Transforming Integrated Care in the Community (TICC)

Blueprint

Interreg
EUROPEAN UNION
2 Seas Mers Zeeën
TICC
European Regional Development Fund

The Health and Europe Centre is the Lead Partner working with thirteen project partners:

The Health and Europe Centre

BUURTZORG

Kent County Council
kent.gov.uk

NHS
Kent Community Health
NHS Foundation Trust

MCH
medway community healthcare

Association Loi 1901
SOIGNONS HUMAIN

public world
democracy at work

Zorgbedrijf Antwerpen

Ten Kerselaere
woonzorg
emmaüs

eurasanté
Invest for Success

vivat
le service comme personne

GROUPEMENT DES HÔPITAUX DE L'INSTITUT CATHOLIQUE DE LILLE

UNIVERSITY OF APPLIED SCIENCES

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Chapter 1: Introduction and Summary

1.a The Project

This report captures the key lessons of a project undertaken by organisations in four European countries to explore what is involved in taking a highly successful innovation in one national context and applying it in others. The example of Buurtzorg was chosen because of its undoubted and extraordinary success in its country of origin, the Netherlands, where it has revolutionised community-based health and care services. Its achievements -- improving care, the jobs of professionals providing care, and resource use -- provided the inspiration for the organisations that came together as partners in this project with a view to replicating its achievements in their own countries and localities. They were able to do so not only because of the generous commitment of Buurtzorg itself to enabling and supporting their experimentation but also because the European Union's European Regional Development Fund Interreg 2Seas funding stream supplemented the very considerable financial investment made by the partners themselves.

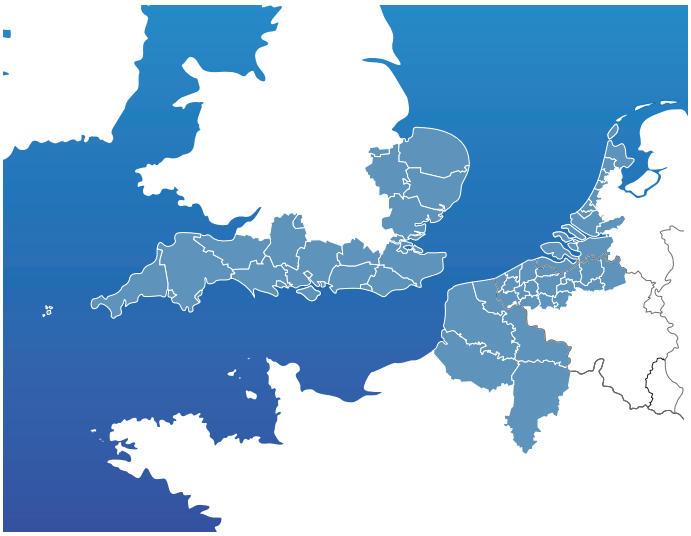
The inspiration provided by Buurtzorg arose from its success in becoming the leading provider of community health and care services in the Netherlands within a decade of its foundation as a start-up social enterprise in 2007. It also became an international exemplar of a form of work organisation based on valuing and mobilising the intrinsic motivation, knowledge, and experience of professionals by enabling and supporting them to work in self-managed teams with high levels of freedom and responsibility. Its success has found expression in well-evidenced and sustained improvements in the quality of care it provides, the job satisfaction experienced by its staff (and their retention) and cost reduction. Among many other awards, Buurtzorg has won top marks from the Dutch health and care inspection agency, been named the Best Employer in the Netherlands five times and received the Future of Work award from Britain's Royal Society for the Encouragement of Arts, Manufactures and Commerce (RSA) in 2019. Its founder Jo de Blok has also won many awards, including The Ideas into Practice Award from Thinkers 50 in 2019, Schwab Foundation award for Social Enterprise 2022 and the RSA's prestigious Albert Medal – whose earlier annual recipients included Marie Curie, Alexander Graham Bell, and Stephen Hawking – in 2014.

Unsurprisingly, these achievements continue to attract the attention of policy makers and practitioners worldwide, in health and care settings and beyond, just as they attracted the partners in this project. The challenges facing health and care systems internationally – demographic, financial, systemic, and more -- need no detailed rehearsal here. They provide the increasingly urgent context in which Buurtzorg's success resonates strongly with those confronted daily – whether at international policy levels or at the 'frontline' of care, and at all points in between – by the growing gap between the efficacy, affordability and resilience of existing services and systems, and the needs of their populations.

Although obvious, it needs saying that those challenges have been brutally exposed and exacerbated by the Covid-19 pandemic, which demonstrated the importance of this project even as it disrupted its continuity and the capacity of its partners to commit resources to it. A hiatus from March 2020 led not only to an extension of the project's completion date by one year but also to some partners being unable to continue even when the majority were able to resume, albeit at a reduced scale in some cases.

The 2Seas area – those parts of nations close to the shores of the English Channel and the North Sea who were members of the European Union when the project started in 2017 – face all the clinical, social, and financial challenges in health and social care that are equally familiar elsewhere as populations age and

public funds are stretched. Indeed, some parts of the areas involved in the project face these challenges to a critical degree. Recruitment and retention of the health and social care workforce is challenging, and the situation is further deteriorating as the existing workforce ages. This has an impact on quality as perceived by communities and patients. Systemic changes in the 2Seas region over the last 20 years have been intended to improve care and contain costs but have led to the fragmentation of care, a task-driven, activity-based approach, and less efficient resource use.



Several initiatives have been highlighted as innovative but rarely get transferred from one country to another. The aim of this project was to identify the causes of these blockages and explore ways of overcoming barriers to transferability by working to introduce the Buurtzorg approach in the organisations and systems of the project's 'delivery partners'. This was done with the help of Buurtzorg itself and its partner in Britain and Ireland, Public World, the project's 'support partners'. Other partners provided other contributions, such as evaluation of the work done by the delivery partners. A list of all the partners and their own descriptions of the role and achievements in the project forms section 1 (c) below. All partners contributed 40% of their costs in the project from their own resources, with the other 60% being funded through Interreg 2Seas.

This project is not unique in attempting to apply Buurtzorg's highly successful model in other countries but is the first time an attempt has been made across more than one country to learn about the barriers and challenges involved, and how they can be overcome. Care providers are blocked by constraints within existing state health structures that have contributed to the difficulty of applying the model elsewhere in Europe. The project partners have brought their own expertise to their attempts to do so and to identifying the barriers blocking innovation transfer. By working in partnership across four countries the aim has been to understand the challenges at a higher level of detail and to highlight barriers individual partners may not encounter in isolation.

The purpose of this report is to capture the challenges the TICC partners have encountered in trying to replicate Buurtzorg's success and the lessons of their experience. It makes no attempt to gloss over those challenges or belittle the barriers involved. On the contrary, the aim of this report is to present a 'warts and all' account of the experience from which all who share the motivations that inspired the Buurtzorg founders back in 2007 can learn as they confront the challenges of renewing and strengthening health and care systems in their own countries.

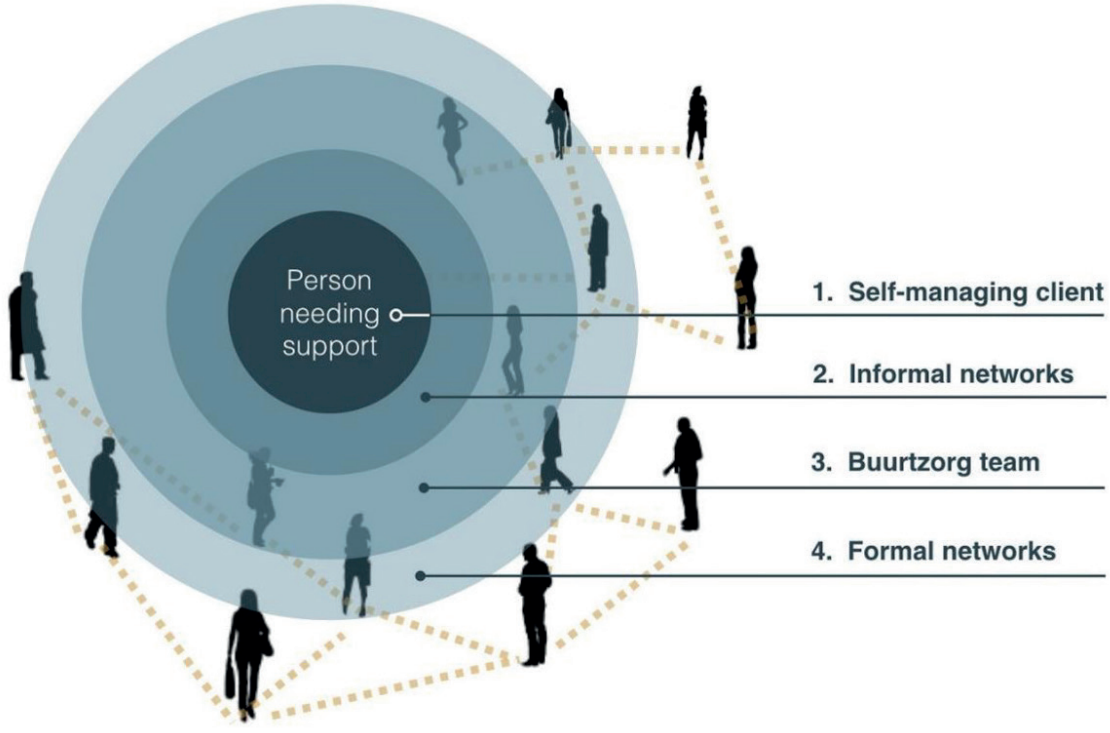
The intention has been to inform, inspire and support systemic change in health & social care, providing services better suited to our ageing population and addressing holistic needs, and to guide others in overcoming blocking points in transferring socially innovative service models from one area to another. We hope this will enable other health and social care organisations to try out new ideas; increase staff productivity, recruitment, and retention; improve patient satisfaction; decrease costs, emergency admissions and staff absence; and postpone the moment when residential and/or end-of-life care is needed.

1.b Buurtzorg – the project's inspiration

In the 1990s, as in many other countries around the world, a series of public service reforms were implemented in the Netherlands with the aim of improving efficiency. In what is often referred to as 'New Public Management', the drive was to define and standardise specific service tasks required to achieve a policy-driven result, to cut costs by assigning them to the lowest price provider, and to hold public service workers accountable for achieving targets in a strict performance management regime. In the Netherlands, the result was that costs doubled in ten years while service quality fell. Patients would be seen by a procession of different professionals and providers, each of whom was responsible for a different aspect of their care, none of them spending more than a few minutes in their home. Patient satisfaction declined, and the nurses themselves became increasingly demotivated to the extent that many left the profession.

In response to this, four Dutch people took decisive action to rescue community nursing and the people it serves from the effects of these reforms. In 2007, Jos de Blok, a district nurse who had also been educated in economics, and three others set up their own social enterprise, Buurtzorg, which is Dutch for 'neighbourhood care'. Self-steering local teams of nurses would be responsible for all aspects of care, working in accordance with their professional ethics, craft, and common sense to do whatever was needed to help their clients to thrive at home. They would start by building a relationship with a prospective client – "first coffee, then care" as Buurtzorg nurses say – and work to help them manage their own care.

Figure 1: the Buurtzorg 'onion' model



The "onion model" in Figure 1 shows the building blocks needed for independence, based on what Buurtzorg's founders see as universal human values:

- People want control over their own lives for as long as possible
- People strive to maintain or improve their own quality of life
- People seek social interaction
- People seek 'warm' relationships with others

The professional attunes to the client and their context, considering the living environment and the client's family, friends, neighbours, and clubs, as well as professionals already known to the client or whose support they might need. In this way, the professional seeks to build a solution that involves the client and their formal and informal networks. Self-management, continuity, and building trusting relationships and networks in the neighbourhood are all important principles for the Buurtzorg teams.

To work in this creative, person-centred, and relationship-based way, the teams must have professional freedom with responsibility. For this reason, all Buurtzorg teams of nurses are self-managing within a simple and clear framework that applies to all teams. The framework defines professional expectations in terms of care standards, teamwork, and resource use, in effect setting the norms and boundaries within which the teams self-manage.

Team members bring a variety of experience, expertise, and qualifications to their work, but all provide holistic care and operate collectively without hierarchy, enabling them to collectively deal with a broad range of client needs. The teams decide how they organise the work, distribute responsibilities and make decisions, sharing and rotating a range of organisational and administrative tasks best done at team level (such as rota management). They use a methodology called solution-driven method of interaction in all their work and a team meeting structure and process based on that methodology. They also have their own education budgets to deploy as they decide. They are entrepreneurial in spirit, continually improving the organisation and services. All Buurtzorg innovations have come from one person or a team having an idea, having the freedom to try something new, and sharing their learning with the rest of the organisation.

Buurtzorg grew rapidly as more and more nurses were attracted back into the profession or were recruited from other providers to set up their own teams in neighbourhoods of their choice. Today, Buurtzorg has more than 900 self-steering teams, each of up to 12 nurses and nurse assistants, supported by 22 regional coaches and a national back office of just 50 people that provides teams with organisational and administrative support services without trying to command or control them. All team members use an IT system – developed within Buurtzorg as the organisation has grown – that supports care assessment, planning and evaluation, and an intranet through which to share and grow collective knowledge.

When the TICC project began in 2017, Buurtzorg had been going for 10 years with increasingly impressive results, growing to become the largest provider of community health care services in the Netherlands. The latest inspection by the Dutch equivalent of the Care Quality Commission produced top marks in every category and patient satisfaction rates are the highest of any healthcare organisation. Buurtzorg has been named Dutch Employer of the Year (across all sectors of the economy) five times, and substantial financial savings have been made as the average number of hours of professional care per client has been reduced by half.

New Buurtzorg ventures are applying the same principles to domestic help, children's support, mental health, maternity care and other areas of health and care services. The movement has also spread internationally, inspiring change in a growing number of countries on all continents. Buurtzorg's remarkable success has been achieved with a consistent logic of care and organisational design. As founder Jos de Blok has put it: "We started working with different countries and discovered that the problems are the same. The message every time is to start again from the patient perspective and to simplify the systems".

1.c The Project Partners

The following is a list of all the partners when the project began, and in some cases their own descriptions of their roles and activities in the project.

The Health and Europe Centre: a social enterprise providing European services to the NHS and other health organisations in the southeast of England. It has the objective of providing learning opportunities through collaborations with colleagues from other countries and is highly experienced in partnership working. (UK) https://healthandeuropecentre.nhs.uk/

> ***"We were the originator of the project – our work across different European health systems and as part of pan-European health networks had led to a realisation that innovative models of care in different countries were not being transferred into other countries. We identified Buurtzorg as being relevant to other countries, built the project consortium, developed the work programme and led on all aspects of the delivery of the project."***

Buurtzorg Concepts: works to promote and support international learning from the experience of Buurtzorg Nederland, a non-profit Dutch home-care organisation that has gained international attention for delivering high quality holistic care at lower cost through self-managing teams of nurses. Set up in reaction to the fragmentation and industrialisation of health and care at home in the Netherlands, Buurtzorg provides holistic person-centered care through small (max 12) teams based in small neighbourhoods. (The Netherlands) https://www.buurtzorg.com/

Kent County Council: a local authority serving over 1.5 million people in the county of Kent, south-east England, including responsibility for social care in the context of the English system. The council aims to develop models to deliver integration across its population and services that improve outcomes and experience of care, making the best use of resources. (UK) https://www.kent.gov.uk/

> ***"KCC tested transformation of domiciliary care through TICC, moving away from nursing teams and developing a self-managing domiciliary care team. This team was supported by occupational therapists and was aligned with a GP practice in Ashford, Kent. The team operated within a small postcode area to help clients with goal setting, enablement, assessing community facilities, promoting independence, and creating community networks to reduce loneliness and isolation. The team worked closely with the social care locality team and GP practice, building relationships and practice.***
>
> ***"This pilot tested whether this model facilitates the transition from traditional time- and task-based care in the community to an approach that is centred on goal setting and enablement. Due to Covid-19 the team were required to support other services within the organisation and return to a more traditional way of working. Due to ongoing staff shortages and difficulties in recruiting, the team disbanded and unfortunately the pilot ended.***
>
> ***"The pilot of the domiciliary care model was very well received by community services, GPs and the clients receiving the support. The team members enjoyed the new way of working and built excellent relationships with people being supported, their families and the local community.***
>
> ***"Kent County Council worked with the project partners in gathering the documentation detailing the barriers and challenges each of the partners faced while trying to implement the principles of the Buurtzorg model. Co-production across the whole partnership led to solutions being created and***

solution templates aligned to each of the barriers and challenges where solutions were found and deemed sustainable."

Kent Community Health Foundation Trust: an experienced provider of community nursing providing 24-hour care seven days a week supporting patients with long term conditions, illness, or frailty within the National Health Service in England. KCHFT also provides intermediate care services and works with patients, family/carers, colleagues in health and social care and the voluntary sector to enable patients to retain their independence and safety at home, recover from illness or injury and avoid unnecessary attendances or admissions to acute hospitals. (UK) https://www.kentcht.nhs.uk/

"Responding to the needs of patients and with one eye on prospective NHS reforms, KCHFT were keen to equip team members with the tools that Buurtzorg use to support personalised care and team decision-making as close to the patient as possible. TICC engaged with 97 teams comprising 974 staff (approximately a fifth of our workforce). We introduced a new electronic patient record system and team dashboards using Microsoft Power BI. We also reduced bureaucratic burden on our frontline teams by cutting out unnecessary policies, streamlining processes and approvals. Our patients and staff contributed to the ethical study run by evaluation partners, general data was shared with them, and challenges and barriers were shared with the partners looking after the creation of the Blueprint.

"Through dialogue and workshops with frontline teams, Executive team and leads in HR, Clinical Governance, Performance, Finance, and IT we worked to develop a simple framework which we tested and refined. This also led us to completely revise our scheme of delegation which had historically been based on banding. After an organisation-wide conversation, a new scheme of delegation was approved which identified the most appropriate role for approvals and sign offs – giving more autonomy to teams but still complying with NHS best practice on finance, procurement, and employment."

Medway Community Healthcare: provides a wide range of community services for people living in Medway and the surrounding area; from health visitors and community nurses to speech and language therapists and out of hours urgent care. The majority of the services provided are NHS though some services are commissioned by the local authority. As a social enterprise they are also able to provide additional services, like physiotherapist-led Pilates classes, podiatry sessions and training courses for schools. Any profit made from these services, is invested back into improving all the services they provide. (UK) https://www.medwaycommunityhealthcare.nhs.uk/

"Medway Community Healthcare (MCH) has embraced the philosophy and principles of the Buurtzorg model. Introducing Neighbourhood Nursing Teams and supporting other integrated community teams, working alongside our back office to simplify processes and release time to care.

"The model fits well with NHS development of Integrated Care Systems (ICSs), organisations that come together to plan and deliver joined up health and care services, to improve the lives of people who live and work in their area. Supported by the reorganisation of services into PCNs (Primary Care Networks), groups of GP practices working closely together - along with other community healthcare staff and organisations - providing integrated services to the local population.

"The transformation of community services and in particular nursing is a journey we are still on. For some, the principles to be embedded are best described as retro-innovative. Returning to smaller teams within neighbourhoods, focussed on holistic and preventative interventions to maintain/support people

optimally with their health and wellbeing or enabling them to die at home with dignity. Enabled where appropriate with technology – innovation.

"In MCH the technology aspect has focused on reducing the multiple systems clinicians have access to where possible into one system, so a single sign-on – development remains in progress to simplify and increase the intuitiveness of systems, reducing the administrative burdens on clinicians. Supported further with smarter and easier access to valid, timely data of team's performance both quantitative and qualitative.

"The benefits of embedding and working towards full implementation of the model has required continued collaboration both internally in MCH and externally with partners to understand its principles and benefits i.e., improving care delivery in the community, reducing fragmentation of provision, focusing on quality of care, not just tasks but outcomes for patients, their families and the health and care economy as demonstrated in the Netherlands. The focus now should be on the long-term sustainability, being solution focussed rather than applying short term quick fixes."

Soignons Humain: promotes new organisation models in the field of home care and health services, with improved satisfaction of patients, employees, and the public purse, in France. (France) https://www.soignonshumain.com/

"We have gradually implemented seven teams of employed nurses (5 FTE per team on average) in the TICC area, supported by two team coaches and two persons in back office: two teams in 2017, one in 2018, three in 2019, two in 2020 and one in 2021.

"On top of the TICC program, and thanks to it, we managed to obtain a specific payment method for nursing care, based on time with patients instead of the general product list. This scheme is named 'Equilibres', one of the 120 Article 51 experimentations authorised in France since 2019. Thisprogramme includes the Omaha-based patient need assessments, and a specific focus on client autonomy and prevention.

"We also included in 2020 three more teams into our TICC operations, two of which are made of private independent nurses.

"Now this 'Equilibres' program is in final discussion with the Ministry of Health for nationwide extension, considering the positive impacts on professional experience, quality of care and better access to care for the most vulnerable people. If confirmed, this would result in a global, systemic, change for the legal framework or nursing care in France, at country level."

Public World: a business-to-business social enterprise that helps build healthy and strong local and workplace communities by supporting self-managed teamwork with the aim of making work fairer, happier and more productive, and institutions more accountable. Trading also as Buurtzorg Britain & Ireland. (UK) www.publicworld.org

"Drawing on our background of supporting public service change internationally and introducing the Buurtzorg model to Britain, Public World provided learning and development support to Kent County Council, Kent Community Health Foundation Trust and Medway Community Healthcare. The support focused especially on training teams in self-management, the solution-driven method of interaction, development of team coaches, and advice about organisational and administrative change.

"Public World also compiled the catalogue of barriers and challenges encountered by all the project partners and the analysis of them as set out in this report, drawing also on our wider experience of supporting the introduction of self-management in health, care and other settings. Having been asked to do so by our fellow partners, we are glad to be hosting the publicly available online archive of all the written materials generated by the project."

Zorgbedrijf Antwerpen: provides services to the elderly and children in the city of Antwerp, Belgium, offering both residential care and home care. (Belgium) https://www.zorgbedrijf.antwerpen.be/

Emmaüs: Emmaüs Elderly Care is just one of the five welfare and healthcare sectors of the Emmausgroup in Belgium. Ten Kerselaere is the oldest and most well-known residential elderly care facility in Heist op den Berg. The concept combines safe and comfortable housing facilities with assisted living facilities and state of the art care. (Belgium) https://emmaus.be/

Eurasante: the economic development agency dedicated to health, nutrition, and healthy ageing in the Hauts-de-France region (and the coordinator of the regional silver economy committee). (France) https://lille.eurasante.com/

VIVAT Service à la personne: established in 2006 and has grown steadily in size and activity scope through the opening of new agencies to provide care services over a wider area of France and comprises VIVAT Marcq Wasquehal, VIVAT Lille Seclin, VIVAT Douai Cambrai, VIVAT Bailleul Bergues and the franchise VIVAT Lomme Lambersart. (France) https://vivat.co/

Groupement des Hôpitaux de l'Institut Catholique de Lille: carries out clinical trials supported by a multidisciplinary team that includes clinical research assistants for trials monitoring, data-managers in charge of databases elaboration, and specialists in biostatistics and methodology who provide assistance in clinical trials development and in the data analysis. (France) https://www.ghicl.fr/

"Were involved in the evaluation of the pilot sites in the participant 2Seas countries. In partnership with the HZ University of Applied Science in the Netherlands, an evaluation protocol was developed to study the impact of this new model on patients, their care givers, but also on the employees concerned. A study was conducted, using methods aimed at gathering outcomes related to the three main outputs of the evaluation: better care for people, better staff retention and cost savings."

HZ University: has 4,500 students offering many different study programmes and a strong international orientation in the Netherlands. The university is divided into seven academies, with some courses taught in English. It conducts innovation pilots regarding cross-sectorial cooperation between health, vitality, and tourism, bringing together entrepreneurs, government, and users, with particular attention to nurse-led community care. (The Netherlands) https://hz.nl/en

La Vie Active: operates over 63 care institutions in the north of France supporting disabled adults, elderly dependent people, and others, some with dementia (11 NH), a guardianship service and a nursing home of 40 beds in Dourges since 2011. (France) https://vieactive.fr/

1.d Summary of barriers and challenges and solutions attempted

A core purpose of the project was to identify and explore solutions to the variety of barriers and challenges when applying the Buurtzorg model in the cultural, institutional and policy environments of the three countries involved in trying to do so. In the course of their efforts to provide their services in ways inspired and informed by Buurtzorg, partners recorded barriers and challenges they experienced over the four years, and how they worked around or overcame some of them.

This work is ongoing, and therefore the eventual impact of the solutions recorded in this report is not necessarily captured in all cases, and some attempted solutions not mentioned in this report might still be emerging. Indeed, commitment to identifying obstacles and trying to overcome them is central to the Buurtzorg commitment to continuous learning and improvement, and has been central to the approach taken by project partners. Therefore, for more and in some cases later details please refer to Appendix A.

