. During the One Care pilot, a number of issues were encountered which have resulted in a biased analysis in favour of staff perspectives. The following will provide some detail.

Sampling bias

The first set of limitations relate to recruitment of patients. As a total of seven patients were recruited for the study, it is clear that the potential for bias is very high, and, further, the opportunity for satisfactory analysis is questionable. In the original plan, as well as conducting qualitative research, it was the intention of the researchers to

concordantly issue questionnaires to patients. As recruitment for the study was low, it was decided that the issuing of any questionnaire would not yield statistically significant results.

The primary reasons for low recruitment were that: some patients withdrew from study entirely without reason; others were unable to participate due to change in circumstances. Also, a large number of patients were complex and too frail to take part.

Slow roll out and short duration of pilot

The six-month evaluation started in May 2017 and was due to report end of October, however the pilot was slow to commence due to set up problems that impacted on referrals into the system described by the participants. The project was extended to accommodate this. Data collection was therefore restricted to a three-month window between September and November, with December and January allocated to data analysis and report writing. This did not allow sufficient time for adequacy in patient recruitment, given the difficulties above, but did permit a satisfactory data capture of professional and managerial perceptions.

8. Recommendations

The final section of this report deals with recommendations for future learning in health and social care, both for Kent NHS CHFT, and, for the sector more widely. As has been evidenced throughout, there are a number of successful 'ingredients' key to the One Care pilot. In negotiation with the Test and Learn steering group, the following recommendations are put forward for consideration.

Continue to explore and implement self-managed teams

- Develop clearer criteria for entry to the service with stakeholders.
- Enable teams to manage their own budget and set them with outcome criteria in order to promote greater throughput of the 'right kind' of patient and accountability for ensuring high caseload levels.
- Base teams more centrally within neighbourhoods so that house calls will be done at more convenient times for the patient and reduce travel time and costs for staff.
- Use practice as a base for continual development of skills and knowledge.

Integrate health and social care professionals within a self-managing team, moving away from separate health and social care tasks

- Align goals and responsibilities for shared health and social care approach to person-centred care within the self-management person-centred ethos.
- Create clear role definitions and agreed pathways to ensure continuity of care from referral to discharge.
- Develop strategies with all agencies involved to overcome barriers related to governance, resource allocation and data sharing.

Ensure favourable environment from the start of new projects

- Set up core infrastructure together with frontline team and before the patients are seen.
- Ensure the skills are in place and identify the necessary training.
- Set up data sharing agreements and data recording processes before the commencement of the project.

- Find ways of developing a closer relationship with referrers, (involvement in set up, improving understanding and knowledge).
- Make more information about the team available to other services as early as possible in the process.
- Plan for a longer pilot period for projects of this nature

Appendix A: Interview Schedule – Patients

Interview schedule (patients)

Evaluation of the Kent & Medway One Care Pilot

1. Experience with receiving the service

The aim of these questions is to get your feedback on what does and does not work with the way your care has recently been given to you.

I. Please give us your thoughts on:

- a) Your overall impressions and experiences of receiving the service*
- b) What went well and what didn't go so well?*
- c) Thinking about any care you received six months ago, have you noticed any difference in the way your care needs are now being met?*
- d) If there are changes, are they better or worse? Please give me an example.*

2. Effects on health and well-being

These next questions ask about whether the care you have just received has made a difference to your health and well-being.

I. Thinking about your general health and well-being:

- a) Do you feel your health and well-being has improved, stayed the same or got worse?*
- b) In what way has it improved, stayed the same or got worse, and why do you think this has happened?*
- c) How do you feel about looking after yourself and being independent? Did the care you received make a difference? In what way?*

II. Thinking about avoiding setbacks to your health and well-being:

- a) Have you been offered any home safety improvements or been given any equipment to help you? If yes, what were you offered and did it help you or not?*
- b) If your health should take a turn for the worse, what would you do? Has the care team helped you with a plan of action?*

3. Care received through the pilot

Now I would like you to think about how the staff work to give you the care you need.