At the time this report was compiled, a total of nearly 250 such barriers and challenges were mentioned, and in analysing them we identified four inter-related categories:

1. Barriers and challenges related to applying the Buurtzorg model in institutional contexts in which Buurtzorg values, culture and goals are not widely shared.
2. Barriers and challenges general to community nursing within the national or international context.
3. Barriers and challenges relating to trying something new.
4. Barriers and challenges relating to the model itself.

The first category was by far the most prevalent, substantial, and specifically relevant to the TICC project goal of identifying barriers and challenges to introducing the Buurtzorg model in different institutional and cultural settings. For this reason, this type of challenge is the main focus of this report, and Chapter 2 is devoted to it, while Chapter 3 explores the other three categories.

All the delivery partners reported encountering challenges of type 1 above, in four main ways:

i) **Inconsistent institutional and organisational goals** meant that teams were being funded and monitored according to indicators that did not reflect the outcomes they were trying to work towards within the Buurtzorg model.
ii) **Lack of integration of services at all levels** meant that teams were trying to work in a holistic, patient-centred way but dealing with regulatory and monitoring systems that did not support this. Funders and regulators divided work up according to type of care (health or social) and geographical boundaries that did not match the neighbourhoods served.
iii) **Hierarchy and competition** within institutions had the effect of undermining the professional autonomy of the teams, obstructing their work, and making it harder for them to operate in a non-hierarchical and collaborative way.
iv) **Systems-led working** meant that teams were often required to adapt their work to fit inflexible institutional systems, rather than systems being designed to support the purposes of their work.

For all these reasons, the experience of the project suggests that the main obstacles to the application of the Buurtzorg model outside its country of origin arise not from any inability of nurses outside the Netherlands to operate with high levels of professional autonomy, but from organisational and systemic failures to support them in doing so. Project partners tried out a range of solutions to this challenge, and their ideas and approaches can be grouped into four overall categories.

i) **Status-quo approach:** Asking nurses and other care professionals in the TICC teams to continue to work to the existing goals, values, and culture of the host organisation, even when these were not well aligned with the Buurtzorg approach. This is likely to have undermined their efforts to optimise the benefits of the model in their own work.
ii) **Workarounds:** Helping the teams to come up with solutions to enable them to work as far as possible within the goals, values and culture of the new model whilst still fitting into the systems of the host organisation. This approach is likely to have enabled the model to be applied to some degree, while requiring an additional administrative burden on staff, thus taking time and energy better devoted to care and, therefore, leading again to sub-optimal impact of the model itself. Such workarounds are also unlikely to be scalable.
iii) **Alternative systems:** Changing parts of the systems of the host organisation, so that the teams were working with different systems than the rest of the organisation. This solved some of the problems encountered and can be a sustainable solution if the model becomes the norm in the organisation and the new systems replace the old ones. In the transition phase, however, while preferable to workarounds for the teams, it adds administrative costs to the organisation as a whole.
iv) **Full integration:** Changing the goals, values, and/or culture of the host organisation in line with the model. This approach is likely to be necessary for full application of the model across whole organisations, and can be the outcome of a strategic application of the parallel systems approach of option iii.

Overall, although partners indicated that applying the model widely and sustainably within their organisations would require full integration, they also reported successes using alternative systems, which allowed the pilot teams to work more effectively within the limits of the institutional context. In both cases, however, the ability of organisations to adapt policies and processes to more effectively enable and support application of the model was also constrained in various ways by wider financial, institutional, legal, regulatory, and structural obstacles in the health and care systems of which they are part.

1.e A blueprint for successful transfer of the Buurtzorg model

One of the main outputs of this project, as expressed in the words of the project's website, www.ticc-transformation.eu, was to be a "blueprint for successful transfer of social innovative service models in health & social care from one country to another benefitting all public/private services".

Drawing on the experience of the project partners, with particular reference to the barriers and challenges they have faced and their various approaches to overcoming them, these general conclusions of the project are set out in Chapter 4.

Chapter 2: Barriers and challenges related to applying the Buurtzorg model in institutional contexts in which Buurtzorg values, culture and goals are not widely shared.

2.a Inconsistent goals throughout organisations

Teams found that a lack of consistent integration of Buurtzorg goals (great care, happy teams, financial sustainability) throughout organisations and wider service-delivery systems was a barrier to their ability to achieve these goals on the ground. This was because teams found themselves in the position of trying to meet one set of objectives in their daily professional work whilst having the results monitored and evaluated according to a set of objectives that were (at least in some respects) different. Consequently, reporting requirements were onerous and time-consuming, and did not enable the teams to record whether or not they were meeting the real objectives of the service they were delivering. This mismatch also put teams under pressure to work in ways that were not consistent with the Buurtzorg purpose and principles.

Irrespective of the way funding is organised, if those who hold the purse strings are not signed up to the goals of the model, this is a barrier to its successful application. For example, whereas the Buurtzorg model aims to be person-centred and relationship-based, funders in both the English and French contexts pay according to the number of tasks performed. This approach does not deal with whether patients' needs are met, which means that teams are focused on outcomes while being funded for tasks completed. This created problems for teams on the ground. One of the partners in England is funded by a commissioning process that funds according to an activity-based model. They reported that "services [are] commissioned based on activity and block contract" (2019, #RW145-145LC).[1] One of the French partners is funded through health insurance which is paid "per-act". Insurance companies required them to report their work in terms of tasks completed, rather than in relation to outcomes agreed between the professional and the client. This put pressure on the teams to speed up their work, which reduced their time with patients and put staff under stress.

> ***"The "per act" pricing scheme does not support holistic care. The nurses have to speed up their interventions to financially break even, hence they cannot do all the prevention activities that would be necessary, because they are not paid by the health insurer." (#RW229-229LF.)***

Another French partner felt that the policy framework they were working within was a barrier. They specified that their regulatory body (Agence Régional de Santé, ARS) had not yet supported the model, and that a change in policy framework from the regulator would be needed to make the project sustainable.

> ***Our policy framework limits/slows down this organisational change process. Indeed, the sustainability of our new model will depend on the validation of our main funding/regulatory institution the Regional Health Agency (i.e., Agence Régional de Santé - ARS) (#RW47-47LPR).***

1 # refers to the numbered row in spreadsheet in Appendix A.

In England, one of the partners found that the monitoring requirements of the Care Quality Commission (CQC) did not fit well with the new way of working, having a set format for inspection and requiring defined evidence, reports, data, etc and that they would "need adapting to better support this model" (#RW175-175LPR). They also found that commissioners, senior managers and the organisation's own behaviours and expectations did not always complement the model.

> ***Commissioners do not understand or recognise the value of the model – focus is on the quick novel fixes rather than longer term substantive solutions. (#RW86-86CBSYC)***

> ***Non-understanding of the model and its clinical and organisational benefits although recognised as potentially beneficial by senior management team. (#RW109-109CBOC)***

> ***Interpretation of the organisation's values and visions by some senior managers do not reflect behaviours that support the model. (#RW113-113CBOC)***

This lack of integration of Buurtzorg values at every level of organisations and systems created onerous reporting requirements, and incentivised ways of working that were detrimental to Buurtzorg goals. Two partners, reported that, in England, "assurance requirements do not currently complement this model" (#RW85-85CBR). One of them elaborated:

> ***Reporting and assurance requirements in the NHS are more onerous than in the Netherlands and do not currently complement the Buurtzorg model. i.e., some unnecessary reporting requirements which don't support patient care or outcomes. (#RW180-180LREP)***

> ***Reporting locally and nationally requirements impact on clinical time to care - we have a plethora of reports and KPIs we are obliged to collate and submit to our NHS commissioners. (#RW129-129CBIT).***

Excessive reporting requirements also impeded this partner's ability to meet the Buurtzorg aim of spending 62% of time doing what in the Netherlands would be billable work – i.e., activities with direct impact on the wellbeing of particular clients -- resulting in higher levels of administrative work by clinicians.

As a French provider working in an insurance-based system, one partner found that an organisational over-emphasis on financial goals, and under-emphasis on quality of care, negatively affected their ability to function as a happy team.

> ***"We in the team feel insecure and stressed about money/revenues of our team. This is a psychological burden; we fear that we might lose our job... By now the financial balance is the only KPI [Key Performance Indicator] that the team can use to check 'what good looks like'." (#RW232-232CBO).***

This suggests that, while financial sustainability is of course necessary, the targets concerned were not well aligned with the reality of what is involved in providing great care or supporting teams to feel that their work is valued. Elevating one of the three Buurtzorg goals (financial sustainability) to the detriment of the other two was thus a barrier to applying the model effectively.

Overall, if funders, monitoring bodies and senior managers are not signed up to the Buurtzorg goals, this makes it harder for the teams on the ground to achieve these goals. This is because:

a) they are incentivised/pressurised to work in ways that are detrimental to Buurtzorg goals.
b) trying to report on the basis of inappropriate success measures creates a time and resource burden that detracts from availability to care for patients; and
c) the requirement to adhere to monitoring requirements that are not well matched to the actual goals of the work creates stress for staff.

2.b Lack of integration of services at all levels

The Buurtzorg model aims to meet patients' needs as they arise, when they arise, by allowing professionals to develop relationships with people and respond to their specific circumstances as they change. This involves flexibility in terms of the kind of support provided. Barriers to this flexibility included separation of health care from social care, geographical separation of services in ways that did not match the neighbourhoods served by the teams and having different rules and systems for different groups of workers.

Partners found that a "siloed regulatory framework" (#RW90-90CBSYC), through which "health and social care are funded separately" (#RW81-81CBF), and regulated separately, was a barrier to achieving integrated person-centred care. The separation of health from social care caused problems relating to budget, regulation and coordination of care. Moving from the previous way of working in England into the Buurtzorg model involved working with patients who were being supported by services funded across several different commissioning pathways.

> ***Community patients may have multiple health providers and local authorities creating a segregation of pathways across multiple teams and the teams commissioned as a result of funding being segregated across health and care. (#RW146-146LC)***

It also meant that qualified nurses would want or need to deliver social as well as health care, as Buurtzorg teams do in the Netherlands when clients need both clinical and personal support. While this holistic approach has benefits to both the people receiving care and the professionals providing it – indeed, it is fundamental to the Buurtzorg model – the salary differentials between nurses and home care workers that are reflected in budget levels for the separate services in England produced challenging budgetary implications (#RW198-198LF).

Furthermore, social and health care organisations operate and are regulated separately in England, so the workers within teams are subject to different sets of rules for example medication administration and other health care activities. In the Netherlands, Buurtzorg teams include individuals with various qualifications and competencies in particular for clinical interventions. It is however easier to manage the effect of a common set of rules on different individual members of staff, within a small team.

In France, some legislation was a further barrier to providing integrated care. One of the partners reported that employing care workers within their nursing teams was prevented by law. This was a major barrier to delivering fully integrated care.

> ***The law does not allow us to hire nurse assistants. … This is a barrier to implementing a fully "integrated care" vision, including social care and case management. (#RW236-236CBPR.)***

Insurance and regulatory issues have caused a delay in carer staff being covered for health care tasks -- therefore a barrier to the model that cannot currently be overcome. (#RW79-79LPR.)

Another barrier to integrated, person-centred care was the geographical organisation of services that did not align with the neighbourhoods served by the teams. One partner was working in an environment in which commissioners were aiming to centralise, rather than localise the organisation of care. This meant that the model was not well matched to funder priorities.

Model requires teams to be located in neighbourhoods - commissioning currently aiming to centralise all teams in Healthy Living Centres (#RW149-149LC).

The same partner found that aligning the geographical scope of neighbourhood teams with those of GP practice patient lists enhanced relationships between professionals, leading to benefits for patients (#RW96-96CBSYC).

2.c Hierarchy and competition

The Buurtzorg model involves removing hierarchy so that professionals exercise greater autonomy and responsibility in collaborating with their patients in assessing, agreeing, and meeting their needs. It successfully combines professional accountability and responsibility with autonomy and trust. Introducing this way of working into pre-existing hierarchical organisations or competitive environments was challenging. Partners identified ongoing hierarchical structures of the wider organisation, and competitive culture, as an obstacle to the successful application of the self-management model. This was because:

- they had to interact with and work within broader hierarchical systems.
- competitive culture caused obstacles to their work.
- the organisational intertwining of status with competency meant that teams did not always have the right balance of competencies; and
- ongoing pervasive hierarchical assumptions made it hard to develop a truly non-hierarchical culture within the team.

Hierarchical systems often involve those lower in the hierarchy being required to seek approval from those higher up before taking action, even if they are themselves qualified with the competency to make their own judgement on the matter. Despite the introduction of self-managed teams, many organisational processes were still designed on the basis of management approval. This created delays for teams when trying to get simple things done.

English partners reported a range of different administrative blocks that caused delays for their teams as a result of inflexible systems that required management approval. For example, for one of those partners each team had a shared electronic folder for their work. When a new member joined the team, the existing team members did not initially have the authority to add the new member to the folder (#RW62-62LICT). This was resolved by giving the required authority to the team, one of several examples of how the project identified sub-optimal locations of authority and was able to make a change to enable more effective alignment.

Another partner found that teams did not have approval to order their own supplies or settle simple expense reimbursement because “NHS rules require a line managers’ approval for orders” (#RW159-

159LICT), and "mileage claims require manager sign-off" (#RW202-202LO). In both cases, basic tasks were delayed and made more labour-intensive because of a lack of autonomy granted to the teams.

As well as causing onerous administrative burdens, this lack of autonomy presented a more fundamental challenge to the ability of teams to operate the self-management model meaningfully. The Buurtzorg model relies on allowing clinical staff to use their expertise to make spending judgements, within clearly agreed guidelines, in order to reduce wastage and ensure that money is spent where it is needed, and supplies are available when needed. However, an evaluation partner, reported that teams in the partners' organisations were still working with a line manager who held authority for matters such as budget management and ordering of supplies (#RW28-28CBPR).

Paradoxically, management processes intended to avoid waste not only added cost but also undermined the capacity of teams to find the most cost-effective and timely solutions in their circumstances. For example, for one of the partners, a rule was put in place that prevented teams from having the necessary range of IT hardware to best support clinical workers working in different environments and as a result their work became more time-consuming and less efficient (#RW128-128CBIT). Another partner also reported that, across the project, there was a lack of clarity about which matters teams had autonomy over and where they needed to gain approval from higher levels of the organisation (#RW38-38CBSM). This implies that boundaries of authority were not sufficiently clear or well suited to enabling and supporting self-management within an agreed framework, an essential feature of the Buurtzorg model.

One partner found that the teams' judgment over what were manageable caseloads for startup Neighbourhood teams was also disregarded initially by substantive teams.

> ***New referrals being added to caseload despite numerous requests from coaching team for this not to happen. (#RW194-194LREF.)***

So, there was a clear conflict between the demands and capacity of the system and the judgement of the professionals about caseload limits compatible with safe practice and sufficient quality of service. Of course, such differences can and do occur in any organisation, but if the view of the hierarchy automatically trumps the judgement of the professionals at the 'frontline', the model's potential to improve safety and quality is undermined.

In their focus groups with partners, one of the evaluation partners found that "having responsibilities taken away or decisions overruled is likely to cause frustration and impact the effectiveness of the new way of care." (#RW36-36CBSM). Despite this, senior managers struggled to allow teams to have autonomy.

> ***Senior managers with overarching responsibility for services -- anxieties of letting go. (# RW99-99CBSMT)***

> ***Executive and Corporate managers anxieties re devolvement of functions to more junior staff within teams. (#RW100-100CBSMT)***

Teams also faced resistance from some of their peers who were not enthusiastic about the new way of working and in some cases saw the new teams as competing for their jobs. In the French context, unions were also opposed to the model. Competitive attitudes from outside of teams led to obstacles to the teams' work.

The new teams formed under TICC may be viewed as replacing the existing community nursing teams. (#RW76-76CBC)

Standard nursing teams lacked understanding of the model, were resistant to change and the culture changes the new model could bring, resulting in strained relationships and morale for the new team. (#RW32-32CBPB)

We are not allowed to do any kind of publicity; hence it is difficult to grow awareness amongst care professionals. The nurses' union believe our aim is to "kill" the self-employed nurse system, then they refuse to communicate about the project. (#RW237-237LR)

A pervasive competitive system or culture undermined teams' ability to work collaboratively toward the purpose of Buurtzorg goals. In addition, the ongoing hierarchical structure of wider organisations also presented a challenge to the development of a non-hierarchical way of working within teams. This manifested in two main ways.

First, where some team members were afforded higher authority than others for matters in which their respective qualifications did not justify the difference, both the ability of the team to share responsibility and the development of a culture of equality were undermined. This was reported by one partner on the basis of conversations with clinical partners.

PIN numbers to systems not being given to all means responsibility cannot be shared equally amongst the team and means that there are signs of hierarchy, which is not supportive of the team structure. (#RW123-123CBIT)

Hierarchy in care organisations impacts the implementation and execution of the new way, staff at certain levels needed to authorise, organisations still referring to staff as their rank. (#RW71-71LPR.)

Another partner continued to refer to staff according to band number, and different levels of authority over different matters were afforded on the basis of band, even if the matter concerned was not necessarily related to the difference in professional competencies. They reported that, as a consequence, sometimes the person who needed to make a decision on the ground did not have the necessary authority to do so even though there was no clinical risk involved. As with an earlier example, once the project identified this issue it was resolved so that authority was located in accordance with functional need, a change likely to yield operational benefits beyond the scope of the project itself while nudging cultural change across the whole organisation.

Second, in the context of enduring hierarchy elsewhere in organisations and systems, workers were concerned about a perceived loss of status caused by working non-hierarchically with those who had lower qualifications or less experience. There was also a sense that certain types of work were markers of higher or lower status, and those with higher qualifications or more experience were resistant to these being shared. One partner reported this as a problem within their new teams, and a reason that some staff in the wider organisation were unsupportive of the project. A different partner ran a focus group with clinical partners, at which partners reported that some staff were unwilling to work within the new model and left as a result.

Senior staff within teams threatened by model – perceived loss of power/control - identity (team members all wear same uniform) (#RW98-98CBSMT)

For staff with a higher rank, the challenge was actually to 'let go' and have trust. For these staff members it was also not always clear what their role would become in the new way of working. (#RW41-41CBW)

Staff not keen on personal care—feel it is not their role…Senior staff not happy for junior staff to undertake different non-clinical roles—triage/allocation/rotas…Staff negative about model - keen to maintain a hierarchy and not let go of banding and own role. (#RW48-48LSM.)

People did leave and you have to accept that. People who had been senior in the hierarchy and want control. We did lose some who didn't like the model. (As told to a partner, Lille meeting, March 2022).

Finally, where organisations use hierarchical status as a way to indicate clinical competency, removing hierarchy from teams presented challenges for ensuring a suitable balance of competency within teams. In Buurtzorg, where teams recruit their own members, they are able to ensure a good balance of qualifications, specialisms and experience based on the actual needs of their clients and neighbourhood.

Changes in service delivery resulting from a requirement to develop a new service, substantially reduced senior clinical staff within community nursing teams. The senior clinicians being redirected to support the new service, reducing community nursing's ability to adequately support junior staff with gaining competence and confidence and clinical supervision. (#RW131-131LRR)

Overall, establishing a non-hierarchical culture that was collaborative rather than competitive, and valued clinical expertise, within a hierarchical organisation, was challenging. These challenges included the time burden of dealing with hierarchical administrative systems, confusions and frustrations relating to a lack of genuine autonomy, concerns about a loss of hierarchical status, and difficulty in ensuring a balance of clinical expertise.

2.d Systems-led rather than purpose-led working

The efficiency of the Buurtzorg model is based on, among other factors, allowing clinical staff to make judgments about what is needed for great care delivery, and it tasks non-clinical staff (back office) with helping to make this happen. As such, administrative systems are designed and adapted to enable the most effective care, rather than expecting care delivery to be done within the parameters of inflexible administrative systems, and the clinical teams are supported by an agile, responsive 'back office'. For TICC partners, attempting to deliver this model within organisations with inflexible administrative systems was a significant challenge.

Partners reported many examples of systems-related problems that were frustrating and obstructive to their work rather than enabling and supporting it.

Feedback from teams has highlighted that there is a lack of knowledge in using various IT systems. This leads to frustration within teams, causing unnecessary time spent trying to navigate a system. (#RW60-60LICT.)

Developing ability for Neighbourhood Nursing teams to manage own interview processes and staff selection failed initially due to lack of understanding and awareness of HR processes. (#RW136-136LRR.)

Our self-managing team sets its monthly planning itself … however, at the beginning, they lacked the knowledge and competences to do it correctly. (#RW52-52LSM.)

While lack of training in using the systems was a manifestation of the problem, this way of framing the issue overlooks the possibility that the systems themselves were poorly fitted to the overall purpose of providing great care, as other insights from the partners suggested:

IT systems have not been created and installed in line with the Buurtzorg's own standard and therefore there are issues in the inputting for frontline staff making it more difficult for them to use the systems available, resulting in loss of time and income. (Partner)

Very bureaucratic process for recruiting staff. (#RW3-35LR.)

Clinicians are required to have access to multiple systems, with multiple logins – impacting on clinical capacity and efficiencies with most being unintuitive. (#RW123-123CBIT.)

Our self-managing team partly manages in-take procedures…however, it is rather complex, and it takes time that our team members cannot always take. (#RW48-48LSM.)

In response to this challenge, at least one partner completely streamlined and redesigned its recruitment processes and offered training to staff taking on new roles, such as interviewing job applicants.

Based on its role in supporting the English partners, one partner felt that the core of the problem was that, despite the best efforts of the professionals in them and the support from senior managers, the back offices were finding it difficult to adapt their way of working in line with the new teams, and this was creating a barrier to the effective application of the model.

The back office is not transitioning and therefore doesn't always understand how to support the frontline staff effectively (Partner).

Clinical partner staff also recognised this, in some contexts.

Lack of awareness/insight from back office of impact [of systems] on clinical teams. (#RW112-112CBOC)

Digital IT strategy does not support reduced burden on clinical staff. (#RW118-118CBOC)

We get a lot of 'you must do' rather than 'how can we help'. (Partner, Lille TICC meeting)

Change of management culture to self-managing teams require back-office support, but there was a lack of understanding about support to be provided for a self-management model (processes not currently meeting the needs) (please see #RW63-63CBO for solutions found)

Partners reported three main problems caused by complicated IT and administrative processes that were not purpose-driven. First, they created delays in getting the new teams up and running effectively.

The run of our new system is still not completed because the process of updating/remodelling our existing system took an unexpectedly longer time: identification / definition of our needs; tendering procedure; design of the new version of our IT system…Our care professionals will be trained to use the new system soon (#RW49-49LICT)

Second, complicated administrative processes meant that frontline teams did not always have what they needed in order to do their jobs effectively. For example, in one of the partner organisations the process of equipping new members of staff with IT and uniform was slow, complicated, and bureaucratic. This meant that staff were starting in the team without the necessary equipment, which caused a delay to them being able to begin work properly (#RW215-215LR; #RW162-162LICT).

Third, cumbersome administrative systems took time away from clinical staff that could be better spent with patients. This was exacerbated by expecting them to take responsibility for more non-clinical work than is necessary for effective self-managed team operations, rather than ensuring that back-office teams were equipped to provide appropriate and purpose-led administrative support to clinical staff.

> ***Managing and covering the administration required to use the recruitment system by the TICC pilot teams. This is time consuming and will take away from patient facing time. (Please see #RW2-18CBR for solutions found).***

> ***Staff and teams were frustrated at the bureaucracy around obtaining signatures. Paperwork is being delayed as electronic signatures are not always acceptable on certain internal documents and can be delayed further if more than one signature is required. (For solutions, please see #RW82-82LO).***

One of the evaluation partners reported that the majority of clinical partners were finding that teams had an increased administrative burden within the model (#RW23-23CBO). This suggests that administrative roles were not being shared between the teams and their back offices in a way well-suited to enabling and supporting self-management while relieving clinicians of tasks better done by others. As a project lead from one of the partners put it, "unnecessary bureaucracy is said to destroy value in innumerable ways, including slowing problem solving, discouraging innovation, and diverting huge amounts of time into politicking and "working the system." (#RW226-226LO).

2.e Solutions

i Status-quo approach

In some cases, where partners reported challenges that involved a problem with the interaction between frontline staff and organisational systems, they suggested that changing the way that frontline staff interacted with these systems was the solution. This tended to emphasise giving staff more information or training about how to navigate systems. For example, to deal with the problem of teams finding the IT system difficult to navigate and time-consuming, one partner provided training for the staff.

> ***Support services are scheduling regular 'drop-in' sessions which will be facilitated by an expert in their field to help provide support and gain a better understanding of how to navigate the systems. These 'drop-in' centres are advertised via our internal intranet and open to all staff. (#RW60-60LICT)***

Similarly, when clinical teams struggled with HR systems, another partner suggested that the solution was providing them with HR training (#RW52-52LSM).

In both cases, an alternative approach was found to reduce the burden on frontline staff. One partner simplified the IT system, and they could have reallocated HR administration tasks to the back office. The tendency toward requiring frontline teams to navigate complicated administration and IT systems is a way in which partners did not always manage to apply the Buurtzorg model and is likely to be a contributing

factor to one of the evaluation partner's overall findings that some TICC teams found themselves with high administrative burdens.

ii) Workarounds

Partner staff who were involved in the TICC project often recognised that bureaucratic administrative systems were creating barriers to frontline work, and that expecting clinical staff to fit into these systems was not the solution because the systems were not aligned with the goals of the project. However, they did not always have the institutional power to make any significant change to the systems causing the problems. In these cases, teams were supported to find ways to work around the problematic system in order to run the experiment as effectively as possible within the parameters of inflexible systems that were not well aligned with the Buurtzorg model.

Workarounds were sometimes used in situations where hierarchical systems required authorisation from a manager. For example, teams of one partner were facing delays caused by the system requirement to gain line manager approval for ordering goods and services. They created a workaround, but the partner lead felt that a change to the system was required to enable a sustainable solution.

> ***A workaround is being used by putting co-workers' email as an approver. … A whole system change is needed to allow teams to become approver/budget holders. (#RW167-167LO.)***

This is an example of workarounds being used to circumnavigate a system that was unnecessary for care delivery. Workarounds (or perhaps work-throughs) were also used to achieve aims where necessary systems did not exist. For example, one partner found that they lacked a communication system that worked effectively to communicate between frontline staff and back office. They instigated a temporary way of doing this, and reported that a longer-term system needed to be designed (#RW164-164LO).

iii Alternative systems

Where organisations had overarching systems, goals and cultures that were inconsistent with Buurtzorg goals, and those overall systems could not be changed by those involved in the TICC project, some partners moved toward creating new ways of working by setting up alternative systems and/or seeking to create their own goals and culture, alongside the 'mainstream' organisation. English partners working within the NHS were limited in what they could achieve in this respect, but in some cases built some new ways of doing things that meaningfully and sustainably improved the ability of teams to make the model work. This was articulated by the project lead of one of the partners.

> ***The NHS as it is currently organised is overly complex, over-regulated and generates substantial transaction costs. Current moves to streamline and simplify the organisation of the NHS in England should continue and may require changes in legislation in due course. There are some big issues for wider challenge but in order to implement Buurtzorg principles within community teams -- we focused on areas of organisational bureaucracy that were unnecessarily burdensome on clinicians, slowed desired outcomes, used unnecessary clinical managerial resource and corporate resource. (#RW226-226LO)***

As we saw above, one partner reported a problem that the ongoing use of banding within the NHS, and the authority associated with different bands over particular matters, meant that "the most appropriate person to 'approve' may not be eligible due to their banding". (#RW71-71LPR). They responded by changing the rule concerned.

The amended document is based on roles rather than banding, so removes the hierarchical element. It has also reduced some of the steps in the authorisation process thereby reducing the time in which it takes to complete. (#RW71-71LPR.)

Similarly, another partner had reported a number of different ways in which hierarchical bureaucracy was creating barriers for their TICC teams. They responded to this by designing new systems for the teams that enabled them to get work done without requiring management approval for a vast range of tasks. As such, they worked to grant genuine autonomy to their TICC teams over a range of matters. This meant they established alternative systems – sometimes referred to as a 'mid-office' or 'service centre' -- for these teams that ran in parallel to the hierarchical systems still in place across the rest of the organisation.

This partner also worked to improve the problem of funder goals not being aligned with Buurtzorg goals by working with commissioners to help them to appreciate the benefits of the Buurtzorg model. Although commissioners did not change the way that they monitored outcomes, (so the task-based reporting problem was not solved), they did change the geographical organisation of the teams' funding (#RW149-149LC). This meant that, while the broader commissioning system was unchanged, it was easier for TICC teams to meet commission requirements.

French teams were limited by insurance systems and collective bargaining agreements, but again, they found creative ways to design systems to enable their work. When they found that a particular administrative system was complicated and that frontline staff were struggling to use it, they simplified the system (#RW48-48LSM). Meanwhile, another partner proposed and tried out a solution to the problems created by the task-based funding models imposed by insurance companies. They suggested that a per-hour funding model might be an improvement to the task-based one, and successfully negotiated a trial period of such an approach for TICC teams. This is an example of a partner designing an alternative way of working for TICC teams that was distinct from the approach taken elsewhere in the organisation.

Overall, where staff within partner organisations were unable to change the overall goals and systems of those organisations, building small pockets that worked differently helped them to overcome the barriers associated with a lack of integration of Buurtzorg goals throughout the organisation. This was done by creating alternative goals, systems and cultures that were adopted by the TICC teams, allowing them to work in a different way from the dominant model within the organisation.

iv Full integration

Project partners felt that the ultimate sustainable solution to the problem of inconsistent goals throughout organisations was to make those goals consistent. This could only be achieved by having Buurtzorg goals and values adopted at all levels of organisations. Systems would then be designed with the specific purpose of working toward these goals, and the problems caused by poorly fitted systems would be resolved. As TICC is a pilot project, this was not achieved by any of the partners. However, some of those involved in the project identified overarching changes that they felt would enable the Buurtzorg model to succeed at scale.

One partner recognised that achieving the goals of great care and happy teams required that they work within a commissioning framework that valued these aims. They have been working with local commissioners to discuss changing the focus of their reporting requirements to be more consistent with Buurtzorg goals rather than volume of tasks performed (#RW85-85CBR, #RW129-129CBIT).

The simple solution identified was ongoing escalation/dialogue with commissioners to educate them about Buurtzorg principles and to encourage a collaborative approach to achieving and reporting outcomes rather than volumes. (#RW129-129CBIT).

Another partner suggested that the quality assurance regime should include evaluating whether the goals of great care and happy teams were being met, as well as the goal of financial sustainability.

The financial balance is the only KPI that the team can use to check 'what good looks like'. We would need to implement regular evaluations about team interaction quality and patient quality, so that teams also focus on those two important aspects of their outcome. (#RW232-232CBO.)

One partner echoed this need for adapting assurance models to be consistent with Buurtzorg goals. They have attempted to negotiate with the Care Quality Commission to adjust their measures for assessing quality (#RW175-175LPR, #RW90-90CBSYC). Similarly, another partner recognised that the sustainability of the new way of working is dependent on validation from their main regulatory body, Agence Régional de Santé (ARS) (#RW47-47LPR). They have been working with ARS on this and are hopeful that ARS will approve a new policy approach on the basis of the success of the TICC experiment.

Partners felt that, in order for the pilot to become sustainable, health and social care needed to be integrated at a funding and regulatory level. In England, a partner-initiated discussions with commissioners to encourage them to commission Neighbourhood Nursing (Buurtzorg model) teams as an integrated service (#RW146-146LC). Another partner also felt that there was a "need to move towards shared budgets and integrated organisations", and they initiated meetings with regulators and funders to initiate this (#RW81-81CBF).

One partner felt that a shift in culture within the NHS was necessary and that this should find expression in a shift from policy-driven management to coaching support for teams to operate within a framework of normative standards.

A culture change is needed from a policy driven focus to team frameworks and a move from management to coaching culture. (#RW174-174CBPR)

Traditionally, change approaches in the NHS have been driven by rational planning logic, underpinned by data. The emergent NHS will need to place more emphasis on emotional connection as this is a pre-requisite for calling people to act, based on their convictions and values as we move from 'have to' to 'want to' change to enable transformation for integration of care in the community. (#RW94-94CBSYC)

An evaluation partner reported partners from across the project felt that there was a need for an overall cultural shift toward trust and autonomy within their organisations, and that this was needed to enable the wider application of the Buurtzorg model.

For the new care model to become successfully implemented more widely, focus group participants emphasised the importance for a hosting organisation to listen to and place trust in the teams they create. (#RW30-30CBPB)

As well as coming from the top, it was suggested that open and honest discussion involving frontline workers would be helpful to instigate cultural change from the bottom up.

Discourse of expectations of newly formed teams from historical team configurations… Need to recognise transformational tensions between new and old models… Encourage open and honest conversations. Support understanding of transformational plan across the organisation. (#RW115-115CBOC).

In general, partners saw the sustainability and wider applicability of the model as closely related to culture change within their institutions.

2.f Buurtzorg's solution: Frameworks

Two partners recommended that, in order to overcome the problem of a lack of consistency of goals at different levels of organisations, a new framework must be put in place within institutions and organisations introducing the Buurtzorg model for the first time. Such a framework is "a set of norms and ground rules" that express shared purpose and vision, as well as boundaries of autonomy and responsibility. Project partners found that, if they launched their TICC teams without such a framework in place, this created a barrier to applying the Buurtzorg model. They also found that, in order to be useful, the framework had to be understood and supported throughout the organisation.

Early in the project, two partners identified that the teams did not have a framework that outlined the organisational priorities expected of them, and that one was needed to "provide a guide to the team and the people they support of the expectations of delivery of support and how the team will work together in delivering care and support" (#RW57-57LO). They worked on developing a draft framework, with support from another partner. One of the partners also reported that it was a challenge for the team to conceptualise the expectations of them before their framework had been developed and agreed upon (#RW168-168CBO).

A lack of such a framework was also a barrier to developing shared understanding with back-office staff (#RW168-168CBO) and gaining full support from the Board of Directors (#RW173-173LO). They developed a framework, which was signed off by the Executive, who also met with Buurtzorg to improve their understanding of the new way of working. However, writing in 2020, a further insight was that in order for the framework to be used to help the teams achieve their purpose, "a culture change is needed from a policy driven focus to team frameworks" and that this required "wider staff engagement, training and reviewing policies with key personnel in the organisation" (#RW174-174CBPR). This suggests that having a written framework may not, in itself, solve the problem of mismatched goals at different levels of organisations. What is needed is for the principles within that framework to be adopted as a cultural understanding at all levels of the organisation. This is consistent with the partner recommendations on the use of a framework, which, rather than being a rigid set of detailed procedures, is intended as a written agreement of basic principles and norms that inform the work of the organisation.

Chapter 3 Other types of barriers and challenges

3.a General community nursing challenges

In addition to barriers related to applying the model within an institutional environment that didn't support its values and goals, teams also faced more general challenges related to providing community nursing. These included responding to the Covid-19 pandemic, remote working, and insufficient resourcing. Of these, the challenges of insufficient resourcing were the biggest threat to the overall sustainability of the model (and, indeed, of business as usual), and it manifested as high caseloads, workforce shortages and lack of access to material resources.

All of the partners experienced delays and setbacks in their projects due to the Covid-19 pandemic. The priorities of their institutions switched to responding to the crisis, and the challenges of the pandemic meant they had to meet new and changing needs in their communities whilst facing staff shortages and lack of access to essential supplies.

> ***Access to GP and practice nurses reduced during the pandemic causing additional work for community teams having to fill these gaps. A few teams also needed dressings from community pharmacies, and this has been challenging through the COVID period with long waits impacting staff time and patient care. (#RW75-75LO)***

> ***Due to Covid 19 the requirement for staff to shield at home if positive to covid19 or if they were highly vulnerable impacted on the resource/capacity within the smaller teams. (#RW207-207LW)***

Another way in which Covid-19 affected the project was through deprioritisation of new initiatives as resources were focused, understandably, on dealing with the crisis. For example, before the pandemic one of the partners had been working with ARS to try to bring funding and regulation of nursing in France more in line with the Buurtzorg goals. This work was suspended due to the pandemic (#RW47-47LPR).

The pilot teams also faced the challenges associated with remote working that were experienced across the community nursing sector and beyond. These included difficulties managing work-life balance, supporting communication and teamwork whilst working from home, and problems with access to the internet.

> ***Having the opportunity to access information from home also makes the boundary between personal and work life thinner. They suggest (having to use) a professional device for this as a potential way to keep the distinction. (#RW18-18CBICT)***

> ***Maintaining contact with teams whilst remote working (#RW65-65CBO)***

The impact of COVID 19 and staff working remotely has led to the introduction of digital tools for meetings. This has resulted in a reduction of breaks between meetings, i.e. for travel, comfort breaks etc. There were reports that staff wellbeing was negatively affected by this. (#RW68-68CBO)

IT connectivity challenges for supporting consistency of access for clinical staff to be able to remote work often in rural areas. (#RW126-126CBIT)

The pilot teams faced the same challenges of insufficient resourcing that are faced more widely in health and social care. They found they were expected to support too many patients with too few staff, and this undermined their ability to apply the Buurtzorg model effectively because, although over time the model can reduce the amount of time needed per client, it does require an upfront investment in relationship building.

Increase in number of patients on caseload as sole provider of home-based nursing care to the population (#RW84-84LC)

One partner reported to specifically struggle with finding the time to perform their specific roles (#RW21-21LO)

Since many years, our team works on tight flow mainly due to a lack of workforce to deliver good quality of care (10 team members for 50 clients living in 14 different towns, as stated in our multi-year contract with our Regional Health Agency or Agence Régionale de Santé - ARS). (#RW46-46LO)

Increased complexity of health needs, demand on community nursing services, not reflected in the investment of workforce (#RW187-187LO)

Team unable to develop self-managing model due to increased patient visits. (#RW206-206LSM)

Recruiting nursing and care staff was a big challenge across all three countries. Some put this down to the low rate of pay, while in Kent the national government's removal of training bursaries was also a factor.

The rate of home care working is €21 per hour. It's not enough for a good salary. (#RW9-2LF).

The care sector is suffering from a lack of attractiveness which leads to difficulties for small care organisations to hire staff members. … This can mainly be explained by the lack of recognition of the value of their work, low salaries. This was the case before TICC started and it is still the case. In France, the pandemic has created new inequities between care professionals working in public hospitals and care professionals working for private non-profit/associations. Salaries have increased in the public sector, but they remain the same rather low salaries in our private sector (although funded by the State) (#RW11-24CBR).

There is a lack of availability of Band 5 staff owing to no training bursaries for three years. (#RW70-70CBO)

Insufficient workforce to support transformation in a timely manner due to national nursing shortages. (#RW121-121CBOC)

UK shortfall in trained nursing staff, recruitment has been slow across the UK pilots. In Kent there has been interest in the pilot and model, but applications have been low. (#RW56-56CBR)

In France we don't have enough money to pay the nurse and care workers enough. (Lille meeting with a partner)

Finally, in one partner organisation they did not provide adequate office space and facilities for the teams (#RW119-119CBOC, #RW190-190LO). This created a delay for the teams in getting the pilot going.

Suggested solutions to the problem of inadequate resourcing were similar in type to those relating to inconsistent goals and values. There was occasional use of status-quo approaches. This put the onus on teams to work within available resources, including very high caseloads and low workforce. This is likely to prevent teams from applying the model successfully.

> ***Teams will need to manage within caseload requirements, otherwise will impact on financial envelope of service (#RW150-150CBCOMP)***

Partners also developed alternative systems approaches, which involved changing the ways that caseloads were allocated, setting minimum workforce requirements for new teams, and upskilling unqualified staff.

> ***Growing our own – supporting and positively encouraging applicants who would wish to progress from Band 2 through the apprentice programme to become either a registered associate practitioner or a registered nurse. (#RW139-139LRR)***

> ***In caseload allocation teams are allowing for this time for the motivational interviews. (#RW69-69LO)***

> ***Ensure new teams gradually build their caseload whilst they are in the set-up phase and traditional teams understand the requirements for them to build up their case load in a more measured way to enable them to embed this new way of working. (#RW206-206LSM)***

> ***Ensure minimum of 8 whole time equivalent workforce available at start of transformation. (#RW97-97CBSMT)***

However, partners in both countries felt that the sustainability of the model relied on adequate resourcing of health and social care, which is equivalent to the full integration approach outlined in section 1.

> ***Public funding must be directed towards the old age and dependency sector. (#RW9-2LF)***

> ***Requires national recognition and review of resources to support… Requires national long-term plan to support demographic changes in care provision out of hospital (#RW187-187LO)***

> ***Increasing our care professionals' salaries would have a sustainable impact on the new care model that we are experimenting. (#RW11-24CBR)***

To apply the model with maximum success and sustainability, it would be necessary for governments to ensure adequate resourcing for the health and social care sectors. In the current context, partners were able to make some alternative system adaptations to improve the efficacy of the project.

3.b The challenge of any change

Some of the challenges partners faced when working towards applying the Buurtzorg model related to adjusting to change. These are closely related to the problems of applying the model within institutional settings that do not share Buurtzorg goals and culture, because some of the problems related to adjusting to a change in goals and culture. However, some of them were more general 'teething problems' relating to adjusting to new systems and requiring support when beginning in new roles.

> *The change to the new IT system was experienced as hard and challenging (#RW49-49LICT)*

> *Capacity of staff to manage the changes alongside business as usual (#RW64-64CBO)*

> *Inadequate level of support to enable new staff to develop confidence and competence in roles. (#RW132-132LRR)*

> *Increasing responsibilities requires some adaptation time to get used to the new way of working. This caused some 'extra' mental workload in the beginning of the implementation. (#RW37-37CBSM)*

There were also new skills for staff to learn, which took time. Selecting new colleagues was a particular skills gap that took time to develop. (This is distinct from learning HR administrative systems, which the Buurtzorg model would not expect clinical staff to spend time on).

> *The self-managed teams take time to learn by themselves (#RW7-1CBW)*

> *Self-management implies peer-recruiting. But our team members lack the knowledge/ competencies required to recruit new members of staff. (#RW50-50CBR)*

> *The teams tend to recruit "young and easy to manage" colleagues. Especially if they themselves are young. They tend to recruit "clones", instead of reflecting about their needs, and looking for the best experience/competence possible. They seem to fear to recruit more experienced, competent colleagues. (#RW233-233LR)*

> *Lack of knowledge and skills in clinical teams to take on roles previously carried out by clinical nurse managers. (#RW108-108CBSMT)*

To address these challenges, partners recommended ensuring that enough time and support was built into the formation of new teams to enable them to learn new ways of working.

> *Review of induction programme and based on feedback from leavers – developed and implemented an extended 12-week induction programme with a clinical lead to support with preceptorship and clinical supervision. (#RW132-132LRR)*

> *Create time to adjust and provide social support to increase self-efficacy. (#RW39-39CBSM)*

> *High input at start-up from coaches, facilitating team meetings, referencing the framework – team probationary minimum 6 months. Reduces risk of 'run away' of self-management, teams not working in line with the framework. Invest in development of roles with associated teams training needs. (#RW108-108CBSMT)*

3.c The challenges of the model itself

There were a few other challenges related to the use of the model itself. For example, the need to learn about how to select new team members was not only a training issue but also an example of the challenges associated with the model itself, since in Buurtzorg teams do recruit their own members. Again, in some cases (such as pervasive use of hierarchical status within teams), this related to the fact that the teams were trying to work within an institutional setting that did not share Buurtzorg culture and values. However, some were more general challenges relating to working collectively.

Partners found that their teams sometimes struggled with internal communication.

> ***Running a self-managing team requires more/efficient internal communication (#RW240-240CBSM)***

> ***The team members have never been used to direct communication between colleagues (#RW241-241CBW)***

This was a particular issue when it came to managing disagreement or resolving conflict.

> ***When somebody doesn't work like the others of the team want, it's difficult to talk and to explain by the team. And also it has an impact for the people helped. … Training to non-violent communication (#RW10-25LO)***

> ***Staff find it difficult to be open and honest and have difficult conversations with each other. (#RW210-210CBO)***

> ***Work together better as a team to deal with different personalities and help allocate patients to the most relevant clinician. (#RW5-37LW)***

Some teams found that it was a challenge to share work out fairly. This included situations in which particular roles were more labour intensive than others, and also challenges of sharing responsibility and accountability evenly within the team.

> ***Some roles and tasks are viewed as more challenging than others, especially the role of planner and, to a lesser extent, that of treasurer are reported to be time-consuming. (# RW22-22CBO)***

> ***Despite the non-hierarchical structure there was a consensus that leaders remained within the team and that this is an unwanted burden. (as discussed with partners at steering group meeting)***

> ***Three partners mentioned that the equitable division of responsibilities and roles was (and for some remains) an issue. More roles and responsibilities end up with those more engaged, more experienced and/or with more leadership traits. (#RW42-42CBW)***

Because competency and expertise are so often associated with hierarchical status, a further challenge was finding ways to ensure that staff felt valued for their competence and supported to progress in their careers.

Outstanding queries/concerns from within and external to the team in respect to the new model of care and the opportunity this provided for career progression (specifically for qualified nurses). (#RW35-35CBSM)

Senior staff within teams threatened by model – perceived loss of power/control -identity (team members all wear same uniform).

Difficulty to differentiate between hierarchy and clinical expertise. (#RW212-212CBW)

Partners suggested that solutions to communications problems lay in a combination of training, collective agreements, relationship building and experience.

To provide and reinforce training on the solution-driven method of interaction approach by all team members, inclusivity and in having challenging conversations. (#RW105-105CBSMT)

It takes time, and training, and coaching intervention to raise up the level of communication maturity. We learn by our errors, which can cause pains. (#RW228-228CBSM)

All our team members establish a 'self-managing team golden rules' or charter in which they have created their own 'DNA' or identity and set out their own rules [that] describe how they deliver home care service. They now talk and listen to each other and participate in regular supervision sessions. (#RW240-240CBSM)

Through team engagement sessions teams have been asked to consider the strengths and diversity they each bring. By noticing, accepting, and celebrating differences teams are able to adapt their communication style and opinion to come to agreement. Teams have adapted these ideas to produce personal profiles of who we are / our strengths/ weaknesses / previous experiences in work and life etc. to draw from each other's strengths and support people's weaknesses. By paying attention to these team dynamics, it enables all team members to contribute fully to finding the best solutions to support patients. (#RW5-37LW)

A recommendation from one partner is to take time at the start of the new care model to really get to know each other and set rules of operation from the beginning. (#RW39-39CBSM)

Solutions to help with unfair distribution of work and responsibility included rotating tasks and working in pairs.

It was found by French partners that rotating roles and duties helped to distribute workload (and develop skills). One partner found that working in pairs, with each pair having a schedule, helped to divide the workload. (#RW22-22CBO)

Solutions for supporting staff to value clinical expertise rather than status included working with them to support them to understand the values of the model and the value each of them brings to the team, and creating opportunities for experienced staff to be involved in setting up new teams. Failure to do the latter led to some staff seeking new jobs.

Engagement with staff on the model and value and strengths of each team member as a collective. Does not detract from recognition of clinical expertise. (#RW98-98CBSMT)

Change of culture, coaching and training. Embed in framework coaching and learn as an organisation what you are expecting from the team; everyone as equal. Organisation has to give the right example and not act like there is a hierarchy. (#RW212-212CBW)

Alterations in the original agreement that career progression would be enabled via their support to establish more new care teams in the future, had contributed to some team members looking for alternative employment. (#RW35-35CBSM)

The importance for some staff within the team to have previous experience/skills relative to delivering community care through a self-managing model was recognised. (#RW39-39CBSM)

Through team engagement sessions teams have been asked to consider the strengths and diversity they each bring. (#RW5-37LW)

Chapter 4 A blueprint for successful transfer of the Buurtzorg model

4.a What is a 'blueprint'?

One of the main outputs of this project from the start was to be a "blueprint for successful transfer of social innovative service models in health & social care from one country to another benefitting all public/private services".

So, what is a 'blueprint'? According to the Cambridge English Dictionary, it can be simply "an early plan or design that explains how something might be achieved". For some purposes such a plan or design might be highly detailed, as implied by the literal source of the metaphorical term, given by the same dictionary as "a copy of a technical drawing that shows white lines on a blue background". And for some technical purposes – bearing in mind that the term originated in the construction industry – a blueprint, says the dictionary, is a "complete plan that explains how to do or develop something".

However, the 'successful transfer of social innovative service models' cannot be accomplished in the same way as builders apply a blueprint handed to them by an architect. Certainly, the skill and experience of the builders themselves is as important to the outcome as the design to which they work, and to that extent there is a parallel with health and care. However, an equally important difference is that, unlike the construction of a building in which success requires them to follow the detail of the design to the letter, success in health and care depends on the professional practitioners themselves co-designing their service with the people they support, drawing on their own qualifications, experiences, and common sense as they go. This applies to any human-centred service, and especially to health and social care, a highly complex environment in which outcomes are the dynamic product of myriad relationships of many kinds.