- I. Thinking about the recent care you received
 - a) *Who has been involved in your care?*
 - b) *Do you feel your needs were met? If yes, in what way? If no, please explain why.*
 - c) *Has your care improved, stayed the same or been worse?*
 - d) *Has the time in which the people involved in your care (your GP and other health care professionals) responded to your needs improved (for example, needing equipment, physio, or other referrals)?*
 - e) *How would you describe the way that the people involved in your care treat you? (respect and dignity, listening, friendliness)*

- II. How do all the different workers treating and caring for you work together?
 - a) *How would you describe the way that they work together?*
 - b) *Do you think that the workers share information with each other about you and your care plan, or do you find yourself having to repeat your story?*
 - c) *Is the information you get from workers consistent?*
 - d) *Do workers know all the important information about you that keeps you as independent as possible at home?*

- III. Do you know who to contact (and how to contact them) if you need to ask questions about your condition(s) or care?
 - a) *Can you go to this person with questions at any time?*
 - b) *If you want to contact a worker, how easy or difficult is it?*
 - c) *How well do you feel this person understands you and your needs?*
 - d) *Has it been easier or more difficult to get information and advice about other support, services and benefits?*

4. Improving the Care

These questions focus on how we can make improvements to the service.

- I. Thinking about the care you have received, what could we do to make the service better?

Final question: Is there anything else you would like to add?

Thank you for your time

Appendix B: Patient Contact Sheet

Contact sheet (for staff use) V1

Evaluation of the Kent & Medway One Care Pilot

Name (please print)

.....

Telephone number

.....

Email (optional)

.....

Preferred times to be contacted

.....

Please email this information to Gregory White at g.c.white@kent.ac.uk

Thank you.

One Care team – Focus Group Schedule

Evaluation of the Kent & Medway One Care Pilot

1. Experience with the implementation of the One Care pilot

- I. Since the pilot has been put in place, give us your thoughts on:
 - a) Your general experience of rolling out the pilot – what has been easy and what has been challenging?
 - b) Which aspects of the pilot were, in your opinion, implemented successfully? What facilitated this success?
 - c) Which aspects of the pilot were, in your opinion, less successfully implemented? What particular things got in the way?
 - d) Are there any changes to the way that patient care needs are now being met and looked at? What are your views about these changes?
 - e) What part have you played in the development of the pilot?

2. Coordination and impacts on patients

- I. In your opinion, has the pilot had any effect on the way you now work together in a coordinated way?
 - a) What has or has not changed?
 - b) How would you describe the way you now work together? How does the skill mix work? (*clear roles and responsibilities; shared goals, decision-making, working as a democracy*)
 - c) What are your perceptions of how information is now shared? (*data sharing agreements*)
 - d) What are your views on how the pilot has impacted on patients receiving care? (*outcomes – health and wellness, self-management, positive experience, seamless care*)
 - e) What are your experiences of working with the One Care team (*health and social care*)?

3. Sustainability

- I. In your opinion, what is needed to ensure the pilot continues to move forward?
 - a) What are the 'active ingredients' that could be passed on to other areas to help them succeed?
 - b) What personal attributes do you think you need to succeed in the pilot?
 - c) What skills did you bring to the team?
 - d) Are there any stumbling blocks that still need to be overcome? (*politics, workforce changes, working environment, culture, relationships, resources*).

4. Professionals working in the pilot

- I. Are you able to draw some conclusions about what works better in the One Care model and why? (*co-ordination, leadership, engagement, information sharing, care planning, culture, relationships*).

5. General workforce issues

- I. What are main issues that have encountered during the rollout of the pilot in regards to your role?
 - a) How have you responded to the implementation of the pilot – thinking specifically about your workload?
 - b) How have you been supported in the transition to this pilot?
 - c) Has the response to the pilot from the team been generally positive or negative – what might have led to this?

6. Issues of staff engagement and retention

- I. How has the rollout of the pilot affected your engagement within the team?
 - a) Has the pilot affected the work undertaken within the team – if so, why might this be?
 - b) Have there been any changes to relationships in or outside of your team – if so, what were they and why might they have happened?
 - c) How has it impacted on patient pathways (*right referral at the right time*)?
- II. Thinking about staff motivation and satisfaction, could you answer the following?
 - a) How would you rate your overall job satisfaction since the rollout of the pilot – what might have affected it?

- b) Have you been more or less motivated to undertake work under the pilot scheme?
- c) Do you think the pilot scheme will have an impact on the retention of staff – will it improve or hinder recruitment of new staff in to the team?
- d) Are you generally aware of issues relating to accountability and responsibilities under the pilot?
- e) What parts of the pilot would you recommend in taking forward for staff engagement and motivation?

Final question: Is there anything else you would like to add?

Thank you for your time

Appendix D: Interview Schedule – Managers

Interview schedule (managers/coach)

Evaluation of the Kent & Medway One Care Pilot

1. Experience with the implementation of the pilot

- II. Since the pilot has been put in place, give us your thoughts on:
- e) Your general experience of managing/being involved with/commissioning and leading the pilot – what has been easy and what has been challenging?
 - f) Which aspects of the pilot were, in your opinion, implemented successfully? What facilitated this success?
 - g) Which aspects of the pilot were, in your opinion, less successfully implemented? What particular things got in the way?
 - h) Are there any changes to the way that patient care needs are now being met and looked at? What are your views about these changes?

2. Coordination and impacts on patients

- IV. In your opinion, has the pilot had any effect on the way professionals now work together in a coordinated way?
- e) What has or has not changed?
 - f) How would you describe the way professionals now work together? (*clear roles and responsibilities; shared goals*)
 - g) What are your perceptions of how information is now shared? (*data sharing agreements*)
 - h) Are you able to draw some conclusions about what works better and why? (*leadership, engagement, information sharing, care planning, culture, relationships*)
 - i) What are your views on how the pilot has impacted on patients receiving care? (*outcomes – health and wellness, self-management, positive experience, seamless care*)

3. Sustainability

- I. In terms passing on lessons learnt from the One Care pilot:
 - a) What are the 'active ingredients' that could be passed on to other areas to help them succeed?
 - b) Are there any stumbling blocks that still need to be overcome? (*politics, workforce changes, working environment, culture, relationships, resources*)
 - c) How will the knowledge about active ingredients and stumbling blocks be passed on to the Tick project?
- II. How did the Buurtzorg initiative lead to the TICC Project? How does it relate to the One Care pilot?
 - a) What guided the decisions behind setting up the TICC Project?

Part 2

4. General workforce issues (managers only)

- II. What are main issues that have been encountered during the rollout of the pilot with regards to the workforce?
 - d) How have staff responded to the implementation of the pilot – thinking specifically about workloads?
 - e) How have the workforce been supported in the transition to this pilot?
 - f) Has the response to the pilot from the team been generally positive or negative – what might have led to this?

5. Issues of staff engagement and retention

- III. How has the rollout of the pilot affected staff engagement within the team?
 - a) Has the pilot affected the engagement of staff within the team – if so, why might this be?
 - b) Have there been any changes to relationships in or outside of the immediate team – if so, what were they and why might they have happened?
- IV. Thinking about staff motivation and satisfaction, could you answer the following?

- a) What is your impression of staff satisfaction since the rollout of the pilot – what might have affected it?
- b) Have staff been more or less motivated to undertake work under the pilot scheme?
- c) Do you think the pilot scheme will have an impact on the retention of staff – will it improve or hinder recruitment of new staff in to the team?
- d) Are staff generally aware of issues relating to accountability and responsibilities under the pilot?
- e) What parts of the pilot would you recommend in taking forward for staff engagement and motivation?