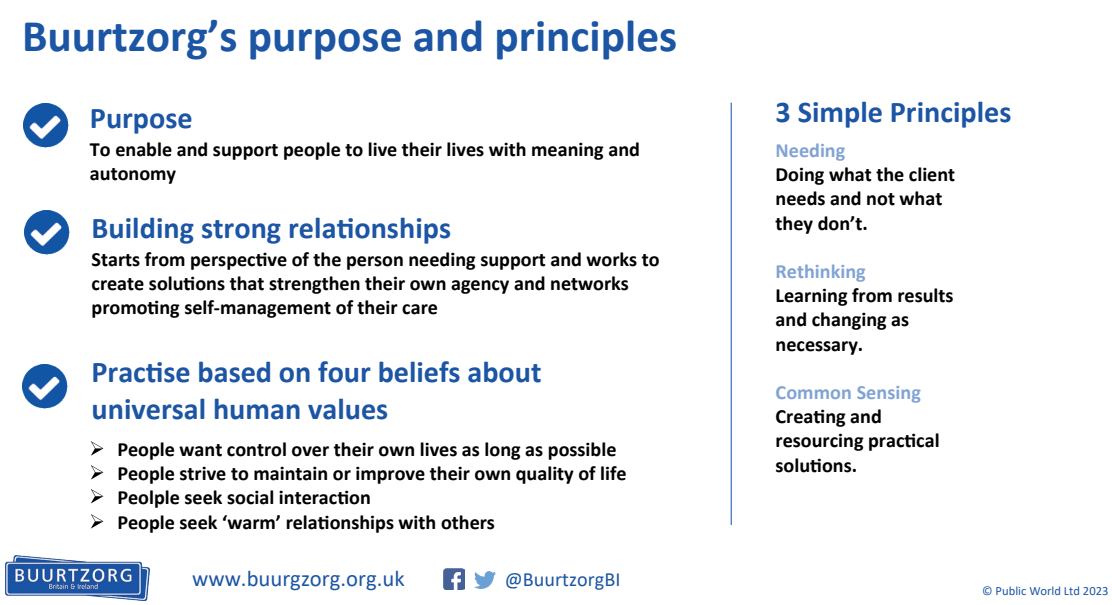
So, the quest for a Buurtzorg blueprint might best start with the reality that the organisation that inspired this project has never, from its conception around a kitchen table in 2006 to its continuing evolution some 17 years later, made a highly detailed plan. Moreover, perhaps the core lesson of the TICC project - as shown in this report's detailed evaluation of what its active participants have done over the last five years, the barriers and challenges they have encountered, and the solutions they have developed in their own contexts -- is that there is no one way to draw inspiration and guidance from Buurtzorg's success.

Of course, it makes sense to pay attention to the methodologies and practices with which Buurtzorg operates, at every level from the relationship between professional and client, through self-managed teamwork, to back-office support. It would be foolish not to study that detail and learn how particular methodologies and practices contribute to the overall continuity of logic that has driven Buurtzorg's continuing and growing success. However, the fundamental point is to understand the principles that consistently guide Buurtzorg's practice and the purpose that underpins them, and to apply these creatively, and if necessary, with adaptation, to your own purpose and context.

4.b Start with purpose and principle

Public World has captured Buurtzorg's purpose and principles in the following representation in Figure 2, used in its learning and development support for this project.

Figure 2 Buurtzorg's purpose and principles

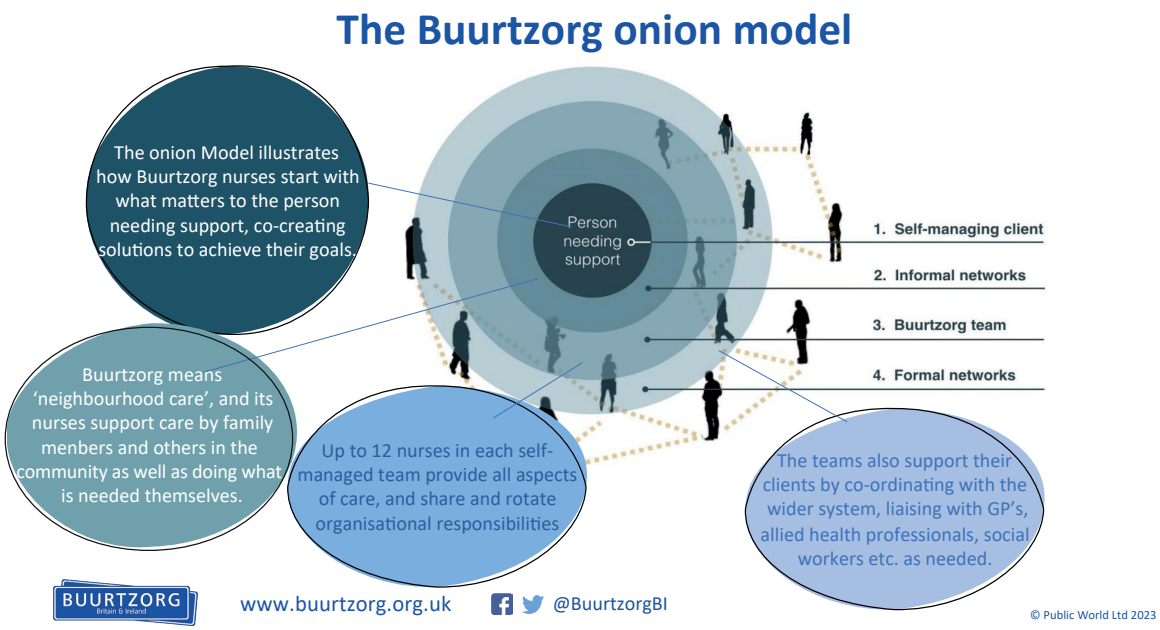


So, clarity of purpose and principles is a fundamental basis for any blueprint about how to apply the lessons of Buurtzorg's success to other contexts. That is not to say that discrete application of this or that detail of how Buurtzorg operates – or, indeed, of how the partners in this TICC project have adapted Buurtzorg practices to their own context – could not produce good results. Indeed, to give one example, some organisations that have learnt about how Buurtzorg self-managed teams conduct their meetings have found the methodology invaluable in a variety of organisational types. Moreover, the adoption of practices can be a useful starting point and stimulus to understanding for organisations seeking to make wider cultural shifts. Nevertheless, a consistent commitment to the fundamentals of purpose and principle is a necessary basis for organisations wishing to optimise results.

4.c Why self-management matters

In the nature of Buurtzorg's purpose and principles, its nurses and nurse assistants must be enabled and supported to work with a high level of freedom and responsibility. This is because clinical and other supports for clients must reflect their changing needs as dynamically understood through their relationships with the professionals, drawing upon and contributing to the strengthening of their own capacities and those of the informal and formal networks around them as appropriate. This approach to care is fundamental to the Buurtzorg model and is represented well by Buurtzorg's onion model graphic, which Public World has developed with a little additional explanation in the representation in Figure 3.

Figure 3 The Buurtzorg onion model



The evidence emerging from this project shows that some partners have found it much more difficult than others to replicate Buurtzorg's approach to care than others, and the same applies to self-management of teams. There have been both organisational and systemic obstacles to doing so, expressing the variety of cultural and institutional contexts in which partners have attempted it. Their efforts have produced a corresponding variety of contextually-adapted solutions, some of which have worked better than others, showing again that this or that characteristic of the Buurtzorg model can bring benefits independently of others. None has shown, however, that the successes produced by Buurtzorg's approach to care can be successfully and sustainably achieved at scale without also adopting its approach to work organisation in self-managed teams.

It is important to note that the model is rooted in the power of the intrinsic motivation, professional competence and both codified and tacit knowledge of frontline practitioners. Therefore, to overstate the need to learn how to self-manage, drawing on the methods used by Buurtzorg, can be to understate the existing capabilities of those professionals. On the other hand, in the context of a history of low-trust organisational processes and cultures in highly hierarchical and bureaucratic environments, the project has shown that some structured and well-designed learning and development support is essential.

4.d The importance of a framework of normative standards

The extent to which organisations and/or the institutional systems in which they operate are willing to trust the professional competence and integrity of 'frontline' staff, and to move away from task-based approaches to care and rules-based approaches to work organisation, has been a key variable factor. In addition, however, a key lesson of experience is that successful self-management itself requires a framework that expresses purpose, required normative standards and red lines. These can and should be articulated as simply and concisely as possible.

We have found that a few simple ground rules in each of three categories of expectations – great care, work relationships and resource use – is all that is necessary, and that, if it is to be truly owned by all, it must be the product of dialogue between organisational leaders and the self-managing teams. Where it is too restrictive it tends to replicate some of the disadvantages of 'command and control' regimes, but where it is absent, insufficiently clear or fails to give expression consistently to the purpose, principles, and standards to which the organisation is committed, self-management can fail. In both cases it can lead to erosion of trust and concomitant undermining of the model.

Therefore, drawing with candour and honesty on the experience of working within the framework is crucial, and for that reason it needs to be adopted initially and revised occasionally through a consultative process in which the people whose work it governs can express their opinions and the lessons of their experience. At any particular moment in between its revisions, however, it is equally important that the framework is treated with rigour so that the purpose and standards required are consistently expressed in day-to-day practice. Otherwise, how can that practice in turn consistently inform organisational and systemic learning?

4.e Enabling and supporting self-management

On the basis of the distribution of authority expressed in the framework, a further condition of success of the Buurtzorg model is that the teams are both enabled and supported by their coaches and their organisation's administrative arrangements. The Buurtzorg back office operates with a consistent culture of treating the organisation's self-managed teams as its clients, in a similarly agile, responsive and co-creative way as those teams support and enable their clients. Again, Public World has tried to capture this in a graphic form, in Figure 4.

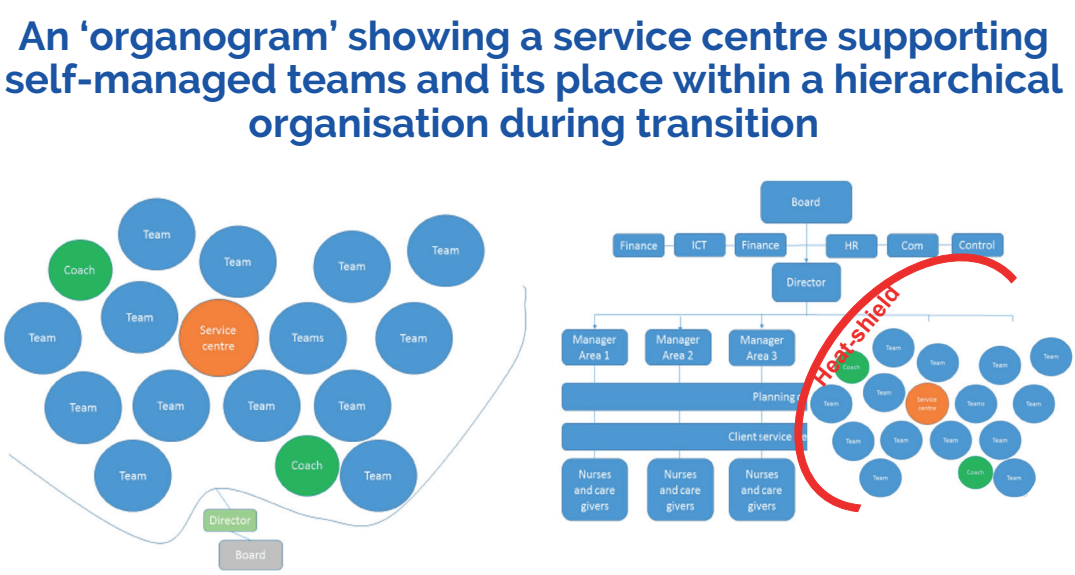
Figure 4 How does the organisation support the professionals?

As with the success factors already discussed, the project has demonstrated in both positive and negative ways the importance of simplifying processes, removing obstacles and providing the supports needed for successful self-management. The extent to which the project partners have been able to put such

arrangements in place has varied. A consistent challenge for already existing organisations -- as opposed to those that, like Buurtzorg itself, have begun to work in this way as start-ups – has been to 'retrofit' the culture, mindsets and structures required within organisations that were designed or evolved with a hierarchical structure. The degree to which they have succeeded with this seems to correlate significantly with the extent to which the teams themselves have succeeded, and without tackling this challenge effectively the model cannot grow to scale within an organisation.

But how to provide such supports within governance and management arrangements designed for hierarchical relationships and still responsible for enabling business as usual as well as the different demands of a new organisational form? Here the potential role of a 'mid-office' or 'service centre', as referenced earlier among the 'alternative systems' solutions tried by one partner, can be important and effective. It provides a liaison and mediation point between the self-managing teams and their organisation's administrative apparatus, enabling both to have a single point of contact as they negotiate their respective needs and wants from each other. It also has the potential to be an embryonic form of new administrative arrangements for the whole organisation in cases where they choose to build from 'alternative systems' to 'full integration', as discussed in Chapter 2, and during transition can also act as a sort of 'heat shield'. Public World has designed a graphic representation of such an arrangement as set out in Figure 5.

Figure 5 An 'organogram' showing a service centre supporting self-managed teams and its place within a hierarchical organisation during transition



4.f From organisational to systemic change

Finally, even those organisations most strongly committed to changing their organisations to be as much like Buurtzorg as possible have faced external constraints of various types, and this – as Chapters 2 and 3 have shown – has been a highly significant variable success factor. Partners have found that the extent to which they have been able to apply all aspects of the model has been limited by legal and regulatory factors and by systemic arrangements for funding and structuring health and care services and the way in which funds are distributed.

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Buurtzorg began with similar constraints, some of which continue to exist, but has shown the importance of creatively taking advantage of all the available systemic space to build and demonstrate the potential of a new approach. By doing so, it has been able – through practice and evaluating and learning from experience – to influence the wider Dutch policy environment in ways that have enabled its model to work more effectively. By combining the demonstration effect of its own success with advocacy about the reasons for that success, and the need for wider system stakeholders – government, regulators, funders, and so on – to create a more favourable environment for sustaining and growing it, Buurtzorg has increasingly contributed to systemic change.

Organisations wishing to emulate its success can learn as much from that approach as from how Buurtzorg has succeeded despite facing similar institutional and political barriers and challenges as those that have experimented as part of this project have encountered. The challenge is not to limit ambition because of organisational and systemic constraints but to use to the maximum the space within those constraints to demonstrate the benefits of reform to the institutional environment.

For policy makers, perhaps the challenge in this regard is to start from the right place, to reshape their systems from the point of view of the needs of the people for whom it exists rather than requiring those people to fit into outmoded and inadequate systems. As Buurtzorg's founder Jos de Blok has put it, drawing on a decade of international experience arising from his organisation's success: "We started working with different countries and discovered that the problems are the same: the message every time is to start again from the patient perspective and simplify the systems."

Appendix A - Barriers and Challenges Pages

Code: RW2-18CBR
Theme: Recruitment Process

Country of Origin/Context: UK
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

Managing and covering the administration required to use the recruitment system by the TICC pilot teams was a barrier to their doing so. This is time consuming and will take away from patient facing time.

Solution(s) Identified & Their Outcomes:

The issue was raised at the challenges and barriers subgroup and a decision was made to escalate to the Executive team as a trust-wide issue.

At the beginning of the pandemic certain processes were streamlined including recruitment, therefore this reinforced the need for change.

The recruitment process is currently under review by the workforce team. The challenges and barriers subgroup and workforce will be working with focus groups to ensure the changes meet the needs and are sustainable.

Part of the solution will be to automate the process using a “bot”. This will mean that information can be captured once and then passed through multiple systems. This will mean that once a new person is recruited their IT credentials (for multiple systems), building security credentials, ID badge etc. will be generated saving time in the front and back office.

Further Information (E.G. Financial Costs, Suppliers):

N/A

Code: RW3-35LR
Theme: Recruitment Process

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable: Yes

Description of the Barrier and/or Challenge:

There are very bureaucratic processes for recruiting staff. The same information had to be entered into two systems - local system 'TRAC' and national system and they were not automatically linked, this meant we were duplicating the time taken when advertising a post. The local system was quite complicated and not intuitive meaning many mistakes occurred slowing down the process even further.

Solution(s) Identified & Their Outcomes:

- Backoffice staff in IT developed a "bot" to automate the linking of the two systems.
- This means that the team or person recruiting only needs to complete the advert details in one system.
- All the data is then taken, shared and coded to the right fields in both the databases.

Outcome:

- This has more than halved the completion time and frees up teams to spend more time with patients or on other value areas.
- Reduced errors between the two systems.
- Reduced staff frustrations.
- Completion time of application/recruitment process halved.

Further Information (E.G. Financial Costs, Suppliers):

Solution developed in house by internal organisations IT department linking generic form system "topdesk" and linking to other systems. Now the IT are looking for other processes to simplify using this approach.

Code: RW4-36LW
Theme: Continuing Professional Development

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable: Yes

Description of the Barrier and/or Challenge:

During Covid teams were unable to maintain their continuing professional development (CPD) owing to increased workload that the pandemic produced.

Solution(s) Identified & Their Outcomes:

Solution:

- Re-introduce shadowing so teams can keep their skills fresh and continue in their CPD journey
- Introduce joint visits to share skill sets
- Share research articles and information through regular best practice meetings and one to one meetings.
- The trust continued to support attendance at "Action Learning Sets" for staff to learn from each other in groups and use a coaching and solution focused approach to real-life problems

Outcomes:

- Staff were motivated in continuing their personal development
- Kept staff engaged
- Encouraged staff to develop professional curiosity
- "Action Learning Sets" supports problem solving, resilience building and the development of a community of leaders

Further Information (E.G. Financial Costs, Suppliers):

Code: RW5-37LW
Theme: Workforce

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable: Yes

Description of the Barrier and/or Challenge:

Working in a team with different personalities, multiple nationalities and with a variety of skill sets and competencies.

Solution(s) Identified & Their Outcomes:

- Identify most appropriate clinical staff to give best patient interaction and care respecting cultural differences.
- Through team engagement sessions teams are asked to consider the strengths and diversity they each bring.
- By noticing, accepting and celebrating differences teams are able to adapt their communication style and opinion to come to agreement.
- Teams have adapted these ideas to produce personal profiles of who we are / our strengths/ weaknesses / previous experiences in work and life etc. to draw from each other's strengths and support people's weaknesses. Taking time for this reflection across a team and allowing teams to talk about & share their strengths, competences & differences allows members of the team to understand each other's needs – and how to work together to achieve the best results.

Outcomes:

- Focusses on how we can best use our strengths to support patients/clients
- Increases trust and psychological safety in a team.
- Increases acceptance and understanding.
- Focusses on individual and team needs.
- Improves communication about performance and quality.
- Encourages bringing your whole self to work.
- Encourages speaking up and speaking out; dare to disagree.
- Focus on team purpose.
- By paying attention to these team dynamics, it enables all team members to contribute fully to finding the best solutions to support patients.
- Builds commitment for better care for patients.

Further Information (E.G. Financial Costs, Suppliers):

Solutions Template

Code: RW6-1LF
Theme: Funding

Country of Origin/Context: France
Local or Cross Border: Local
Sustainable: No

Description of the Barrier and/or Challenge:

With the health crisis, support measures were taken for the care professions and the associative sector however private companies that apply the principle of autonomous teams were disadvantaged

Solution(s) Identified & their Outcomes:

We have taken lobbying action with deputies and political actors

Further Information (E.G. Financial Costs, Suppliers):

The lobby of the health sector is much more powerful than that of the home help sector

27.09.2022 - No measures have been taken to consolidate the home help sector.

State announcements focus on retirement homes and hospitals

Solutions Template

Code: RW7-1CBW
Theme: Workforce

Country of Origin/Context: France
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

The self-managed teams take time to learn by themselves. Whilst we as an organisation paid this working time, we were not able to bill for it.

Solution(s) Identified & their Outcomes:

We have asked financial partners like Conseil Géneral to pay for the development of self-organised teams a few times

Further Information (E.G. Financial Costs, Suppliers):

The decision made would be a long-term commitment. In May 2019, Conseil Général du Nord have confirmed there could be a re-evaluation of the way payments are made for homecare workers and it's interested in how it can make payments for different types of time such as training time.

29.09.2022 – There has been no further change to this

Code: RW8-2LW
Theme: Workforce

Country of Origin/Context: France
Local or Cross Border: Local
Sustainable: No

Description of the Barrier and/or Challenge:

VIVAT have now been working for 3 years as self-managed team and it's difficult to improve employee health. The sickness rate is still an issue and equal to the challenges faced before the re-organisation into self-managed teams.

Solution(s) Identified & their Outcomes:

We have to work with pension funds and private insurance companies to train staff in caring for their own health

We also need to facilitate access to additional financing. Provide skills (social workers, occupational therapist ...)

Further Information (E.G. Financial Costs, Suppliers):

The preparation of a financing file with the actors of employee health in France is complicated and takes time. In addition, the financing methods at the end of the action do not attract home support structures

29.09.2022 - The region's pension fund refused to identify self-managed teams as an added value in terms of quality of life at work. They will not finance any actions to strengthen this model and the means necessary for its implementation.

Code: RW9-2LF
Theme: Funding

Country of Origin/Context: France
Local or Cross Border: Local
Sustainable: No

Description of the Barrier and/or Challenge:

The hourly rate of pay for home care working is 21€. It's not enough for a good salary, digitalisation and training.

Solution(s) Identified & their Outcomes:

Trying to fix higher prices or find subventions like TICC

Public funding must be directed towards the old age and dependency sector.

Measures to combat undeclared work in home employment must be visible and effective. It's illegal competition

Further Information (E.G. Financial Costs, Suppliers):

French public funding does not take dependency into account in the same proportion as its European neighbours.

In April 2022, the French government will implement the tax deduction at source linked to the use of home help.

29.09.2022 - In the Nord department, social policy aims to limit the cost of services for the poorest people. As a result, the Department regulates the prices of home help companies. The level of supervision does not allow the structures to live economically

Code: RW10-25LO
Theme: Operational

Country of Origin/Context: France
Local or Cross Border: Local
Sustainable: Yes

Description of the Barrier and/or Challenge:

We have experienced communication problems within the team. There are many conflicts in the teams as a result of organising themselves without hierarchy

Solution(s) Identified & Their Outcomes:

We have found that training in the profession of caregiver does not include the discovery and mastery of a mode of communication adapted to teamwork.

Professionals are not sufficiently trained to express what they feel in the organization of their work or in the relations with their colleagues

Two training areas are developed at our organisation. Awareness of Marshall Rosenberg's non-violent communication techniques and intensive use of SDMI methods developed by Buurtzorg

The training is now being rolled out across all the teams as it has been a good outcome.

Further Information (E.G. Financial Costs, Suppliers):

Code: RW11-24CBR
Theme: Recruitment Process

Country of Origin/Context: France
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge

The care sector is suffering from a lack of attractiveness which leads to difficulties for small care organisations to hire staff members, Due to the pandemic, we have greater difficulties in recruiting new staff members; although our staff turnover has reduced, we still have some vacancies.

This can mainly be explained by the lack of recognition of the value of their work; low salaries however this was the case before TICC started and it is still the case today.

In France, the pandemic has created new inequities between care professionals working in public hospitals and care professionals working for private non-profit/associations. Salaries have increased in the public sector, but they remain the same rather low salaries in our private sector (although funded by the State)

It's harder and harder to find new home care workers even with the introduction of working in self-managed teams.

Solution(s) Identified & Their Outcomes

One of our partners joined the TICC project believing that adopting the Buurtzorg model could help to make the job more attractive for our current and future workers. This is the case as most of our current team members explained that they were happy and proud to test this new model, however, self-management and higher autonomy also means skills development which should include higher salary. This same organisation has now denounced this new inequity and is engaged in promoting higher salaries for its care professionals (i.e., obtaining the 'segur' and 'Grand âge' salary bonuses for all and not only public hospitals).

This work is more fun. We need to do more communication on the positive impact of the self-managed teams.

Further Information (E.G. Financial Costs, Suppliers):

We should work on positive communication campaigns and change the image of the profession, promoting care and relationships in the profession. Increasing our care professionals' salaries would have a sustainable impact on the new care model that we are experimenting.

The Buurtzorg team and coach training sessions (in English with the support of an interpreter) + Skype sessions (in French) are very useful for our team of care professionals. We need to keep training them and we hope that this will contribute / help to retain our care professionals in our organisation.

One partner has joined a network of private care organisations to sign a joint declaration formulating recommendations in which we are denouncing the lower salaries for our care professionals. We will be striking against these inequities on 30/11/22.

Code: RW12-1CBE
Theme: Evaluation

Country of Origin/Context: France
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

Throughout the project we have found it difficult to find control groups for evaluation

Solution(s) Identified & their Outcomes:

Some partners found adequate control groups. For others, just a control for the staff was found.

As a result, some adjustments were done to the protocol, with more weight on the analysis of the evolution of the indicators.

For French partners, a second evaluation protocol based on the Public Health database has been submitted to authorities and is on-going. Also, the qualitative part of the evaluation will be more developed than initially planned.

Further Information (E.G. Financial Costs, Suppliers):

However, this is only a part of the solution to allow proper evaluation on some aspects (the specific French protocol, the partial control groups), but for some partners, no solutions were found.

Code: RW13-2CBE
Theme: Evaluation

Country of Origin/Context: All
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

There has been difficulty to get feedback from the delivery partners, so difficulties in the research protocols were found.

Solution(s) Identified & their Outcomes:

As a result of the challenges multiple adjustments were made on the protocol to ease the data gathering process.

Further Information (E.G. Financial Costs, Suppliers):

Specific discussions with the project partners were needed to understand the difficulties.

The final protocol contains fewer questionnaires and take less time to fill in.

The communication difficulties between such a high number of partners, coming from various fields and various countries, with heterogeneous administrative difficulties, should be well anticipated.

Code: RW14-3CBE
Theme: Evaluation

Country of Origin/Context: All
Local or Cross Border: Cross Border
Sustainable: No

Description of the Barrier and/or Challenge:

The data gathering (inclusion of new patients) is slow, and the final number of answers is lower than expected. The COVID-19 crisis worsened the situation.

Solution(s) Identified & their Outcomes:

Communication on the necessity to gather data was done all along the project, the protocol was modified to lighten the burden on the teams.

Further Information (E.G. Financial Costs, Suppliers):

The numbers for our data is still low.

Also, some planned questionnaires were not passed to the patients, so the risk is that the conclusion for some indicators won't be available.

Code: RW15-12CBW
Theme: Workforce

Country of Origin/Context: Various
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

Working in the Buurtzorg way might not be for everybody. It comes with more responsibilities than standard care and not everybody has the skills or willingness to take these on.

Solution(s) Identified & their Outcomes:

- Coaches to work with teams and reassure and support them in the development in becoming self-managed teams, create review periods with coaches.
- Increase autonomy
- There needs to be clear frameworks of responsibility and clear escalation for when needed so that team members don't feel abandoned or isolated.
- We need to review and update scheme of delegation, review and detail who can do what and when, revise if constraints need to be in place in line with framework.
- Update teams and organisations on project development, share the positives of creating the new team and new way of working
- Encourage team members to share their own experiences working in the new way
- Understand not everyone will want to work to the new model and that staff may leave if it is not right for them and they prefer to work with the hierarchical structures they are used to.
- Conversations about purpose – coaches spend time with teams considering what their purpose is and ensure they understand the change in role aligned with the purpose.
- Identify with the staff what their barriers and challenges are so that they can be addressed with back office/senior leadership.
- Team dynamics – traditional teams work with the referee/management and the change to the self-managing means that they need to work together and have conversations, so we need to support the shift to communicating as a group to resolve their issues. Social time helps build relationships

Further Information (E.G. Financial Costs, Suppliers):

We have created a skills and knowledge matrix by role to recognise where they may need additional training such as recruitment. How to deal with informal HR issues, how to order.

Code: RW16-16LW
Theme: Workforce

Country of Origin/Context: France
Local or Cross Border: Local
Sustainable: Unknown

Description of the Barrier and/or Challenge:

In France it has been noted that more and more care workers are self-employed.

This could potentially pose a threat for forming close-knit (TICC) teams focussing on the same (long-term) goals and objectives.

Solution(s) Identified & their Outcomes:

No Solution yet found

Further Information (E.G. Financial Costs, Suppliers):

Code: RW17-17LF
Theme: Funding

Country of Origin/Context: Belgium
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

In Belgium, legislations with regards to billing for smaller care activities makes it difficult to fully get the project off the ground financially.

Assessment might not identify a significant enough need to put a package in place and therefore it falls to family to provide or find solutions.

Solution(s) Identified & their Outcomes:

In some circumstances health teams might help for a short period to get people ready to be left on their return home.

Further Information (E.G. Financial Costs, Suppliers):

This is a system challenge in allowing the professional to make the decision that seems most appropriate. Funding needs to consider the holistic approach across the services. We have noticed that there is less clarity in the definitions about what is health and what is social care, recognising that both do a little of both. There is goodwill going either way.

We need to focus on putting humanity at the heart. Remove task and time and think about what is best for the individual.

Commissioners need to understand more of the challenges of the staff and what staff might be doing to be proactive and reactive.

Code: RW18-18CBICT
Theme: ICT

Country of Origin/Context: France
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

Having the opportunity to access information from home also makes the boundary between personal and work life thinner

Solution(s) Identified & their Outcomes:

Having a professional device for this as a potential way to keep the distinction.

There is the newly developed vitality monitor role which we will look into.

Setting expectations and supporting staff to understand they can switch off, who they should be contacting if something crops up.

In addition, the development of team agreements is important to establish how they will communicate with one another on and off shift.

Further Information (E.G. Financial Costs, Suppliers):

Work devices are great if the organisation are not locking down tools that the staff use. As example we had to jump through hoops to have access to Eurostar/Booking.com. This doesn't demonstrate trust.

Code: RW19-19CBICT
Theme: ICT

Country of Origin/Context: All
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

The change to the new IT system was experienced as hard and challenging.

During the change process there were IT changes concurrently that were not linked to the change process and there were periods of downtime.

Solution(s) Identified & their Outcomes:

Discuss and determine the needs and possibilities of the system itself and provide support of system use where needed.

Access needs to be arranged for all employees to make sure that it is aligned with need of role.

Training

Onboarding/induction process

Further Information (E.G. Financial Costs, Suppliers):

There is a need to revise the IT again to see how it is working now we are further into the programme of change. This is an ongoing learning process of how IT serves the professional and the client but alongside how the reporting fits.

The dynamic is now changing when someone asks for data the organisation can push back if it is not useful for client or professional.

We are having conversations with our Integrated Care Board on Key Performance Indicators and what is needed and what isn't connecting it to better patient outcome of care. If it is only to assure someone higher then is it really needed?

Some of this is also not going to be an ongoing issue because it was a one off

As a result of the global pandemic, we couldn't do face to face training and the traditional roll out type processes were made harder.

Code: RW20-20LO
Theme: Operational

Country of Origin/Context: Belgium
Local or Cross Border: Local
Sustainable: Yes

Description of the Barrier and/or Challenge:

A possible downside of the improved communication and exchange within the team was flagged by one of our Belgium partners in the first focus group: communication with other teams proved to be more difficult as the other team is not involved in decision making (and therefore sometimes disagreed) and writing up reports from the meetings could take up to several days.

On some occasions support was needed and we were working together across Traditional teams and new teams and across teams in different Primary Care Networks

Solution(s) Identified & their Outcomes:

We found that it was useful to have joint team meetings across a Primary Care Network so that they can share experiences and knowledge across the teams and be a part of the greater area.

This could also support problem solving, coach support, best practice sharing.

Further Information (E.G. Financial Costs, Suppliers):

This became less of an issue as we progressed through the transformation, and they got to know one another and how they work.

This is something a manager may have taken control of in the traditional approach, but teams are seeing the benefits such as cross sharing skills.

Code: RW21-21LO
Theme: Operational

Country of Origin/Context: Belgium
Local or Cross Border: Local
Sustainable: Yes

Description of the Barrier and/or Challenge:

One of the Belgium partners reported they specifically struggled with finding the time to perform their specific roles as planned time was often interrupted by unexpected things.

Solution(s) Identified & their Outcomes:

This is the nature of the job, but the development of the team should allow people to share safely when things are getting too much.

The role is less defined in terms of when things need to be done. Customer first

These are also considered teething issues with the new model; this gets easier as people get used to what needs doing.

Community could be more flexible in the timings of tasks then some settings.

Further Information (E.G. Financial Costs, Suppliers):

Code: RW22-22CBO
Theme: Operational

Country of Origin/Context: Belgium/France
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

Some roles and tasks are viewed as more challenging than others. Especially the role of planner and, to a lesser extent, that of treasurer are reported to be time-consuming.

Solution(s) Identified & their Outcomes:

It is a practice of Buurtzorg teams to rotate roles & duties, which helps to distribute workload (and develop skills).

Some partners worked in pairs and each pair has a scheduling role to divide the workload.

Some of the tasks in some of the roles needed more training than others.

For some it was better to break down those roles to tasks and share those out.

This is a case of getting to know the task

Leaving the teams to decide when things need to be rotated based on development of assumed hierarchy or challenge, and to call on the coach for support when needed.

Further Information (E.G. Financial Costs, Suppliers):

Scheme of delegation was reviewed in line with this. IT needs to give access based on who needs access to what.

Questions partner asked included Is the task small/big enough to support, if not who can support it. The smaller the group the bigger need for support from other resources.

Code: RW23-23CBO
Theme: Operational

Country of Origin/Context: All
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

The majority of teams, across all countries, flag the administrative burden when working under the new care model.

Solution(s) Identified & their Outcomes:

Some partners pushed some of the admin back to the back office because it didn't make sense for the teams to be doing it.

However, these issues worked themselves out more as we went along it was a case of needing to work out what didn't need to be done, is it in the right place, could it be made easier, rewriting processes to allow for all this.

Working out along the way what needs to be where.

Risk assessment needs reviewing.

Further Information (E.G. Financial Costs, Suppliers):

Code: RW24-24CBO
Theme: Operational

Country of Origin/Context: All
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

This new approach runs the risk of being perceived as being too intrusive and not all patients are open to working on more self-management and patient autonomy.

Solution(s) Identified & their Outcomes:

It might take some adjustment in mentality for some, especially when used to a different type of care

Consider how and when you communicate the new approach to all stakeholders including patients and their families.

Further Information (E.G. Financial Costs, Suppliers):

Code: RW25-25CBO
Theme: Operational

Country of Origin/Context: All
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

One or more teams raised that they were unsatisfied with the team base (office).

The initial choice of team base selected by the trust (a small ground floor, windowless room within a local community centre) was reported by the team to have not been adequate or appropriate for their needs (e.g. insufficient space for storage, lack of privacy/patient confidentiality risks due to public access).

Another team temporarily moved to a new team base due to Covid and experienced this positively.

Solution(s) Identified & their Outcomes:

The location of the team base should be determined in collaboration with or solely by the team itself.

The base should be near/within the service area. There have been positive experiences with the team base in the GP's office to improve/facilitate collaboration.

Further Information (E.G. Financial Costs, Suppliers):

Code: RW26-26CBO
Theme: Operational

Country of Origin/Context: France/UK
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

We needed better communication methods for the new teams to communicate amongst themselves

Solution(s) Identified & their Outcomes:

For at least three teams across France and UK digital communication services were used to facilitate communication (e.g. WhatsApp, Messenger, Slack).

This allowed the teams to choose what worked for them as a means to communicate.

Further Information (E.G. Financial Costs, Suppliers):

Code: RW27-27CBO
Theme: Operational

Country of Origin/Context: France
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

The new levels of communication can be challenging for teams

Solution(s) Identified & their Outcomes:

Having face-to-face meetings with the team is highly appreciated by all teams and appears to be important to share information about the patients, exchange ideas, provide feedback, and to build and maintain personal relationships (within the team and with the coach).

According to one of our French partners, team meetings also helped to discuss the evolution of the service, and possibly re-adjusting the new model along the way.

Further Information (E.G. Financial Costs, Suppliers):

Code: RW28-28CBPR
Theme: Policy & Regulation

Country of Origin/Context: France
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

Teams have found that working as a self-management team whilst the rest of the organisation is still working in a hierarchical way is a challenge.

Solution(s) Identified & their Outcomes:

In general, various teams still work with a line manager (on paper). E.g., managing budget or order supplies this tends to reduce as confidence builds. Each partner is needing to find their own solutions to the process.

Further Information (E.G. Financial Costs, Suppliers):

Code: RW29-29CBPB
Theme: Professional bodies

Country of Origin/Context: France
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

Engagement with other clinical services was initially slow to establish and this was attributed to a lack of awareness in terms of the existence and remit of the new care team.

Solution(s) Identified & their Outcomes:

In some quarters professional engagement outside the team had improved following increased awareness which was created through various stakeholder communications including events.

Further Information (E.G. Financial Costs, Suppliers):

Code: RW30-30COPB
Theme: Professional Bodies

Country of Origin/Context: France
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

For French partners it was noted that there were no continuous supports experienced during implementation of TICC teams.

Solution(s) Identified & their Outcomes:

For the new care model to become successfully implemented more widely, focus group participants emphasised the importance for a hosting organisation to listen to and place trust in the teams they create.

In addition create clarity about future plans and responsibilities of the team.

The communication element of this work is considerably more important than most partners preempted.

Further Information (E.G. Financial Costs, Suppliers):

Code: RW31-31CBPB
Theme: Professional Bodies

Country of Origin/Context: UK
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

Participants described having received generally negative reactions from colleagues delivering standard care services within the trust as a result of their involvement in this pilot.

Participating in the wider promotion of the project was also recognized to have likely contributed to the negative reaction from some staff within standard care teams.

TICC-team professionals have the impression out of some negative reactions from out standers with a higher rank (or educational profile) that they will lose their status.

Solution(s) Identified & their Outcomes:

In some quarters professional engagement outside the team had improved following increased awareness.

Again we raise that the communication not only at the beginning but throughout the process is key to the roll out.

Further Information (E.G. Financial Costs, Suppliers):

Code: RW32-32CBPB
Theme: Professional Bodies

Country of Origin/Context: France
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

When other disciplines don't really understand what the Buurtzorg model is about, this can harm collaboration and impact staff morale.

Solution(s) Identified & their Outcomes:

It is therefore important to liaise and communicate with stakeholders ahead of and during the implementation of working in a new way.

Further Information (E.G. Financial Costs, Suppliers):

Code: RW33-33CBR
Theme: Recruitment

Country of Origin/Context: All
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

It's noted by multiple teams that the additional responsibilities under the new care model could be a barrier for recruitment.

Solution(s) Identified & their Outcomes:

We also recognise this for retention but that was for the early implementation phase and it is less of an issue now we are further in.

However it is ongoing for a small number when they are used too working with hierarchy and not needing to do some of the other elements of the approach.

Further Information (E.G. Financial Costs, Suppliers):

It is important therefore to offer as much training as we can provide

Code: RW34-34CBRE
Theme: Referrals

Country of Origin/Context: UK
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

In the UK our workload is determined by referrals from the GP. For example, GPs would commonly duplicate referrals, sending to both the new care team and the District Nursing teams who had been working independently of each other within the locality.

Solution(s) Identified & their Outcomes:

In some quarters professional engagement outside the team had improved following increased awareness.

Communication with the GP should be accessible. E.g., a team have had positive experience in phone contact instead of e-mail.

Further Information (E.G. Financial Costs, Suppliers):

Code: RW35-35CBSM
Theme: Self Management

Country of Origin/Context: All
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

Career path and development has been raised by staff.

There are outstanding queries/concerns from within and external to the team in respect to the new model of care and the opportunity this provided for career progression (specifically for qualified nurses).

Clarity of this issue was seen as important for staff recruitment and retention.

Solution(s) Identified & their Outcomes:

Alterations in the original agreement that career progression would be enabled via their support to establish more new care teams in the future, had contributed to some team members looking for alternative employment.

Career progression will also come through specialist training which the teams can request or arrange themselves.

Further Information (E.G. Financial Costs, Suppliers):

Code: RW36-36CBSM
Theme: Self-management

Country of Origin/Context: UK
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

Having responsibilities taken away or decisions overruled is likely to cause frustration and impact the effectiveness of the new way of care.

Solution(s) Identified & their Outcomes:

Locating the team-base near the premises of a GP or other disciplines can help to build relationships.

Further Information (E.G. Financial Costs, Suppliers):

Code: RW37-37CBSM
Theme: Self-management

Country of Origin/Context: France
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

Increasing responsibilities requires some adaptation and time to get used to the new way of working. This causes some 'extra' mental workload in the beginning of the implementation.

Solution(s) Identified & their Outcomes:

It is important in planning to create time to adjust and provide social support to increase self-efficacy. We need to make clear it is a common experience in the adaptation process but not a consequence that will last ongoingly.

Further Information (E.G. Financial Costs, Suppliers):

It can again be useful to communicate successes and find ways to share experiences.

Code: RW38-38CBSM
Theme: Self-management

Country of Origin/Context: All
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

It remains unclear where the boundaries of self-management are, what decisions can be made by the team and what decisions on higher levels.

Solution(s) Identified & their Outcomes:

It is key to create clarity in tasks and responsibilities making best use of the framework, supporting the teams with coaches who support decision making alongside the framework. If changes are made ensure they are communicated to all teams well.

Further Information (E.G. Financial Costs, Suppliers):

Code: RW39-39CBSM
Theme: Self-management

Country of Origin/Context: France
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

Learning and adapting to the new way of working (Buurtzorg).

Solution(s) Identified & their Outcomes:

Participants stated that it was easier for a small, new team to start working according to the new model, then it was for a larger, traditional team.

The importance for some staff within the team to have previous experience/skills relative to delivering community care through a self-managing model was recognised.

A recommendation from one of our French partners is to take time at the start of the new care model to really get to know each other and set rules of operation from the beginning through team agreements.

Further Information (E.G. Financial Costs, Suppliers):

Code: RW40-40CBSM
Theme: Self-management

Country of Origin/Context: UK
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

Participants expressed disappointment around divergence from their understanding of the initial plan which would have involved staff migrating to form other new teams as part of the wider roll-out of the model across the trust.

Solution(s) Identified & their Outcomes:

It is important to make decisions well in the first instance and then to communicate and consult with teams if things are going to change especially when it affects something that is important to their own career progression.

Don't assume you know what is important.

Further Information (E.G. Financial Costs, Suppliers):

Code: RW41-41CBW
Theme: Workforce

Country of Origin/Context: France
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

One of our French partners indicated that for staff with a higher rank, the challenge was actually to 'let go' and have trust in others. For these staff members it was also not always clear what their role would become in the new way of working.

Solution(s) Identified & their Outcomes:

No solution yet listed

Further Information (E.G. Financial Costs, Suppliers):

We would suggest considering how higher-ranking staff can continue to contribute with their additional skills, can they be offering training to others as an example.

Code: RW42-42CBW
Theme: Workforce

Country of Origin/Context: All
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

In the second set of Focus Group Meetings three partners mentioned that the equitable division of responsibilities and roles was (and for some remains) an issue. More roles and responsibilities end up with those more engaged, more experienced and/or with more leadership traits

Solution(s) Identified & their Outcomes:

Further Information (E.G. Financial Costs, Suppliers):

The Buurtzorg teams ensure fair rotation of roles for numerous reasons such as being fair with workload. Upskilling team members is also an added benefit of the approach.

Code: RW43-43CBW
Theme: Workforce

Country of Origin/Context: France
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

Increased engagement can potentially increase workload

Solution(s) Identified & their Outcomes:

No solution listed

Further Information (E.G. Financial Costs, Suppliers):

Code: RW44-44CBW
Theme: Workforce

Country of Origin/Context: UK
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

TICC-teams professionals do not always know what is possible and allowed financially.

Solution(s) Identified & their Outcomes:

It is therefore essential to create clarity in tasks and responsibilities and keep communicating with teams and across them.

Further Information (E.G. Financial Costs, Suppliers):

Code: RW45-45CBO
Theme: Operational

Country of Origin/Context: All
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

The Buurtzorg model implies that our team of care professionals move from a very hierarchical organisational model to a more horizontal model, which includes greater responsibilities for each team members. This organisational change takes time.

Solution(s) Identified & Their Outcomes:

Now, we can consider that this organisation change is completed because our care professionals/team members show greater autonomy in their daily work (this transformation is highlighted in this film in which our team members explain how TICC has changed their way of working).

This successful change was mainly possible thanks to:

- the training programme made out of study visit (touchbase) sessions with Buurtzorg, Public World training and support and peer-support provided by other TICC partners also experiencing this change in France, Belgium and the UK
- the change of management approach acquired by our 'former' Nursing Director' who is now acting as a coach (e.g. using the SDMI method, etc.). Our manager was also trained by Buurtzorg.
- The book 'Self-management how it does work' is also very useful on a daily basis and/or during the integration process of new staff/team members

Further Information (E.G. Financial Costs, Suppliers):

Code: RW46-46LO
Theme: Operational

Country of Origin/Context: France
Local or Cross Border: Local
Sustainable: Yes

Description of the Barrier and/or Challenge:

Implementing this new organisational model should help us to increase the time spent delivering care to our clients. However, over the years, our team works on tight schedules mainly due to a lack of workforce to deliver good quality of care (10 team members for 50 clients living in 14 different towns, as stated in our multi-year contract with our Regional Health Agency or Agence Régionale de Santé - ARS).

Solution(s) Identified & their Outcomes:

Promoting a 'community based' home care service. This could only be achieved by making recommendations to Agence Régionale de Santé - ARS based on the achievements and success factors highlighted by Buurtzorg in the Netherlands.

The likeliness that we would succeed is very low but we can use the TICC experiment as an opportunity to raise awareness with ARS and bring change.

Further Information (E.G. Financial Costs, Suppliers):

Working more 'community-based', just like Buurtzorg do in the Netherlands.

This particular point will be raised during our final TICC meeting with ARS for the first semester 2022

Code: RW47-47LPR
Theme: Policy and Regulation

Country of Origin/Context: France
Local or Cross Border: Local
Sustainable: Yes

Description of the Barrier and/or Challenge:

By joining the TICC project, one of the French organisations team took the decision to transform its way of delivering care. However, our policy framework limits/slows down this organisational change process.

Indeed, the sustainability of our new model will depend on the validation of our main funding/regulatory institution the Regional Health Agency (i,e, Agence Régional de Santé - ARS)

Solution(s) Identified & their Outcomes:

WP2 has set several deliverables/activities that enables Project Partners to engage discussion with our institutional partners: A policy round-table was held in Lomme on And a Local Strategic steering group between La Vie Active and ARS was held. We received positive comments from ARS but a final meeting must be organized in order to confirm the sustainability of our new model

Further Information (E.G. Financial Costs, Suppliers):

Today, our care professionals/staff members are highly satisfied by the new model and by showing the results of the TICC experiment in our team, we have good reasons to believe that ARS will approve our ambition to continue with this model after the TICC project end-date

This activity was delayed due to COVID-19. Now we are working on the preparation of our final TICC meeting with ARS for the first semester 2022.

Code: RW48-48LSM
Theme: Self-management

Country of Origin/Context: France
Local or Cross Border: Local
Sustainable: Yes

Description of the Barrier and/or Challenge:

Our self-managing team partly manages in-take procedures (still under supervision of our Nursing Director acting as a coach); however, it is rather complex, and it takes time that our team members cannot always take

Solution(s) Identified & their Outcomes:

A solution is to simplifying the in-take procedure by updating/remodeling our existing system. The team member still sometimes needs the support from the secretary/back office and the coach. So, it is ongoing.

Further Information (E.G. Financial Costs, Suppliers):

For one of the French partners, their home care service has set up a new team meeting about this specific issue 'in-take procedure'.

Code: RW49-49LICT
Theme: ICT

Country of Origin/Context: France
Local or Cross Border: Local
Sustainable: Yes

Description of the Barrier and/or Challenge:

The run of our new system was delayed because all processes of updating/remodelling our existing system unexpectedly took longer than planned. At organisation level, we had to go through:

- identifying / defining our needs
- preparing the specifications and launching tendering procedure
- providing time to our selected external service provider to design the new version of our IT system
- training of our care professionals to use this new system
- equipping them with smartphones and tablets
- besides, internal staff change between September 2018 and late December 2019 (hiring a new EU project manager)

Code:Solution(s) Identified & Their Outcomes:

From January 2019, we worked hard to catch up:

- Our IT service provider was selected on early March
- the new system was installed in May
- Our care professionals were trained to use the new system and each team member was equipped with 1 smartphone and 1 tablet in June

Ever since, we experience a smooth roll-out of the new system because it is supervised by our internal IT specialist and a back-office staff member – i.e. the secretary of our Home care service for the elderly engaged in the project – was trained in order to support new staff members to use our system.

Further Information (E.G. Financial Costs, Suppliers):

Code: **RW50-50CBR**
Theme: **Recruitment**

Country of Origin/Context: UK
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

Self-management implies peer-recruiting. But our team members lack the knowledge and/or competencies required to recruit new members of staff.

Code:Solution(s) Identified & Their Outcomes:

To keep promoting these jobs, especially through our 'new way' of working (i.e. self-managing teams), which could attract new employees. Organising internal basic HR trainings for the team members.

Since our team members have started to recruit their new colleagues themselves, our coach has noticed that our team is more stable (less turnover). They are responsible from publishing the job advertisement, to collecting applications and conducting the job interviews. Everything is not perfect, but it is never the case when speaking of recruitment.

Further Information (E.G. Financial Costs, Suppliers):

Date closed: 27/09/2021

Code: RW51-51LSM
Theme: Self-management

Country of Origin/Context: France
Local or Cross Border: Local
Sustainable: Yes

Description of the Barrier and/or Challenge:

Our self-managing team partly evaluates & manages external costs/expenditures for specific care services (still under supervision of our Nursing Director acting as a coach); however, we regularly point out mistakes as it requires knowledge / experience to manage this mostly due to misleading statements given by the clients and their families to the insurance system.

Code:Solution(s) Identified & Their Outcomes:

Improving team members communication / raising awareness of clients and their families about their obligations towards the insurance system.

It appears that this problem will never be totally solved. However, our front-line care workers together with our secretary/back office have found a way to handle these scenarios especially thanks to greater awareness and anticipation from our front-line care workers and better communication with our secretary/ back office

Further Information (E.G. Financial Costs, Suppliers):

Code: RW52-52LSM
Theme: Self-management

Country of Origin/Context: France
Local or Cross Border: Local
Sustainable: Yes

Description of the Barrier and/or Challenge:

Our self-managing team sets its monthly planning itself (still under supervision of our Nursing Coordinator acting as a coach); however, at the beginning, they lacked the knowledge and competences to do it correctly

Solution(s) Identified & Their Outcomes:

Organizing internal basic HR trainings for the team members (especially about annualized or monthly hours arrangements).