Final question: Is there anything else you would like to add?

Thank you for your time.

Appendix E: Information Sheet – Patients

Information for service user participants

Evaluation of the Kent & Medway One Care Pilot

Invitation to Participate in the Service Evaluation

We are researchers at the University of Kent and will be doing a review of the above service you have just received. You are being invited to take part in the evaluation because you have recently received care from this service. This information sheet explains why it is being done and what it would involve for you. Please do contact us if you have any questions. Our contact details are at the end of this sheet.

Purpose of the study

The One Care service you have just received is new. Locally, different health and social care workers are trying to find better ways of working together to improve care for people like you, living at home. As researchers, we will be looking at whether or not the new service is improving the way they share the care and work together to meet your needs. We will also be looking at how the service can help you stay well and manage your own conditions, making sure you are safe at home, and seeing if services can become better at what they do.

Why have I been invited?

We want to find out from people like you who have actually been using this new service whether you feel you have benefitted from it and generally what you think about the care you received.

What will happen?

We are asking your permission for you to take part in our study in two ways.

Taking part in a questionnaire

Firstly, we are asking you to complete a questionnaire. The questionnaire will ask you about how you feel about managing your own health and wellbeing. Depending on your preference, we will do the questionnaires with you face-to-face in an interview, or wait while you complete them yourself, or we will post you a copy of the questionnaire and ask you to post it back to us (in a prepaid envelope). The questionnaire will take about 20 minutes to complete. We will also ask you to fill in a short form to get information about your age, gender, home circumstances and any medical conditions you may have.

Taking part in an interview

We would like to invite you to take part in a face-to-face interview. This can be done at the same time as the questionnaire and in a place of your choice. We would like to ask you some questions about your recent experiences of the service. It will take about 45 minutes of your time and we would like to record it with your permission so that we can better analyse it.

If you are interested in taking part, your contact details will be passed to the research team who will contact you to arrange the next step.

Do I have to take part?

It is entirely up to you whether or not you take part in both of these things. You can choose to do either the survey, or the interview, or both, it's your choice. If you decide to take part but change your mind, you are free to do so and you can stop at any time. Taking part in the evaluation or not will have no effect on the care you receive.

Will my taking part in this study be kept confidential?

We would like to reassure you that any information collected about you will be coded and strictly confidential, and we will protect your identity. It will be stored on a password protected network at the University and will only ever be accessed by the evaluation team. Once the project is finished, data collected for the research will be kept for a short period. This will be for a period not exceeding three months. We will immediately any personal data collected about you and anonymised data will be destroyed after five years. You will not be identifiable in any written reports.

Things you say during the interview may be directly quoted in written reports and publications, but your name or anything else that could make you identifiable will be removed. If you like, we can give you a draft of the report to read through before it is made public to make sure you are satisfied with the level of anonymity.

Our policy

As is common practice in anonymising interview data, your contribution will be coded for identification purposes of the researcher only. This means that your contribution will be assigned a series of letters and numbers that only the researcher will know.

In terms of data security, your contribution to the research will be treated in the strictest of confidence and privacy. Only you and researcher will know the content, and this will remain the case from the point of initial contact.

Benefits and risks of taking part

We will ensure that there are no risks to you by taking part in the study. Furthermore, any sensitive information you give us regarding yourself, or other health and care workers will not be shared with anyone. The information you give us will be a vital part of planning improvements to your service and to improving the quality of care to older people in your area. Your information will also give us a better idea of how we can improve health and care services across the country.

What will happen to the results of the study?

Regarding the collection and publishing of results, your participation in the research will be anonymous and any data collected from you will remain confidential. This means that only you and the researcher will know the detail of your own contribution. No other individual will be able to identify you from your contribution. In addition, any sensitive information you do divulge will remain private, and, knowledge between you and the researcher.

Who can I contact if I have any further questions?

If you have any further questions or concerns about the study, please do not hesitate to contact: Gregory White, Research Associate

Phone: 01227 824327

Email: g.c.white@kent.ac.uk

Who can I contact if I want to make a complaint about the study?

If you are unhappy about any aspects of the study and wish to make a formal complaint, you can do this through contacting Nicole Palmer.

Phone: 01227 824797

Email: n.r.palmer@kent.ac.uk

Thank you for your time.

Appendix F: Information Sheet – Frontline Staff

Information for pilot team (focus group)

Evaluation of the Kent & Medway One Care Pilot

Invitation to Participate in the Service Evaluation

We are researchers at the University of Kent and will be undertaking the Evaluation of the Kent & Medway One Care Pilot. You are receiving this letter because you are involved in the One Care pilot which is looking to improve its integrated approach to care. We would like to invite you to take part in the evaluation. This information sheet explains why it is being done and what it would involve for you. Please do contact us if you have any questions. Our contact details are at the end of this information sheet.

Purpose of the study

The service aims to improve user experience of co-ordinated care and self-management at home; contribute to a reduction in A&E demand and onward admission in the short term; and reduce pressure on acute services and long term care home placements in the longer term.

The team at the University will be evaluating the processes and outcomes of the One Care pilot from May 2017 to October 2017. We will be investigating a number of aspects from the One Care pilot team, as well as managers, GPs, commissioners, the coach and patients. We will be trying to find out things like the experiences of patients and the One Care pilot team, what the 'successful ingredients' are that are making a difference to service delivery, whether there have been any changes to the way resources have been used, and what could be improved, replicated in other areas and sustained.

Why have I been invited?

It is vitally important that we find out from the One Care pilot team who have actually been involved in delivering and implementing integrated care services about what you feel the impact has been on patients, works well and what does not, the effectiveness and level of collaboration of the One Care pilot, and where you see improvements can be made.

What will happen?

We are seeking your permission for you to take part in a face-to-face focus group with your One Care pilot team members. Firstly, we will ask you to fill in a questionnaire with a short demographic sheet asking for age range, gender and occupational group. We will then spend about 45 minutes talking through a range of subjects related to the service, for example, team working and co-ordination, the nature of any changes, strengths and weaknesses of implementation, roles and responsibilities, impacts on patients, success factors and overcoming challenges. We will also be asking you about any effects of the project on recruitment and retention, and motivation. We would like to record it with your permission so that we can better analyse it.

Do I have to take part?

It is entirely up to you whether or not you take part. Alternatively, it may be more convenient for you to have an individual interview either in person or over the phone at a time suitable to you, it's your choice. If you decide to take part, but change your mind, you are free to do so and you can stop at any time. Taking part in the evaluation or not will have no effect on you as a One Care pilot team member.

Will my taking part in this study be kept confidential?

We would like to reassure you that any information collected about you will be strictly confidential and we will protect your identity. It will be coded and stored on a password protected network at the university and will only ever be accessed by the evaluation team.

Once the project is finished, we will immediately destroy any personal data collected about you and coded data will be destroyed after five years. You will not be identifiable in any written reports. Things you say during the interview may be directly quoted in written reports and publications, but your name or anything else that could make you identifiable will be removed. Although we will not name the pilot you are working in, there is a possibility that it may be identifiable to local staff, but we will make every effort for this to be minimised. If you like, we can give you a draft of the report to read through before it is made public to make sure you are satisfied with the level of anonymity.

Our policy

As per common practice in anonymizing interview data, your contribution will be coded for identification purposes of the researcher only. This means that your contribution will be assigned a series of letters and numbers that only the researcher will know.

In terms of data security, your contribution to the research will be treated in the strictest of confidence and privacy. Only you and researcher will know the content of your contribution, and this will remain the case from the point of initial contact.

Benefits and risks of taking part

We will ensure that there are no risks to you by taking part in the study. Furthermore, any sensitive information you give us regarding yourself, other health and care workers or patients and their informal carers, will not be shared with anyone.