Although it was not possible to organize formal HR training for the team members, they rather adapted themselves with 'hands-on training'. Of course, there were important mistakes that had to be corrected by our coach at the early stage; but now our coach confirms that they do it correctly and independently.

Further Information (E.G. Financial Costs, Suppliers):

Code: RW53-53LW
Theme: Workforce

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable: No

Description of the Barrier and/or Challenge

Multiple Employers for the Integrated Pilot Team: The team members are divided by employer organisation and therefore will have different organisations and people to approach when there are HR issues and payment of salaries.

Insurance for the homecare workers: as a project we investigated the possibility of having blended roles within the team, homecare workers could carry out minimal health related tasks as well as the social care element, freeing up time of the nurse and supporting development.

Insurance became a barrier as the homecare workers had to be employed by the health organisation to perform health related tasks, as we could not pay partner to partner the blended role approach did not form part of the pilot project.

Solution(s) Identified & Their Outcomes

A formal contract has been written and signed off by one partner and the private homecare provider who they have commissioned the homecare workers from, as an interim while the contract is being prepared a letter of agreement is in place.

Research into insurance completed and report written

Further Information (E.G. Financial Costs, Suppliers):

This has not been a solution and now this doesn't work.

We believe that there is an opportunity to revisit as the introduction of Integrated Care Partnerships is introduced, are set up and take control of their own budgets.

Code: RW54-54LO
Theme: Operational

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable: Yes

Description of the Barrier and/or Challenge

Framework: The team do not currently have a framework this is being drafted. Teams require a framework to support in the development of working in a self-managed way, detailing roles and responsibilities, how the service will meet the needs of the clients/patients they support and accountability to their employer.

Solution(s) Identified & Their Outcomes

A strawman framework has been drafted, further feedback is to be sought from Public World and templates to support the development of an appropriate framework.

Following feedback a draft Framework is now in circulation.

Frameworks help provide a guide to the team and the people they support of the expectations of delivery of support and how the team will work together in delivering care and support.

Further Information (E.G. Financial Costs, Suppliers):

It is useful if not important for the framework design to come before the teams get started.

Code: RW55-55LPR
Theme: Policy and Regulation

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable: Yes

Description of the Barrier and/or Challenge

Delegation and Supporting of Medication Administration: In health registered nurses can administer medication, whereas in social care, care workers can prompt or administer if relevant training has been completed.

Solution(s) Identified & Their Outcomes

Administering medication became a joint responsibility within the team, home care workers are required to complete the Handling Medicines Safely course before the administration of medicines can commence, ongoing observational supervision and competency framework completed to support in this task.

Administration of medication is a Health-related task; however, the homecare and community support do administer to support across services, local authorities would not commission medication support only, however within the our pilot team we allowed this to be part of the support as the model allowed the flexibility of this approach.

There are fewer risks in relation to delegated responsibility in relation to medication as there is greater consistency in the team, supervision/oversight and the teams will know their cohort of patients well to know impact of medications.

Further Information (E.G. Financial Costs, Suppliers):

Code: RW56-56CBR
Theme: Recruitment

Country of Origin/Context: UK
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

There is a UK shortfall in trained nursing staff, recruitment has been slow across the UK pilots. In Kent there has been interest in the pilot and model but applications have been low.

Solution(s) Identified & their Outcomes:

We have utilised Bands 4's and try to train into nursing, a programme will be needed from universities. We are monitoring current staff on apprenticeships.

We carried out social media campaigns as well as printed materials and we have tried posting vacancies via social media and through having conversations with potential applicants to inform them of the project and meeting with private providers.

Other suggested solutions include Recruitment campaigns; Examine integration of existing services / remodelling; Target recent leavers/return to work; Provide incentives; Value based recruitment

Following using the traditional recruitment system in the organisation and driving through social media we have trialled promoting via word of mouth through our networks and a short one-page online application form so we can reduce timeframe from advertising to interview. We have also adopted the use of an informal group-based information session rather than a formal interview.

This approach is allowing us to be more creative with attracting new members of the team

Further Information (E.G. Financial Costs, Suppliers):

Until the programme is known by the university's options are limited. High interest in TNA and Nursing degree programmes, staff developing. Recruitment has been steady and we have recruited at each interview session which is monthly. TNA programme active and supported by service.

We now see people applying to be a part of the new model, it is drawing new recruits.

Code: RW57-57LO
Theme: Operational

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable: Yes

Description of the Barrier and/or Challenge:

There is a need for quality time clinically to complete required paperwork

Solution(s) Identified & their Outcomes:

Improved domiciliary system by allocating one Band 7 to liaise with GP surgery for medicines required which will allow other clinicians more time to see patients.

Further Information (E.G. Financial Costs, Suppliers):

Code: RW58-58CBRE
Theme: Referrals

Country of Origin/Context: UK
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

We have received a low number of referrals and not meeting Buurtzorg model. Need to ensure direct communication with GP and Acute trust

Solution(s) Identified & their Outcomes:

Referral criteria defined

Referral process established to allow direct access

Review Rapid response function and integration

Team is continuing to build their formal network which is supporting more appropriate referrals

Further Information (E.G. Financial Costs, Suppliers):

Considered sustainable but only if mitigations put in place

Code: RW59-59CBICT
Theme: ICT

Country of Origin/Context: UK
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

Organisational capacity to manage multiple projects with potentially conflicting timescales.

One partner introduced a new patient record system due to the old system no longer being fit for purpose and third-party support for the system being withdrawn after a specific date.

The project took high priority within the organisation. However, it was felt that the front-line staff would not have capacity to learn a new system whilst also going through the changes required to fulfil the TICC obligations.

Solution(s) Identified & Their Outcomes:

We worked with the IT project team and operational staff to agree a delay in TICC teams moving to the new system.

A wider solution to this problem would be to have a Project Management Officer in place monitoring projects across the organisation to help reduce the likelihood of clashes and therefore increase the success rate of new projects.

Further Information (E.G. Financial Costs, Suppliers):

There is so much to the new approach it is important to consider all new projects in line with the new approach to avoid clashing of messaging and mistakes.

Code: RW60-60LICT
Theme: ICT

Country of Origin/Context: UK
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

Feedback from teams has highlighted that there is a lack of understanding of certain processes and IT systems. This leads to frustration within teams, causing unnecessary time spent trying to navigate a system. At present there is an on-line helpdesk called Top Desk to raise issues, however this is time consuming when an issue may need resolving immediately. In most cases this means interaction between front line staff and support teams is done digitally rather than verbally or face to face.

Solution(s) Identified & Their Outcomes:

- Support services have developed regular informal 'drop-in' sessions where anyone can raise an issue. These sessions are run by a subject matter expert who can provide the support required.
- These 'drop-in' centers are advertised via our internal intranet and open to all staff. The subject regularly rotates to cover systems covering Rostering, Leave, Sickness, Patient records, Finance, Estates etc.
- Anything that can't be resolved immediately can be signposted to the back office – support services use the help desk to record all queries to keep an audit trail of resolved issues and to provide evidence for reflection, learning and improvement. This improves system design, system training and front-line support.

Outcomes:

This will help gain a better understanding on how to navigate the systems.

Further Information (E.G. Financial Costs, Suppliers):

Code: RW61-61LICT
Theme: ICT

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable: Yes

Description of the Barrier and/or Challenge:

The introduction of a new client information system to enable all services to benefit from only recording information once. There were too many assessment forms attached using a drop-down option and forms were not always consistent (changing format).

Solution(s) Identified & Their Outcomes:

- The principle is for all staff to access all information about the client and make holistic decisions with them based on the whole person availability of information.
- The team set up 'question and answer' service for the system and are working to shorten the drop-down options to be more service specific.
- There is an on-going staff user group who make suggestions to improve the system and make it more efficient.
- The organisation continues to listen to front line staff and to make adjustments, e.g. streamlining of safe guarding process.

Further Information (E.G. Financial Costs, Suppliers):

Code: RW62-62LICT
Theme: ICT

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable: Yes

Description of the Barrier and/or Challenge:

Teams have their own team folders on a shared drive only accessible by them - when a new member joins there is a long process involved to give them access to the folder.

A request via the IT help desk has to be made which will be sent to the folder's owner who then has to approve or reject the request - this can take a long time.

Currently only the IT department have access to who the current users are on individual folders and the owner has to request the information via IT request system.

Solution(s) Identified & Their Outcomes:

- Introduce a new IT tool to allow team members to apply directly to the folder 'owner'.
- The 'owner' can be any team member not just a manager.
- Allows 'owner' to either reject or approve the request.
- Gives 'owner' access to folder information to allow them to manage folder directly.

Outcomes:

- Allows the folder 'owner' direct access to information on who has access, manage and review current users directly without having to request changes via IT.
- Teams have more control on their own folders rather than a manager having to approve changes.

Further Information (E.G. Financial Costs, Suppliers):

A new IT tool was devised which will allow a team member to apply directly to the folder 'owner' who will then be able to either accept or reject the access. It will also allow the folder 'owner' direct access to information on who has access, manage and review current users directly without having to request changes via IT.

Code: RW63-63CBO
Theme: Operational

Country of Origin/Context: UK
Local or Cross Border: Cross Border
Sustainable: No

Description of the Barrier and/or Challenge:

Whilst working with existing nursing teams to transition to the new way of working it became apparent that there is a greater need for support from the back-office functions and managers particularly around administrative tasks as opposed to clinical duties.

Solution(s) Identified & Their Outcomes:

- Held engagement sessions with back-office teams to discuss how they can support front line teams to work in the new way discussed the administrative barriers, i.e. lengthy recruitment process, IT issues, delegation of authority process etc.
- Invited a pilot team nurse along for real life experience and this enabled better communications between nursing team and support services.
- Worked with corporate services to review existing policies, procedures and processes to see where changes can be made to streamline.
- Launched a Rock, paper, scissors campaign to continue to identify and fix things that frustrate front line teams.
- Engagement sessions with Organisational Development Business Partners and team leaders:
  - to explain the programme to discuss their responsibilities in supporting teams through the process
  - discuss the potential barriers with programme roll-out dates due to external pressures
  - liaise with team leaders to establish the team's current dynamics to increase engagement and positive outcomes from the programme.

Further Information (E.G. Financial Costs, Suppliers):

Needs the development of a mid-office as the programme progresses Reduction of managers and change of leadership style to facilitatory/coaching long term across the organisation

Code: RW64-64CBO
Theme: Funding

Country of Origin/Context: Belgium
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

Capacity of staff to manage transition alongside business as usual.

A key factor to consider in the UK is the way we are commissioned. This is on an activity basis rather than a timed basis therefore we have to deliver a certain number of treatments per area, per team and per person to meet KPI's and comply with our contracts.

The fear expressed by teams – "How could all patients needs be met whilst allowing us the necessary time to grow and adjust to a different way of working."

During our informal chats with clinical staff it was noted that not all felt they have control over their caseload.

Solution(s) Identified & Their Outcomes:

Ensure the team are the correct size and have the relevant competencies for the cohort. If not, recruit to fill gaps.

Review of caseload: closing dormant cases, consider if patients who require infrequent treatments such as B12 injections should remain as an active case.

Ensure senior managers support the change and support their staff to "allow" time for transition.

Joint planning between the project team and operational management to take account of other issues that may be affecting teams, for example development of Primary Care Networks across Kent & Medway, introduction of new Electronic Patient Recording system, winter pressures, Pandemic etc.

Code: RW65-65CBO
Theme: Operational

Country of Origin/Context: UK
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

The Covid pandemic had changed the way teams work. Instead of reporting to a team base each morning and between patients' - teams have done much more remote working. This has led to a loss of regular team contact.

Solution(s) Identified & Their Outcomes:

- Set up What's App groups with each team to improve communication with each other.
- The What's App also ensured security when visiting patients in remote areas by allowing staff to maintain contact with team members.
- Use digital tools for regular team meetings such as MS Teams video calls.
- Implement 'working parties' to discuss patients and issues involving the team.
- Set up 'virtual office time' to create an office environment whilst working remotely.
- Ensure meetings start with some social time to maintain team harmony.

Outcome:

Teams can build on the rapport already established and maintain relationships although not working together in an office environment.

Further Information (E.G. Financial Costs, Suppliers):

Code: RW66-66LO
Theme: Funding

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable: Yes

Description of the Barrier and/or Challenge:

Due to a change in commissioning arrangements and the effect of COVID 19 a twilight rota needed to be established across several teams in a district.

Solution(s) Identified & Their Outcomes:

- There was initially resistance from team members as there was concern of the impact on existing caseloads and teams.
- A meeting was arranged with members from local teams to look at solution focused ways to produce a Rota that was practical, workable, and equally distributed.
- By working together, it was agreed to Rota one member in turn from each team as a trial to ensure that all team members took part.
- Staff used the philosophy of "let's try it" and "even if you don't love it, can you live with it?". This allowed staff to experience the new way of working rather than focusing on why the change couldn't happen.

Outcome:

- Once staff were able to try this way of working together to find a solution they found that the impact on existing caseloads and team members wasn't as much as was feared.
- Working together across multiple teams has also had other benefits including building relationships between adjacent teams and transfer of skills and competencies.
- Staff felt included in how the solution was designed which has empowered them when responding to other challenges.

Further Information (E.G. Financial Costs, Suppliers):

Code: RW67-67CBO
Theme: Operational

Country of Origin/Context: UK
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

Office noise levels a distraction when people return to office or are on phone affecting concentration.

Solution(s) Identified & Their Outcomes:

- Use 'Working with Me Manual/Personal Profile' document. This is a series of questions in a word document that allows people to reflect on their needs, their working style and how they do their best work. Taking time for this reflection across a team and allowing teams to talk about & share their manuals allows members of the team to understand each other's needs – and how to work together to achieve the best results.
- Allocate a quiet space within office which will remain a 'Do Not Disturb' space.

Outcomes:

- Increases trust and psychological safety in a team.
- Increases acceptance and understanding.
- Focusses on individual and team needs.
- Improves communication about performance and quality.
- Supports bringing your whole self to work.
- Allows team members to fully engage with non-patient facing activities.
- Ensures confidential space, for peer-to-peer discussions or sensitive patient conversations.

Further Information (E.G. Financial Costs, Suppliers):

Code: RW68-68CBO
Theme: Operational

Country of Origin/Context: UK
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

The impact of COVID 19 and staff working remotely, has led to the introduction of digital tools for meetings. This has resulted in a reduction of breaks between meetings, i.e. for travel, comfort breaks etc. This is negatively impacting staff wellbeing as well as productivity.

Solution(s) Identified & Their Outcomes:

- Reduce times of meetings from one hour to 50 minutes for example, to allow a short break before commencing next meeting.
- To embed a culture whereby it is acceptable to have allocated breaks within your diary,
- To consider if the meeting is actually necessary and ensure the attendees are aware if their attendance is compulsory or optional.
- Use the Buurtzorg approach to meetings by ensuring a minute taker/time keeper is appointed for each meeting.
- A guide has been produced to share with teams to promote the Buurtzorg approach to meetings.

Further Information (E.G. Financial Costs, Suppliers):

Code: RW69-69LO
Theme: Operational

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable: Yes

Description of the Barrier and/or Challenge:

We have been unable to promote motivational interviewing to enhance patient wellbeing owing to workload. Time restraints and impact of COVID preventing the promoting motivational interviewing to enhance patient wellbeing such as, weight loss, giving up smoking.

Solution(s) Identified & Their Outcomes:

- Teams are now reintroducing the holistic coaching model for care planning with patients to make sure every contact count.
- In caseload allocation teams are allowing for this time for the motivational interviews.

Outcome:

- Encourage communication of patient care during handover.
- Consistent messages to patient.
- Holistic approach to care is better to patient and team.
- Although holistic assessments can take longer - it saves time throughout the patient care journey.

Further Information (E.G. Financial Costs, Suppliers):

Code: RW70-70CBO
Theme: Operational

Country of Origin/Context: UK
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

There is a lack of availability of Band 5 staff owing to no training bursaries for 3 years.

Solution(s) Identified & Their Outcomes:

Employ Band 4 to upskill, utilize Band 6's to cover shortfall.

Rigorous recruitment campaign, with potential to offer incentives if numbers are low. Establish own nursing academy.

Up-skilling of staff is sustainable, however, utilising over-skilled is not sustainable.

Band 6's being used not to their full capacity. Risks: de-skilling, low staff morale, retention of staff.

Code: RW71-71LPR
Theme: Policy and regulation

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable: Yes

Description of the Barrier and/or Challenge:

The current Scheme of delegation document does not support devolved decision making. It is hierarchical in that it refers to job bands rather than roles. This means that the most appropriate person to "approve" may not be eligible due to their banding.

Solution(s) Identified & Their Outcomes:

- Some "myth busting" is required to ensure staff understand who is responsible and at what level.
- Set up a working group, consisting of the relevant representation from across the trust
- Groups tasked with reviewing the current document and amending to refer to "authorised person" as opposed to "Band X".
- Review the various levels of approval
- Update where applicable to reduce the number of steps involved with authorisation.

Outcome:

- The amended document is based on roles rather than banding so removes the hierarchical element.
- It has also reduced some of the steps in the authorisation process thereby reducing the time in which it takes to complete.

Further Information (E.G. Financial Costs, Suppliers):

Code: RW72-72LPR
Theme: Policy and Regulation

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable: Yes

Description of the Barrier and/or Challenge:

Whilst reviewing the extensive list of existing policies, procedures, and guidelines, it has become apparent that there is a lack of consistency on how these are produced. This leads to confusion, out of date documents etc. It can also mean whilst a process may streamline one person's workload, it may add to someone else's in a different team/services.

Solution(s) Identified & Their Outcomes:

- Set up a working group
- Ensure representation from across the organisation i.e. management, frontline, support services etc.
- Task the group to develop a single set of "Principles" that would be followed by all when reviewing existing or creating new policies, procedures and guidelines.
- Ensure the document promotes "best practice".

Outcomes:

- This supports all staff to consider the wider impact of change.
- It provides clear guidance for staff to identify whether existing documents should be reviewed and updated or an additional one created.
- Simplified documents are accessible to all relevant parties.

Further Information (E.G. Financial Costs, Suppliers):

Code: RW73-73LO
Theme: Operational

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable: Yes

Description of the Barrier and/or Challenge:

Due to the changing needs of patients a team felt that their Standard Operating Procedures (SOP's) were no longer fit for purpose.

Solution(s) Identified & Their Outcomes:

Following team engagement:

- The team did an analysis of patient's goals.
- SOP's were reviewed and updated.
- Amended to reflect the current roles and practice requirements.
- This exercise prompted a larger review of the service taking place.

Outcome:

- SOP's are now fit for purpose and meeting patients' needs.
- A larger review of the service allowed clinicians more empowerment to make decisions.

Further Information (E.G. Financial Costs, Suppliers):

Code: RW74-74LO
Theme: Operational

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable: Yes

Description of the Barrier and/or Challenge:

When the first two pilot teams were set up it was agreed that access to their performance indicators were required to review the sustainability of the project. This information was only available to senior managers, in order for teams to measure their success/achievements/KPI's it was agreed to set up a dashboard for teams to review their own performance. The information available was 6 weeks in the past, so not up to date.

Solution(s) Identified & Their Outcomes:

- Meeting was arranged between the Performance Manager and the first two pilot teams and an interim excel dashboard was set up for the teams to be able to obtain access to their performance indicators.
- This interim dashboard was tested for 18 months/2 years with feedback captured from teams and reviewed.
- This has now been developed further by using Microsoft Power BI which interacts with our new client information system allowing teams to have access to up to date information.
- The information supplied is updated every 24 hours.
- This new team dashboard approach was released across the trust in March 2022.

Outcome:

- New system has been viewed over 4,000 times by 90 individuals and continues to be promoted.
- Teams can now obtain:
  - Performance monitoring reports.
  - Review HR information
  - Patient safety information
  - Contractual information
  - View waiting list positions and waiting times for some consultant led services.
  - Obtain ethnicity reports.

Further Information (E.G. Financial Costs, Suppliers):

Code: RW75-75LO
Theme: Operational

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable: Yes

Description of the Barrier and/or Challenge:

Access to GP and practice nurses reduced during pandemic causing additional work for community teams having to fill these gaps. A few teams also needed dressings from community pharmacies, and this has been challenging through the COVID period with long waits impacting staff time and patient care.

Solution(s) Identified & Their Outcomes:

- By using the team coaching approach, the teams have considered their position, their communication methods, and their goals.
- This helped clarify the needs and expectations that teams needed to be met by local partners in the formal network.
- Proactively communicating and setting up local discussions focused on patient care and wellbeing have improved relationships and understanding between local partners. For example, explaining the wellbeing impact of one partner action on other partners and the patient.
- Teams are now much more proactive in planning how to work with their formal networks.
- This has improved access for obtaining dressings and further medical supplies.
- It has also led to better knowledge sharing and improved solutions for patients.

Further Information (E.G. Financial Costs, Suppliers):

Code: RW76-76CBC
Theme: Competition

Country of Origin/Context: UK
Local or Cross Border: Cross border
Sustainable: Yes

Description of the Barrier and/or Challenge:

The new teams formed under TICC may be viewed as replacing the existing community nursing teams.

Solution(s) Identified & their Outcomes:

The new teams formed under TICC will be working alongside the existing community nursing teams and this will need to be carefully communication and managed. The patient information leaflet will also reinforce this stance.

Further Information (E.G. Financial Costs, Suppliers):

Code: RW77-77LO
Theme: Operational

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable: Yes

Description of the Barrier and/or Challenge:

Training: Need firmer training plans established with Buurtzorg NL and Buurtzorg BI/Public Work for Teams, Coaches & Heatshields, and back office

Solution(s) Identified & Their Outcomes:

Buurtzorg BI/Public World have suggested a different approach for Charing Neighbourhood Care team which will better support team training.

Coaches training with Buurtzorg NL has worked well – but need UK support which is being developed. Suggest UK based coaches set up regular support sessions from June 2019 which is now possible on the Humanity at the Heart community space.

Further support for Heatshields is required.

Further Information (E.G. Financial Costs, Suppliers):

It is important to establish your own internal training over a period of time

Code: RW78-78LPR
Theme: Policy & Regulations

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable: No

Description of the Barrier and/or Challenge:

There are significant changes to the NHS landscape (10 year plan) and there is Development of Primary Care Networks and Integrated Care Partnerships.

Solution(s) Identified & their Outcomes:

Senior leaders involved in developing our offer which includes this model should consider all changes to the national landscape with their new model in mind. How can changes do more to support the new approach we have been adopting. Workforce plans developed (Sustainability and Transformation Plans) to support program

Further Information (E.G. Financial Costs, Suppliers):

Integrated Care Boards & Primary Care Network's are likely to make Multi Disciplinary Team's more viable - supporting the Buurtzorg approach.

Code: RW79-79LPR
Theme: Policy and Regulation

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable: No

Description of the Barrier and/or Challenge:

CQC registration for Local Authority is under social care and Community Health Foundation Trust under Hospitals division's therefore there are different methodologies. Social care is only registered for personal care

Solution(s) Identified & their Outcomes:

Social care providers to increase registration to include treatment of disease and disorders to enable carers to be legally covered to complete Health activities.

Staff being seconded/employed directly to overcome this for the time being.

There is a new models of care CQC team who are to be involved to enable joint registration and a new way to inspect self-managing teams.

Insurance and regulators issues have caused a delay in carer staff being covered for health care tasks therefore barrier to the model that cannot currently be overcome.

Further Information (E.G. Financial Costs, Suppliers):

If you are looking to merge social care teams and medical teams there are challenges in the way different organisations are insured which was a huge challenge for one team resulting in them not continuing in the process.

CQC also couldn't make changes to the way they regulate to fit the mode although this should be reviewed at a later date.

Code: RW80-80LPR
Theme: Policy and Regulation

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable: No

Description of the Barrier and/or Challenge:

In attempting to create a team over a Health Foundation Trust and Local Authority it was discovered there are numerous policies and local protocols for both organisations.

Solution(s) Identified & their Outcomes:

There was an agreement to use the health foundation trusts documents for pilot sites.

A review of policy on policy and reduction in clinical policies. Access to clinical protocols

Need a set of national clinical protocols (updated and maintained nationally). Medicines policy and procedure has been escalated to the UK partnership board.

Further Information (E.G. Financial Costs, Suppliers):

This team however did not continue as the various challenges working across two organisations for one team were too great.

Code: RW81-81CBF
Theme: Funding

Country of Origin/Context: UK
Local or Cross Border: Cross Border
Sustainable: No

Description of the Barrier and/or Challenge:

There are funding differences between health and social care

Solution(s) Identified & their Outcomes:

Time limit on caseload and research funding used to trial model

Further Information (E.G. Financial Costs, Suppliers):

Health and social care are funded separately.

Distant conversations about integration but not seen yet.

Need to move towards shared budgets and integrated organisations.

Review pathways to simplify process; hold discussions with appropriate services/regulators/funders to ensure integrated working.

Grey areas working group being established.

This isn't a TICC challenge this is a huge UK challenge and cannot be solved. Doesn't hold organisations back from working in an integrated way by referring to the services as they always have.

There is considerable agreement that there are opportunities with the introduction of the Integrated Care Partnerships

Code: RW82-82LO
Theme: Operational

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable: Yes

Description of the Barrier and/or Challenge:

Staff and teams were frustrated at the bureaucracy around obtaining signatures. Paperwork is being delayed as electronic signatures are not always acceptable on certain internal documents and can be delayed further if more than one signature is required.

Solution(s) Identified & Their Outcomes:

- Issues around the red tape to obtain signatures was discussed at the Cutting Unnecessary Bureaucracy steering group.
- Meetings were arranged with internal audit and finance to discuss whether electronic signatures can be accepted on paperwork.
- Procedures are now in place and this works in conjunction with the new revised Scheme of Delegation.

Outcomes:

- Electronic signatures will avoid staff having to go to a building or post paperwork when a signature is required.

Further Information (E.G. Financial Costs, Suppliers):

Code: RW83-83LO
Theme: Operational

Country of Origin/Context: UK
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

With more decision-making being delegated to front line teams, it is even more important for staff to feel safe when lone working. Owing to social distancing and teams being unable to be together team members need to feel reassured that their whereabouts were known.

Solution(s) Identified & Their Outcomes:

- Investigation and then introduction of a smart phone app enabled staff to call for help in an emergency situation when and where needed.
- It features a lone worker system and emergency messaging facility which is available 24/7
- This can also be downloaded onto a mobile and smart tablet.
- This has helped facilities to keep staff safe, such as severe weather warnings, traffic hazards, etc.

Outcome:

- Staff are now able to raise an alert if in an emergency and obtain help.
- Help facility ensures staff know of any potential hazards whilst travelling to patients or office.

Further Information (E.G. Financial Costs, Suppliers):

Code: RW84-84LC
Theme: Commissioning

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable: No

Description of the Barrier and/or Challenge:

There is an Increase in the number of patients on caseloads as sole provider of home-based care to the population and differences in current caseload and jurisdiction e.g., Practice nurses not included within the UK which may impact on funding and sustainability

Solution(s) Identified & their Outcomes:

Review of the population size and size of teams required.

Review future model to potentially include practice nurses and rapid response

Further Information (E.G. Financial Costs, Suppliers):

Code: RW85-85CBR
Theme: Reporting – Locally and Nationally

Country of Origin/Context: UK
Local or Cross Border: Cross Border
Sustainable: No

Description of the Barrier and/or Challenge:

Organisational and National reporting and assurance requirements do not currently complement this model.

Solution(s) Identified & their Outcomes:

We need to develop internal performance and reporting mechanisms that meet the local measures.

IT systems are to be implemented that enable data to be extracted without the team's input.

There also needs to be a back-office change of culture and reconfiguration to always consider how data can be captured without adding to the work of the frontline staff.

Further Information (E.G. Financial Costs, Suppliers):

Code: RW86-86CBSYC
Theme: System Culture Change

Country of Origin/Context: UK
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

The model to be imbedded requires a radical review of the health and care systems in enabling the clinical teams to be able to do what they have been trained to do.

Care for the whole person and the family, individualized care planning and do what they determine as the best interventions to provide the best outcomes – rather than be constrained by detailed service specifications and boundaries through a fragmentation of health and care provision.

Commissioners do not understand or recognise the value of the model – they focus on the quick novel fixes rather than longer term substantive solutions.

Solution(s) Identified & Their Outcomes:

There needs to be engagement and sharing of model with commissioners.

Further Information (E.G. Financial Costs, Suppliers):

The model fits with the development of Primary Care Networks, supporting the delivery of local care – teams developed based on understanding of population health modelling with team resource of 8 Full time Working time equivalents for populations of 10-15,000. Primary Care Networks s may have more than one team but are aligned to General Practice surgeries.

Code: RW87-87CBSYC
Theme: System Culture Change

Country of Origin/Context: UK
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

There is an issue with the lack of Primary Care Networks and General Practice surgeries understanding of the model.

Solution(s) Identified & Their Outcomes:

We therefore held stakeholder engagement sessions and sharing of model.

Further Information (E.G. Financial Costs, Suppliers):

Provide presentation on model and plan to develop closer working with General Practice colleagues to benefit patients and families.

Undertake Question and answer sessions

support development of more collaborative approaches to care.

Code: RW88-88CBSYC
Theme: System Culture Change

Country of Origin/Context: UK
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

Adult Social care commissioners and providers do not understand the model and the work we are doing to implement it.

Solution(s) Identified & Their Outcomes:

We have held engagement sessions for stakeholders and have been sharing the model.

Further Information (E.G. Financial Costs, Suppliers):

Provide presentation on model and develop relationships with social care and care providers.

Discuss the health and care opportunities of the model.

Build direct professional links with neighbourhood teams.

Code: RW89-89CBSYC
Theme: System Culture Change

Country of Origin/Context: UK
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

Voluntary Organisations in our patches do not yet know anything about the model .

Code:Solution(s) Identified & Their Outcomes:

Again we have held engagement sessions and sharing of model.

Further Information (E.G. Financial Costs, Suppliers):

Provide presentation on model and plan to develop increased relationships with volunteer providers.

Build links within teams to these organisations and social prescribers within Primary Care Networks.

Code: RW90-90CBSYC
Theme: Systems Culture Change

Country of Origin/Context: UK
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

Care Quality Commission

Code:Solution(s) Identified & Their Outcomes:

Discussions held with CQC and on the model and its implications within the UK.

Further Information (E.G. Financial Costs, Suppliers):

The CQC recognise the ambition to create more integrated health and care systems, and that its current siloed regulatory framework and organisation structure are not always helpful. Working together with providers there is a need to consider and obstacles within their current framework be reviewed to support innovation.

Code: RW91-91CBSYC
Theme: Systems Culture Change

Country of Origin/Context: UK
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

The "Bureaucracy Challenge", Mr Hancock stated that "every new proposed regulation or process" should be questioned as to whether "it makes sense given the realities of modern, integrated healthcare".

Solution(s) Identified & Their Outcomes:

Challenge, more challenge, harness national powerhouses that support the principles of the model being imbedded within neighbourhood teams.

Further Information (E.G. Financial Costs, Suppliers):

The theory of challenge from grass root is supported by the NHS people plan which includes - We each have a voice that counts, we all feel safe and confident to speak up and we take the time to really listen to understand the hopes and fears that lie behind the words – but national directives about what is best still keep coming, with questionably meaningful targets, that are mandated – discourse remains within the systems.

Code: **RW92-92CBSYC**
Theme: **Systems Culture Change**

Country of Origin/Context: UK
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

Failure to recognise the untapped potential within community nursing to further support unplanned hospital admissions and support the health and wellbeing of people within their communities.

Code:Solution(s) Identified & Their Outcomes:

Share the evidence base with system and organisation leaders.

Further Information (E.G. Financial Costs, Suppliers):

Evidence base:

https://www.qni.org.uk/news-and-events/news/untapped-potential-dn-services-and-the-avoidance-of-unplanned-admissions-to-hospital/

https://www.qni.org.uk/wp-content/uploads/2022/02/Workforce-Standards-for-the-District-Nursing-Service-2022.pdf

Code: RW93-93CBSYC
Theme: Systems Culture Change

Country of Origin/Context: UK
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

Traditionally, change approaches in the NHS have been driven by rational planning logic, underpinned by data. The emergent NHS will need to place more emphasis on emotional connection as this is a pre-requisite for calling people to act, based on their convictions and values as we move from 'have to' to 'want to' change to enable transformation to provision to integration of care in the community.

Code:Solution(s) Identified & Their Outcomes:

Support and develop leaders driven by their own convictions and values reflected within such care models, which makes them credible and authentic to others in their organisations and networks.

Further Information (E.G. Financial Costs, Suppliers):

It is said... Often, we see a disconnection between the aspiration of senior leaders for radical change and the need of the system to preserve order and control/avoid risk.

https://www.england.nhs.uk/improvement-hub/wp-content/uploads/sites/44/2018/09/Change-and-Transformation-White-Paper.pdf

Code: RW94-94CBSYC
Theme: Systems Culture Change

Country of Origin/Context: UK
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

There are significant workforce shortages – Nursing – result of multiple changes/inadequate national planning

Code:Solution(s) Identified & Their Outcomes:

National review /planning forwards Nursing workforce

Further Information (E.G. Financial Costs, Suppliers):

QNI red lines work provides a basis for a community nursing safety level. Contained within the workforce standards

Code: RW95-95CBSYC
Theme: Systems Culture Change

Country of Origin/Context: UK
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

Fragmentation of care through tendering is impacting on continuity of care for patients, increased footfall through patients houses and resources.

Code:Solution(s) Identified & Their Outcomes:

Teams working for best outcomes for patients will impact on other community teams.

Further Information (E.G. Financial Costs, Suppliers):

Patients admitted to hospital under Neighborhood Nursing teams should be facilitated home by those same teams.

Code: RW96-96CBSYC
Theme: Systems Culture Change

Country of Origin/Context: UK
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

GP practices caseloads containing patients not within a geographical footprint.

Code:Solution(s) Identified & Their Outcomes:

We requires local modelling to support this and the Buurtzorg approach to location based nursing.

Further Information (E.G. Financial Costs, Suppliers):

For enhanced relationships and effective working General Practitioners' and Neighbourhood teams aligned to a local footprint is beneficial to both patients and professionals.

Code: RW97-97CBSMT
Theme: Self-managing Teams

Country of Origin/Context: UK
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

There is an inadequate workforce to instigate teams and enable teams to develop the required skill set to become self-managing

Code:Solution(s) Identified & Their Outcomes:

Ensure minimum of 8 Full time equivalents workforce available at start of transformation

In ensuring these minimum numbers for a team we have reduced start risk failures of team development and further lack of retention of workforce.

Further Information (E.G. Financial Costs, Suppliers):

This means that we are more dependent on workforce capacity.

Code: RW98-98CBSMT
Theme: Self-managing Teams

Country of Origin/Context: UK
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

Senior staff within teams feel threatened by the model – there is a perceived loss of power/control and an impact on their identity (team members all wear same uniform).

Some senior staff noted they felt that it did not reflect all their hard work to get where they are.

Code:Solution(s) Identified & Their Outcomes:

It has be recognized that this model will not be for everyone.

Engagement with staff on model and value and strengths of each team member as collective. Does not detract from recognition of Clinical expertise.

Further Information (E.G. Financial Costs, Suppliers):

Code: RW99-99CBSMT
Theme: Self-Managing Teams

Country of Origin/Context: UK
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

Senior managers with overarching responsibility for services have anxieties about letting go and delegating responsibility as they are still the ones that will be held to account.

Code:Solution(s) Identified & Their Outcomes:

We need to work on the integration and have training on the types of conversations and decision making, we also need to review roles within mid office functions to support teams.

Clinical nurse manager role has been redesigned in collaboration with staff members to meet unmet provision of structured and robust clinical induction for new staff.

Further Information (E.G. Financial Costs, Suppliers):

Staff within teams can access support for updates, there should be renewal of competencies where required – we will carry out peer reviews – and provide supporting clinical governance

Code: RW100-100CBSMT
Theme: Self-Managing Teams

Country of Origin/Context: UK
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

Executive and Corporate managers have anxieties re the devolvement of functions to more junior staff within teams.

Code:Solution(s) Identified & Their Outcomes:

There needs to be collaboration with the back office – they need to be supporting the model, understanding the principles, building in security to new and simplified processes.

Advertising for new staff, complicated process on unintuitive system. Budget authorisations required at executive level may need to be reviewed.

Further Information (E.G. Financial Costs, Suppliers):

Teams review budgets – request advertising from mid office – agree role, advert and JD with team and advertise.

Staff budget to be devolved to teams (back office and mid office have oversight).

This will take time to build in terms of skills and also trust.

Code: RW101-101CBSMT
Theme: Self Managing Teams

Country of Origin/Context: UK
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

Executive, Corporate, and senior managers anxieties re devolvement of functions to more junior staff within teams.

Code:Solution(s) Identified & Their Outcomes:

Ensure teams have access to the framework which provides the core principles in which they will operate.

When things wrong – review framework team and coach to identify if team was operating within the framework or framework requires adjusting.

Further Information (E.G. Financial Costs, Suppliers):

This is a live document that requires review and referencing initially by the team to ensure they are working within and it will need adjustment with learning.

Code: RW102-102CBSMT
Theme: Self Managing Teams

Country of Origin/Context: UK
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

Anxieties about the element of risk with new teams initially developing skills, experience and knowledge to work effectively as a self-managed team.

Code:Solution(s) Identified & Their Outcomes:

To have high levels of engagement with coaches whilst development of skills and decision making in the initial 6 months to a year – agree with teams when they are fully fledged self-managed teams.

A team had been significantly impacted by staff absenteeism, which they self-managed and did not escalate impacting negatively on patient care provision.

Further Information (E.G. Financial Costs, Suppliers):

The management of risk is contained within the team's framework and includes highlighting to the coach for support if risk concerns – addressed has learning for the team.

Code: RW103-103CBSMT
Theme: Self managing teams

Country of Origin/Context: UK
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

We are raising that there are a lack of skills, knowledge, and experience for teams to act as self-managed teams, they have been working on a hierarchy for long periods.

Code:Solution(s) Identified & Their Outcomes:

There is a need to identify functions devolved and provide a training matrix to support required knowledge/ experience for team members.

Managers interview staff for teams

Further Information (E.G. Financial Costs, Suppliers):

Teams select and interview prospective team members – this requires HR support with selection and interview skills

Code: RW104-104CBSMT
Theme: Self managing teams

Country of Origin/Context: UK
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

There is a lack of understanding about other roles that support teams to become self-managed. These roles are those of the planner, the caretaker, the reporter etc that each Buurtzorg team must allocate to someone amongst the team and rotate.

Code:Solution(s) Identified & Their Outcomes:

There should be a clear description of roles/function/areas of accountability "Soft" rollout of teams. Not self-managing until the coach signs them off as competent. Increased training, particularly so that staff have the "soft" skills to have difficult conversations with their colleagues and manage conflict in the team.

The Planner role supports devising rota and work allocation, organises PDR,121s and supervision for the team. Authorises and calculates annual leave. Supports return to work interviews, informal sickness review.

Further Information (E.G. Financial Costs, Suppliers):

Roles are shared out and agreed by team members these can be rotated has agreed by the team.

Code: RW105-105CBSMT
Theme: Self Managing Teams

Country of Origin/Context: UK
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

There is an inability to have open and honest conversations across the differing levels within the team through inexperience as a result of working in hierarchical teams. For example when one team member falls out with another team member their first call is to approaches a manager/coach to resolve.

Code:Solution(s) Identified & Their Outcomes:

There is therefore a need to provide and reinforce training on the Solution Driven Method of Interaction approach by all team members, inclusivity and in having challenging conversations.

Some partners have worked on methodologies for creating psychological safety too.

Further Information (E.G. Financial Costs, Suppliers):

A staff member should be supported with strategies to have an open conversation to resolve. The team may also become involved if impacting on performance. Coach may be approached to facilitate resolution if previous strategies failed.

It is important to remember though that this is not caused by the model but takes time to move towards a different style without the need for parenting.

Code: RW106-106CBSMT
Theme: Self Managing Teams

Country of Origin/Context: UK
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

Devolved decision making is not consistent or cohesive with existing mid office/back-office processes and policies.

Examples would include requests for new uniform. Statutory and mandatory training, leave authorization all of which required manager approval.

Code:Solution(s) Identified & Their Outcomes:

There is a need to engage with back office supports, provide understanding of the model, which areas of responsibility are to be devolved to teams – review policies /SOPS to reflect proposed changes and ensure that tools such as IT are amended to support staff taking on these devolved responsibilities.

Further Information (E.G. Financial Costs, Suppliers):

For some partners tasks were devolved as it was felt appropriate for the individuals and roles within the team.

There may be need to do this work incrementally as teams get used to each new element.

Code: RW107-107CBSMT
Theme: Self Managing Teams

Country of Origin/Context: UK
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

Teams have no access to performance tools and online team specific dashboards that currently sit with team managers, the data is currently provided in complex formats to senior managers with overarching responsibility for services.

Code:Solution(s) Identified & Their Outcomes:

We need to develop a team performance dashboard based on key outcomes that enable them to be able to monitor and discuss their performance.

Further Information (E.G. Financial Costs, Suppliers):

The result is a simplified dashboard that shows size of caseload, length of time patients open on the caseload, % of patient facing time, PDR and statutory and mandatory compliance to be reviewed at team meetings (mid, back office and coaches have sight of).

Code: RW108-108CBSMT
Theme: Self Managing Teams

Country of Origin/Context: UK
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

There is a lack of knowledge and skills in clinical teams to take on roles previously carried out by clinical nurse managers.

Code:Solution(s) Identified & Their Outcomes:

There needs to be a high input at startup of a team from coaches, facilitating team meetings, referencing the framework – we took to having a period of team training and support, a minimum of 6 months.

We have found it reduces risk of 'run away' of self-management, teams not working in line with the framework.

Further Information (E.G. Financial Costs, Suppliers):

Organisations should invest in development of roles with associated teams training needs

Code: RW109-109CBOC
Theme: Organisational Culture

Country of Origin/Context: UK
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

Non-understanding of the model and its clinical and organisational benefits although recognised has potentially beneficial by senior management team, fall into the difficult to fix

Code:Solution(s) Identified & Their Outcomes:

Nominate an executive sponsor of the model and key senior staff to engage with them in understanding the principles of the model.

Plenty of stakeholder engagement is important.

Further Information (E.G. Financial Costs, Suppliers):

Engagement executive and non-executive Directors.

Scope services to be early adopters. Harness key clinical and corporate staff to advocate the model.

Understand population health data and impact for clinical teams.

Code: RW110-110CBOC
Theme: Organisational Culture

Country of Origin/Context: UK
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

There is pushback from within the organisation when challenging the status quo and working to imbed the model's principles.

Code:Solution(s) Identified & Their Outcomes:

Organisations should attain commitment and support from the CEO/Managing Director

Further Information (E.G. Financial Costs, Suppliers):

Provide a social business case to outline the model and requirements.

Introduce the 'Heatshield' role – individual/individuals who constructively challenge across the organisation demands and processes on clinical staff and protect and support early adopter teams.

Code: RW111-111CBOC
Theme: Organisational Culture

Country of Origin/Context: UK
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

Senior managerial staff of clinical teams feel threatened by the model – loss of control and they question will they be needed

Code:Solution(s) Identified & Their Outcomes:

There is a need to share understanding of repurposing of roles to best support clinicians.

Further Information (E.G. Financial Costs, Suppliers):

Recognise role transformation will be required. Include accountability to be a 'heatshield' for managers supporting clinical teams. Refocus roles on leadership, clinical quality, service, workforce development.

Code: RW112-112CBOC
Theme: Organisational Culture

Country of Origin/Context: UK
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

Lack of awareness/insight from back office of their impact on clinical teams.

Code:Solution(s) Identified & Their Outcomes:

Clinical teams to feedback on impacts and processes that are cumbersome and blocking.

Further Information (E.G. Financial Costs, Suppliers):

Actively engage staff in sharing challenging processes and re purpose back of functions – releasing time to care.

Support staff to better understand the impact of back-office decisions on clinical staff – example Directive clinical staff can only have one piece of IT – IPad or laptop.

Code: RW113-113CBOC
Theme: Organisational Culture

Country of Origin/Context: UK
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

Interpretation of the Organisations values and visions by some senior managers do not reflect behaviours that support the model

Code:Solution(s) Identified & Their Outcomes:

Organisations senior managers interpretation of values and vision behaviours require review to ensure in line with model.

Further Information (E.G. Financial Costs, Suppliers):

Reinforcing organistional behaviours with values that support the model

Code: RW114-114CBOC
Theme: Organisational Culture

Country of Origin/Context: UK
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

Understanding of coaching support role for teams versus management roles.

Code:Solution(s) Identified & Their Outcomes:

Develop a coach JD and communicate and reinforce role definition and expectations of the role both organisational and with staff.

Further Information (E.G. Financial Costs, Suppliers):

Reinforcing with teams the coaching approach.

Review policies and processes to support role definition - coach versus senior mid office operational/clinical managers.

Code: RW115-115CBOC
Theme: Organisational Culture

Country of Origin/Context: UK
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

Discourse of expectations of newly formed teams from historical team configurations.

Code:Solution(s) Identified & Their Outcomes:

Need to recognise transformational tensions between new and old models and find ways to change these or support them appropriately.

Further Information (E.G. Financial Costs, Suppliers):

Encourage open and honest conversations.

Support understanding of transformational plan across the organisation.

Code: RW116-116CBOC
Theme: Organisational Culture

Country of Origin/Context: UK
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

There was a challenge with the interpretation of terminology – what do we mean with phrases such as Mid Office/Back Office – roles/accountability.

Code:Solution(s) Identified & Their Outcomes:

Create a template outline as a live document to be reviewed and developed through the transformation.

Further Information (E.G. Financial Costs, Suppliers):

Code: RW117-117CBOC
Theme: Organisational Culture

Country of Origin/Context: UK
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

Historic Culture of NHS does not fit with the model.

Code:Solution(s) Identified & Their Outcomes:

Imbedding principles throughout the organisation that will support the transformation

Further Information (E.G. Financial Costs, Suppliers):

1. Keeping it simple.
2. Coffee and Care.
3. Humanity over Bureaucracy.
4. Can you live with it?
5. Solution Driven.

Code: RW118-118CBOC
Theme: Organisational Culture

Country of Origin/Context: UK
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

Our Digital IT strategy does not support reducing burden on clinical staff.

Code:Solution(s) Identified & Their Outcomes:

We needed to review and consider IT developments in line with the Buurtzorg approach and asking ourselves questions such as 'does it support clinicians?' and 'does it benefit clinical care?'

Further Information (E.G. Financial Costs, Suppliers):

We suggesting that organisations:

1. Aim for single log in.
2. Develop intuitive systems.
3. Consider constructing Omaha for demonstrating patient outcomes.
4. Collect regulator or other bodies required data unobtrusively for staff and clients.

Code: RW119-119CBOC
Theme: Organisational Culture

Country of Origin/Context: UK
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

Our Estate department's inability to support clinically appropriate accommodation within Neighbourhoods.

Code:Solution(s) Identified & Their Outcomes:

Estate department needs to explore and identify with GP surgeries if there are potential sources for accommodation on their sites. This relates to the improvements for teams in working more closely with the GP teams.

Further Information (E.G. Financial Costs, Suppliers):

1. Requires tenacity.
2. This should be built in at the start of project as it requires organisational commitment to support a very different approach.

Code: RW120-120CBOC
Theme: Organisational Culture

Country of Origin/Context: UK
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

The organisational position on agreeing to external requests for data that impact on clinical capacity – we are feeding the beast.

Code:Solution(s) Identified & Their Outcomes:

To support pushing back or thinking differently about requests for data there needs to be a cultural change to push back, challenge and assess the impact of these requests on clinical capacity.

Further Information (E.G. Financial Costs, Suppliers):

1. This requires communication and reinforcement from the organisation to enable staff to consider the principle of 'if it does not impact directly patient care, it should not touch the clinician.'
2. The different organisational departments need to consider alternative sources or means of data gathering.
3. There is also a need to question whose purpose a request serves.

Code: RW121-121CBOC
Theme: Organisational Culture

Country of Origin/Context: UK
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

For all partners there is an insufficient workforce to support transformation in a timely manner due to each nations own national nursing shortages

Code:Solution(s) Identified & Their Outcomes:

There is a need to recognise and develop teams in line with nursing resources.

Further Information (E.G. Financial Costs, Suppliers):

1. Within Buurtzorg teams are no smaller than six staff members and no larger than twelve people. For one partner teams were based on populations size of 8 Whole Time Equivalent and there was a requirement for full establishment to support model transference. Patient populations 10 – 15,000.
2. Consistent with The Queen's Nursing Institute (QNI) – Red Lines work – patient safety/clinical quality https://qni.org.uk/news-and-events/news/new-workforce-standards-for-district-nursing-launched/

Code: RW122-122CBIT
Theme: Repurposing IT

Country of Origin/Context: UK
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

Omaha is a research-based, comprehensive standardised nursing taxonomy which enables improved captured documentation and supports qualitative outcomes. In considering taking on the use of the taxonomy it was found to be a great challenge to overlay on an organisation's electronic patient records.

Code:Solution(s) Identified & Their Outcomes:

The solution would be to develop a configuration to enable the Nursing teams to be able to complete a holistic assessment and use the problem rating scale

Further Information (E.G. Financial Costs, Suppliers):

This requires a focused piece of work, with creative configuration and an ability/capacity to be able to rework over time which has been done by a French partner but not by UK partners so far although it is still an ambition.