The information you give us will be a vital part of planning improvements to your service and to improving the quality of care to older people in your area. Your information will also give us a better idea of how we can improve health and care services across the country.

What will happen to the results of the study?

Any information you give us will be made completely confidential and anonymous. The results of the study will be used to improve the care provided at your service. We will work directly with local stakeholders on making improvements based on the results of the study.

The results will also be published in journals and conferences to share the learning from the study with others.

Who can I contact if I have any further questions?

If you have any further questions or concerns about the study, please do not hesitate to contact:

Gregory White, Research Associate

Phone: 01227 823052

Email: g.c.white@kent.ac.uk

Who can I contact if I want to make a complaint about the study?

If you are unhappy about any aspects of the study and wish to make a formal complaint, you can do this through contacting Professor Jenny Billings.

Phone: 01227 823052

Email: j.r.billings@kent.ac.uk

Thank you for your time.

Appendix G: Information Sheet – Managers

Information for participants (managers/coach)

Evaluation of the Kent & Medway One Care Pilot

Invitation to Participate in the Service Evaluation

We are researchers at the University of Kent and will be undertaking the Evaluation of the Kent & Medway One Care Pilot. You are receiving this letter because you are involved in the management or commissioning of the One Care pilot in the Kent & Medway area. We would like to invite you to take part in the evaluation. This information sheet explains why it is being done and what it would involve for you. Please do contact us if you have any questions. Our contact details are at the end of this information sheet.

Purpose of the study

The service aims to improve user experience of co-ordinated care and self-management at home; contribute to a reduction in A&E demand and onward admission in the short term; and reduce pressure on acute services and long-term care home placements in the longer term.

The team at the University will be evaluating the processes and outcomes of the One Care pilot from May 2017 to October 2017. We will be investigating a number of aspects from One Care pilot teams, patients, and managers, GPs, commissioners and the coach. We will be trying to find out things like the overall experiences of the One Care project, what the 'successful ingredients' are that are making a difference to service delivery, whether there have been any changes to the way resources have been used, and what could be improved, replicated in other areas and sustained.

Why have I been invited?

It is vitally important that we find out from people like you who have actually been involved in leading, managing or commissioning the implementation and delivery of the One Care pilot, what you feel works well and what does not, the effectiveness and level of collaboration of the One Care pilot, and where you see improvements can be made.

What will happen?

We are seeking your permission for you to take part in our evaluation through an interview. We will talk through a range of subjects related to the service, for example, team working and co-ordination, the nature of any changes, strengths and weaknesses of implementation, roles and responsibilities, impacts on patients, effects of recruitment and retention of staff, success factors and overcoming challenges. We will arrange this with you either face-to-face or over the telephone at a time suitable for you and it will take up about 45 minutes of your time. We would like to record it with your permission so that we can better analyse it.

Do I have to take part?

It is entirely up to you whether or not you take part. If you decide to take part, but change your mind, you are free to do so and you can stop at any time. Taking part in the evaluation or not will have no effect on you as a professional.

Will my taking part in this study be kept confidential?

We would like to reassure you that any information collected about you will be strictly confidential and we will protect your identity. It will be coded and stored on a password protected network at the university and will only ever be accessed by the evaluation team.

Once the project is finished, we will immediately destroy any personal data collected about you and coded data will be destroyed after five years. You will not be identifiable in any written reports. Things you say during the interview may be directly quoted in written reports and publications, but your name or anything else that could make you identifiable will be removed. If you like, we can give you a draft of the report to read through before it is made public to make sure you are satisfied with the level of anonymity.

Benefits and risks of taking part

We will ensure that there are no risks to you by taking part in the study. Furthermore, any sensitive information you give us regarding yourself, colleagues or patients and their informal carers, will not be shared with anyone.

The information you give us will be a vital part of planning improvements to your service and to improving the quality of care to older people in your area. Your information will also give us a better idea of how we can improve health and care services across the country.

What will happen to the results of the study?

Any information you give us will be made completely confidential and anonymous. The results of the study will be used to improve the care provided at your service. We will work directly with local stakeholders on making improvements based on the results of the study.

The results will also be published in journals and conferences to share the learning from the study with others.

Who can I contact if I have any further questions?

If you have any further questions or concerns about the study, please do not hesitate to contact:

Gregory White, Research Associate

Phone: 01227 823052

Email: g.c.white@kent.ac.uk

Rasa Mikelyte, Research Assistant

Phone: 01227 823666

Email: r.mikelyte@kent.ac.uk

Who can I contact if I want to make a complaint about the study?

If you are unhappy about any aspects of the study and wish to make a formal complaint, you can do this through contacting Professor Jenny Billings.

Phone: 01227 823052

Email: j.r.billings@kent.ac.uk

Thank you for your time.

Appendix H: Consent Form – Patients

Consent Form (patients)

Evaluation of the Kent & Medway One Care Pilot

Participant ID:

Please initial if you agree:

I have read the attached information sheet and understand that I am being asked to take part in two possible ways (please initial each aspect of the study you want to be involved with):

Taking part in a survey Taking part in an interview

I understand that my participation is voluntary and that I can stop taking part in this project at any time. Any information I have offered up to this point will not be included in the project.

I have asked and been given answers to questions about this project to make sure that I fully understand.

I understand that I do not have to answer any questions that I do not feel comfortable with.

I understand that by participating in an interview that I am consenting to have my comments recorded.

I understand that any comments I make may be reported but I will not be identifiable in any report.

I understand that the health care I receive will not be affected by my decision to participate.

I understand that all information gathered during the interview will be kept confidential and will be safely stored on a password protected network with restricted access and in the offices of the Centre for Health Services Studies (CHSS) at the University of Kent.

I understand that my signature below means I have given permission to participate in this project.

Name.....Signature..... Date

Researcher..... Signature Date

Appendix I: Consent Form – Frontline Staff

Team Consent Form (Focus Group) V1

Evaluation of the Kent & Medway One Care Pilot

Participant ID:

Please initial if you agree:

- I have read the attached information sheet and have been given the opportunity to ask questions. I understand that I am being asked to take part in a focus group
- I understand that my participation is voluntary and that I can stop taking part in this project at any time. Any information I have offered up to this point will not be included in the project.
- I understand that I do not have to answer any questions that I do not feel comfortable with.
- I understand that by participating in a focus group that I am consenting to have my comments recorded.
- I understand that any comments I make may be reported but I will not be identifiable in any report. Although the pilot team will not be named, they may be potentially identifiable.
- I understand that all information gathered during the interview will be kept confidential and will be safely stored on a password protected network with restricted access and in the offices of the Centre for Health Services Studies (CHSS) at the University of Kent.
- I understand that my signature below means I have given permission to participate in this project.

NameSignatureDate

ResearcherSignatureDate

Appendix J: Consent Form – Manager

Manager/GP/Commissioners/Coach Consent Form

Evaluation of the Kent & Medway One Care Pilot

Participant ID:

Please initial if you agree:

- I have read the attached information sheet and understand that I am being asked to take part in an interview
- I understand that my participation in the interview is voluntary and that I can stop taking part in this project at any time. Any information I have offered up to this point will not be included in the project.
- I understand that I do not have to answer any questions that I do not feel comfortable with.
- I understand that by participating in an interview that I am consenting to have my comments recorded.
- I understand that any comments I make may be reported but I will not be identifiable in any report.
- I understand that all information gathered during the interview will be kept confidential and will be safely stored on a password protected network with restricted access and in the offices of the Centre for Health Services Studies (CHSS) at the University of Kent.
- I understand that my signature below means I have given permission to participate in this project.

Name..... Signature Date

Researcher..... Signature Date