Code: RW123-123CBIT
Theme: Repurposing IT

Country of Origin/Context: UK
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

In our current systems clinicians are required to have access to multiple systems, with multiple logins – impacting on clinical capacity and efficiencies with most being unintuitive. (Annual leave, subject access requests, Datex etc). This is very different to the systems that have been created for and with the end user staff within Buurtzorg.

Code:Solution(s) Identified & Their Outcomes:

Partners have been able in some instances to Replace several back-office databases with single Enterprise Resource Planning solution. Fewer logins means less duplication. The existing electronic patient record (EPR) systems are already integrated with General Practice and Hospital Electronic Patient Record systems and so partners decided to stick with our EPR system for patient records but have tried to get as many back-office functions working from one integrated enterprise resource planning system.

This has achieved a reduction in the number of logins and systems that users need to be trained in but there is still further integration that could be done.

Further Information (E.G. Financial Costs, Suppliers):

The level of challenge this presents will be different for each organisation. The ideal outcome would still be to have one fully integrated system for electronic patient records (EPR) and back office functions (finance, HR, procurement etc). In the UK this is extremely challenging given the limited number of EPRs for community services that are accredited/accepted by NHS England commissioners.

Code: RW124-124CBIT
Theme: Repurposing IT

Country of Origin/Context: UK
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

Communication is challenging within and between community teams, based in multiple locations.

Code:Solution(s) Identified & Their Outcomes:

Developing and using an internal wiki a website that is collaboratively created by multiple users.

Supporting collaborative content management system (CMS) for collecting and organizing media that is created and revised by its users

Further Information (E.G. Financial Costs, Suppliers):

This requires project support and an early adopter to assist in design of key components that would assist the team/s service provision.

Code: RW125-125CBIT
Theme: Repurposing IT

Country of Origin/Context: UK
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

For teams made up of staff working across more than one organisation there were challenges in relation to access to networks.

Code:Solution(s) Identified & Their Outcomes:

There needs to be work across organisations to manage network connections owned by other stakeholders.

Further Information (E.G. Financial Costs, Suppliers):

It is complicated and time intensive work that is required to support a longer-term solution that will be implemented with the Health and Social Care Network (HSCN) providing a reliable, efficient, and flexible way for health and care organisations to access and exchange electronic information – this remains a work in progress.

Code: RW126-126CBIT
Theme: Repurposing IT

Country of Origin/Context: UK
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

There are IT connectivity challenges in the consistency of access for clinical staff to be able to remote work often in rural areas.

Code:Solution(s) Identified & Their Outcomes:

This requires national investment – 2022 Building Digital UK (BDUK), part of the Department for Digital, Culture, Media & Sport (DCMS) is responsible for ensuring that every UK home and business can access fast and reliable digital connectivity.

The government is investing £5 billion to ensure that everyone will have the same access to gigabit-capable broadband. There's a further £1 billion joint investment by the government and the four mobile network operators to increase 4G mobile coverage throughout the UK to 95%.

Further Information (E.G. Financial Costs, Suppliers):

National Issue

Code: RW127-127CBIT
Theme: Repurposing IT

Country of Origin/Context: UK
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

Many of our systems are based on hierarchical access – managers have to improve everything

Code:Solution(s) Identified & Their Outcomes:

Our workaround has been to enable Neighbourhood Nursing team members to be able to authorise each other's.

Further Information (E.G. Financial Costs, Suppliers):

Governance arrangements can be added to a mid-office function to review reports i.e. such as mileage claims

Code: RW128-128CBIT
Theme: Repurposing IT

Country of Origin/Context: UK
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

Clinical IT Hardware access – the challenges of the back office managing financial spend by reducing the number of IT Hardware items clinicians can have – this does not reflect the range of requirements to optimally support clinicians

Code:Solution(s) Identified & Their Outcomes:

A heatshield in the mid office supporting clinicians with conversations to have access to relevant types of hardware that best support efficiencies and effectiveness.

Further Information (E.G. Financial Costs, Suppliers):

This remains a challenge and would require a culture shift.

Code: RW129-129CBIT
Theme: Repurposing IT

Country of Origin/Context: UK
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

Reporting requirements both locally and nationally impacts on clinical time to care – we have a plethora of reports and KPIs we are obliged to collate and submit to our NHS commissioners.

Code:Solution(s) Identified & Their Outcomes:

The simple solution identified was ongoing escalation/dialogue with commissioners to educate them about Buurtzorg principles and to encourage a collaborative approach to achieving and reporting outcomes rather than volumes.

Further Information (E.G. Financial Costs, Suppliers):

This remains a challenge and would require a culture shift.

Code: RW130-130CBIT
Theme: Repurposing IT

Country of Origin/Context: UK
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

Performance indicators

Code:Solution(s) Identified & Their Outcomes:

TBC

Further Information (E.G. Financial Costs, Suppliers):

Rob drafting something

Code: RW131-131LRR
Theme: Recruitment and Retention

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable: Yes

Description of the Barrier and/or Challenge:

Changes in service delivery resulting from a requirement to develop a new service, substantially reduced senior clinical staff within community nursing teams. The senior clinicians being redirected to support the new service, reducing community nursing's ability to adequately support junior staff with gaining competence and confidence and clinical supervision.

Code:Solution(s) Identified & Their Outcomes:

Recruitment of two senior wound care staff to support clinical supervision in practice with junior staff and updating of substantive staff.

Recruitment of two diabetic nurses to support competence development with new staff and to review and support hospital discharges with titration of medication and use of free style libra's where appropriate to optimise diabetic control where clinically appropriate.

Further Information (E.G. Financial Costs, Suppliers):

Wound care accounts for 40% plus of our activity and there is a high clinical risk of harm if not managed correctly.

Insulin administration and diabetic patients account for a high volume of the 40% of patients who require daily medication administration.

Code: RW132-132LRR
Theme: Recruitment and retention

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable: Yes

Description of the Barrier and/or Challenge:

We have found that there is an Inadequate level of support to enable new staff to develop confidence and competence in roles

Code:Solution(s) Identified & Their Outcomes:

We have carried out a review of the induction programme and based on feedback from leavers developed and implemented an extended 12-week induction programme with a clinical lead to support with preceptorship and clinical supervision.

Further Information (E.G. Financial Costs, Suppliers):

Code: RW133-133LRR
Theme: Recruitment and retention

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable: Yes

Description of the Barrier and/or Challenge:

We have challenging recruitment processes.

Solution(s) Identified & Their Outcomes:

One solution has been to centralise functions to key mid office staff who are notified of requirements by clinical staff, then manage the system and are supported by a dedicated HR business partner with Job descriptions, adverts and following up with successful candidates in optimizing required processes to facilitate start dates.

Further Information (E.G. Financial Costs, Suppliers):

Recruitment processes include using an unintuitive system which is only used sporadically by clinical teams, causing delays and impacting on clinical time.

Code: RW134-134LRR
Theme: Recruitment and retention

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable: Yes

Description of the Barrier and/or Challenge:

We have challenging new starter processes and there is multiple form filling and delays in obtaining clinical and IT equipment and relevant access to systems

Code:Solution(s) Identified & Their Outcomes:

These tasks have been moved to a mid-office role who is notified by HR business partners of new starters start dates, ensures all relevant forms completed and submitted, ensures that all clinical equipment and IT equipment made available on 1st day and arranges the organisations induction day.

Further Information (E.G. Financial Costs, Suppliers):

Traditionally clinical teams managed as and when which caused delays in equipment etc enabling staff to optimally function from day one

Code: RW135-135LRR
Theme: Recruitment and retention

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable: Yes

Description of the Barrier and/or Challenge:

There are inadequate processes to fully understand what the primary reasons for our leavers are and this is currently managed by clinical teams.

Code:Solution(s) Identified & Their Outcomes:

The HR business partner is now notified of all leavers and offers and arranges a meeting to understand why staff are leaving to establish if there is anything we can do to support retaining staff.

Further Information (E.G. Financial Costs, Suppliers):

This has improved our understanding of reasons for staff leaving and resulted in providing more support for staff and identifying where some teams require additional help with self-management.

Code: RW136-136LRR
Theme: Recruitment and retention

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable: Yes

Description of the Barrier and/or Challenge:

Developing the ability for Neighbourhood Nursing teams to manage their own interview processes and staff selection failed initially due to lack of understanding and awareness of HR processes for interviews and consideration of selection based on team performance requirements.

Code:Solution(s) Identified & Their Outcomes:

The coaches now support initial recruitment and interviews with teams. Our HR business partner also supports teams with a training package on recruitment.

Further Information (E.G. Financial Costs, Suppliers):

Teams require a high level of support from coaches in the first six to twelve months. Providing this has led to increasing the coach capacity and the task is released from clinical manger posts who wanted to develop in this role.

Code: RW137-137LRR
Theme: Recruitment and retention

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable: Yes

Description of the Barrier and/or Challenge:

There is a loss of senior clinical staff having direct contact and daily clinical conversations with junior staff, which is impacting on support and is reducing the improvement of outcomes for patients (reorganisation based on NHS England's requirements to provide an urgent response service).

Code:Solution(s) Identified & Their Outcomes:

To develop the role of the neighbourhood nurse prescriber across the Primary Care Network to work alongside the teams within a PCN and their GP colleagues, supporting teams with clinical conversations, clinical supervision, holding a complex case load and supporting them with their unwell patients and escalating as appropriate.

Further Information (E.G. Financial Costs, Suppliers):

This role has been positively received as it enables clinical career progression within the service and has attracted external candidates.

Code: RW138-138LRR
Theme: Recruitment and retention

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable: Yes

Description of the Barrier and/or Challenge:

It has been a challenge to support staff optimally during the probation period

Code:Solution(s) Identified & Their Outcomes:

Current staffing levels have impacted negatively on processes – we will be supporting mentors with training on process requirements going forwards.

Further Information (E.G. Financial Costs, Suppliers):

This has been an interim position supported by coaches.

Code: RW139-139LRR
Theme: Recruitment and retention

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable: Yes

Description of the Barrier and/or Challenge:

There are high levels of vacancies within the NHS – the challenge has been our ability to attract staff in a competing market.

Code:Solution(s) Identified & Their Outcomes:

We revised and simplified job descriptions.

We advertised the model we were aspiring to.

Candidates could apply online or by paper if preferred (previously only on-line applications accepted)

Advertised on Facebook

Invested in recruitment days/showcasing service

Offered interviews on the day

Further Information (E.G. Financial Costs, Suppliers):

This was driven by the HR Business Partner

Code: RW140-140LRR
Theme: Recruitment and retention

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable: Yes

Description of the Barrier and/or Challenge:

There are a high level of vacancies within the NHS which is decreasing our ability to attract staff in a competing market

Code:Solution(s) Identified & Their Outcomes:

Our solution is Growing Our Own – We are intending on supporting and positively encouraging applicants who would wish to progress from Band 2's through the apprentice programme to become either a registered associate practitioner or a register nurse.

Further Information (E.G. Financial Costs, Suppliers):

Code: RW141-141LRR
Theme: Recruitment and retention

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable: Yes

Description of the Barrier and/or Challenge:

There are a high level of vacancies within the NHS which is decreasing our ability to attract staff in a competing market

Code:Solution(s) Identified & Their Outcomes:

We have increased the number of applications supported to undertake the District Nurse Qualification.

Further Information (E.G. Financial Costs, Suppliers):

This has led to us attracting external candidates.

Code: RW142-142LRR
Theme: Recruitment and retention

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable: Yes

Description of the Barrier and/or Challenge:

We have a challenge retaining staff through professional development opportunities.

Code:Solution(s) Identified & Their Outcomes:

Our solution to this has been working with another community trust and a local university to develop a community master's programme.

Further Information (E.G. Financial Costs, Suppliers):

This only went live 2022 and so we are waiting to review impact.

Code: RW143-143LRR
Theme: Recruitment and retention

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable: Yes

Description of the Barrier and/or Challenge:

We find that there are staff in roles that do not best utilise their aspirations and strengths.

Code:Solution(s) Identified & Their Outcomes:

Through discussions with leavers and staff who were unhappy at work facilitated with HR business partner we are now considering what the service requires, how best can strengths and aspirations support the needs.

Further Information (E.G. Financial Costs, Suppliers):

This has resulted in some very positive staff retention.

Code: RW145-145LC
Theme: Commissioning

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable: Yes

Description of the Barrier and/or Challenge:

Traditionally in the UK services are commissioned based on activity and block contract. Time and Task

Solution(s) Identified & their Outcomes:

We have found that no short-term solution is required as it is seen as a research project and not a commissioned service giving us more flexibility.

Further Information (E.G. Financial Costs, Suppliers):

We are working to develop relationships with commissioners as they are currently driven by contract not by need, finance, and complexity of nursing needs. We are also working on keeping caseloads manageable based on the agreed geographical area.

We continue to work with Buurtzorg.

There is a difficulty in maintaining the Primary Care Network Neighbourhoods due to General Practice coverage across Medway. The new integrated care programme for 2020 should support changes in line with the model.

To ensure staff are meeting with their Primary Care Network surgeries.

Identify Neighbourhood Nursing Teams for surgery, provide them with the contact number for Neighbourhood Nursing Teams.

Code: RW146-146LC
Theme: Commissioning

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable: No

Description of the Barrier and/or Challenge:

Community patients may have multiple health providers and local authorities creating a segregation of pathways across multiple teams and the teams commissioned as a result of funding being segregated across health and care.

Solution(s) Identified & their Outcomes:

We are having discussions with commissioners where we have identified locations where Neighbourhood Nursing teams impact across discretely commissioned service provision.

Further Information (E.G. Financial Costs, Suppliers):

We have found that commissioners will commission service based on this model.

To date our engagement with commissioners has been positive and is on-going.

20201- There has been an increase in sharing of the potential of the model in our Local care meetings.

Code: RW147-147LC
Theme: Commissioning

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable: No

Description of the Barrier and/or Challenge:

Health Commissioners will want to commission this model and the service will need to enter tendering.

Solution(s) Identified & their Outcomes:

Include commissioners in understanding the model/include in stakeholder events and meetings and invite them to work with the teams.

Further Information (E.G. Financial Costs, Suppliers):

To date our engagement with commissioners has been positive and is on-going.

We held a stakeholder event held on 18th November 2019, we have also distributed newsletters and commissioners will be invited to our virtual launch.

2021- The model is being supported by the Local Care Agenda.

Code: RW148-148LC
Theme: Commissioning

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable: Yes

Description of the Barrier and/or Challenge:

Key Performance Indicator's and funding streams of pathways are impacted by Neighbourhood Nursing's provision of intermediate care.

Solution(s) Identified & their Outcomes:

We have an internal work around in place.

Further Information (E.G. Financial Costs, Suppliers):

A roll out of the adaptation of pathways would require adjustment of service specifications and Key Performance Indicator's

There is also a work around in place for Home First patients

Code: RW149-149LC
Theme: Commissioning

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable: No

Description of the Barrier and/or Challenge:

The model requires teams to be located in Neighbourhoods however commissioning is currently aiming to centralise all teams in to Healthy living centres and there are potential cost implications

Solution(s) Identified & their Outcomes:

We are having open discussions with commissioners and reviewing the impact on finances of the two different approaches.

Further Information (E.G. Financial Costs, Suppliers):

We have found that commissioners will commission services based on this model.

The model supports Sustainability and Transformation Plans and so the local care agendas are to be kept under review.

The work we are doing is being recognised in local care as there are positive solutions.

Code: RW150-150CBCOMP
Theme: Competition

Country of Origin/Context: UK
Local or Cross Border: Cross Border
Sustainable: No

Description of the Barrier and/or Challenge:

Historically teams have large caseloads which has an impact on the model outcomes and the workforce requirements are unknown.

Solution(s) Identified & their Outcomes:

- Commissioning procurement has now changed. The previous tendering approach meant two localities would be bidding for the same area of work, which would have caused difficulty in implementing the model due to the constraints of current working arrangements.
- France - no historical teams, create own competition they will still work on their own even though they have received development through a new team.
- Caseloads can cause tension across different teams, but historic teams understand quality over quantity. All teams support natural caseloads.
- Smaller caseloads are making a big difference for patients and less complaints are being generated.
- Teams share their compliments and complaints with each other through private social media accounts.
- There has been reduced demand through increased emphasis on early intervention, prevention, and self-management.
- Roll out plan based on reduced demand through increased emphasis on early intervention, prevention and self-management. We will monitor with the pilot team and ongoingly with the roll out of teams.

Further Information (E.G. Financial Costs, Suppliers):

Recorded as a risk-on-risk register.

Teams will need to manage within their caseload requirements, otherwise there will be an impact on their financial envelope of service.

Code: RW151-151LF
Theme: Funding

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable: No

Description of the Barrier and/or Challenge:

A social care charging model does not exist for the work that the teams under TICC will be carrying out.

Solution(s) Identified & their Outcomes:

To prevent destabilising the homecare market and to prevent profit being made as part of the project the nurse-led team in East Kent are not to take on patients who have an existing social care package with Kent County Council.

However, they are to work collaboratively with social care colleagues including there being a potential for reviewing funding streams and models of delivery for long term care needs.

Further Information (E.G. Financial Costs, Suppliers):

A long-term solution needs to be sought and agreed as the current solution only resolves these issues during the project's lifetime.

We need to maintain open and on-going dialogue and consider how the Buurtzorg approach is adapting to meeting needs.

Cross organisational discussions have been delayed due to the pandemic and the capacity throughout 2020.

Code: RW152-152LICT
Theme: ICT

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable: Yes

Description of the Barrier and/or Challenge:

We have found that the process for the management of annual leave is too complex. There is too much time being spent on authorising leave.

Solution(s) Identified & their Outcomes:

The solution to this challenge is to simplify processes which are managed on Zone Standard. The platform manages annual leave and sick absence and carries out reporting for payroll - This simplification work is in progress.

Further Information (E.G. Financial Costs, Suppliers):

The work is in progress and is supported by our back office.

Meetings are being set up to resolve the challenges.

Code: RW153-153LICT
Theme: ICT

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable: Yes

Description of the Barrier and/or Challenge:

Information governance is an area of challenge

Solution(s) Identified & their Outcomes:

We use On Zone as standard which requires realignment to the service through the back-office function.

Further Information (E.G. Financial Costs, Suppliers):

Work in Progress

Code: RW154-154LICT
Theme: ICT

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable: Yes

Description of the Barrier and/or Challenge:

Infrastructure is needed to support IT for teams based in General Practice surgeries and external buildings.

Teams working from GP surgeries are currently unable to connect to the hosted server, as they have limited access to desktop IT.

There is a lack of access to the internet outside of the IT cloud solution at certain sites, which causes difficulty with tools such as Skype which requires staff to have access to the internet.

Solution(s) Identified & their Outcomes:

The General Practice IT Team to host PC and line and the organisation IT team to load systems to PC.

We are using limited hotspots and awaiting installation of internet port. IT has now provided access at the designated site.

With the use of newer technology and Wi-Fi we are to keep this challenge under review as a potential barrier, however the previous issue no longer relevant.

Further Information (E.G. Financial Costs, Suppliers):

The parties involved are currently still in discussions with the GP team. The Neighbourhood Nursing Team are using mobile IT solutions to work out of the base until a wired solution can be agreed.

New hardware with sim-enabled connectivity Dec 2020 - to be kept under review as teams roll out.

Code: RW155-155LICT
Theme: ICT

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable: Yes

Description of the Barrier and/or Challenge:

IT Equipment for New Starters - Surface Go.

The online form requests a candidate's contact details (phone number and email address). These are not known at the point of completing the form.

Solution(s) Identified & their Outcomes:

The Project Support Officer now requests this information as part of the back-office function for processing New Starters. The online form is completed with required details.

The candidate's personal phone number and email address (provided by HR Team) is now entered.

Further Information (E.G. Financial Costs, Suppliers):

We will now monitor this way of working as previously TBC was added and the Coach was contacted for collection of equipment, but email did not state staff members name - delaying the staff member collecting their Surface Go.

Code: RW156-156LICT
Theme: ICT

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable: Yes

Description of the Barrier and/or Challenge:

The Mobile Phone of a member of staff is not easy to transfer if they move between teams. This process is reliant on the Project Support Officer being informed of internal transfers to start the process.

Solution(s) Identified & their Outcomes:

The Project Support Officer requests, as part of the back-office function, the processing of phones of staff being transferred between internal teams. Online forms are completed with required details.

Further Information (E.G. Financial Costs, Suppliers):

Code: RW157-157LICT
Theme: ICT

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable: Yes

Description of the Barrier and/or Challenge:

Setting up a mobile phone for new starters is reliant on the TICC email address being sent the new starters start day and their email to start the recruitment process.

Solution(s) Identified & their Outcomes:

The Project Support Officer requests, as part of the back-office function, for the processing of New Starters. They complete the online form with the required details.

Further Information (E.G. Financial Costs, Suppliers):

This is work in progress which is being supported by the back office team.

Code: RW158-158CBICT
Theme: ICT

Country of Origin/Context: UK
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

Configuration of our existing systems to capture Omaha taxonomy whilst keeping it easy to use by front line staff.

Solution(s) Identified & their Outcomes:

It has been factored in how other systems can be configured to support Omaha in our IT replacement procurement.

Further Information (E.G. Financial Costs, Suppliers):

A preferred supplier option has been identified in one of the UK organisations and the project went live in January 2021.

We incorporated the Ohama approach within our new IT systems, simplifying the IT to free up clinician time for Patient facing. There are significant plans to simplify IT for clinicians.

Single Assessment configured with Omaha.

Outcomes Measures included in Omaha to be incorporated into our plan.

Code: RW159-159LICT
Theme: ICT

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable: Yes

Description of the Barrier and/or Challenge:

Procurement: SBS Ordering – There is an existing hierarchy in NHS finance rules which requires line managers approval for orders.

Budget authorization and management are causing challenges for the TICC teams.

Solution(s) Identified & their Outcomes:

We now have dedicated support for Neighbourhood Nursing Teams by a member of the Procurement Team.

The approval authority set up is to be looked at.

Further Information (E.G. Financial Costs, Suppliers):

This is work in progress supported by back office.

This is a workaround to reduce burden on clinical staff and the long term solution is being developed.

Code: RW160-160LICT
Theme: ICT

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable: Yes

Description of the Barrier and/or Challenge:

There is a need to review and revise the Communication Strategy and tools to support the transformation and redesign of Neighbourhood Nursing teams, operational service centre and back-office service centre.

Solution(s) Identified & their Outcomes:

Solutions are in development with discussions about the use of Actualised Living and Wikies

Further Information (E.G. Financial Costs, Suppliers):

We have inadequate communications across our service.

We are looking to use the Actualised Living system for our in-house directories.

For Live Streaming we are using MS Teams more effectively now.

Code: RW161-161LICT
Theme: ICT

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable: Yes

Description of the Barrier and/or Challenge:

The process for sickness management is currently too complex. We need to put a simple process in place for staff which can trigger informal and formal stages.

There is a lack of warning of sickness escalation.

Solution(s) Identified & their Outcomes:

We need to identify a simple solution to manage this process.

Zone Standard is the tool we currently use to manage Annual leave and Sick Absence, it also does the reporting for payroll.

Further Information (E.G. Financial Costs, Suppliers):

This is work in progress which is supported by our back office.

Meetings are being set up to resolve these issues.

Code: RW162-162LICT
Theme: ICT

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable: Yes

Description of the Barrier and/or Challenge:

When staff move between teams, the process we have for changes to uniform causes issues. We are reliant on the Project Support Officer being informed of the internal transfer to start the process.

Solution(s) Identified & their Outcomes:

The Project Support Officer requests, as part of the back office function, for the process of transferring staff between internal teams. Online forms are completed with required details.

Further Information (E.G. Financial Costs, Suppliers):

Code: RW163-163LICT
Theme: ICT

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable: Yes

Description of the Barrier and/or Challenge:

For Uniform for New starters the teams are reliant on the TICC email address being sent the New Start Date Email to start the recruitment process.

Solution(s) Identified & their Outcomes:

The Project Support Officer sends out the requests as part of the back-office function for processing New Starters. The Online form is completed with required details.

Further Information (E.G. Financial Costs, Suppliers):

This is work in progress supported by the back office.

Code: RW164-164LO
Theme: Operational

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable: Yes

Description of the Barrier and/or Challenge:

Our Clinical nursing leadership team is needed to support and facilitate training, updating evidence-based practice, reviewing impact of changes to legislation, implementing new practices currently supported by resource within community nursing teams.

Solution(s) Identified & their Outcomes:

We are looking at reviewing the activity that can be realigned to the back-office function and the requirement includes the development of more appropriate communication tools and feedback mechanisms with Neighbourhood Nursing teams.

1. Communication Champion within each Neighbourhood Nursing Teams
2. Role of Clinical Leads
3. Communication in Teams.

Further Information (E.G. Financial Costs, Suppliers):

For now, we have work arounds in place which requires development of smarter access for clinicians – a more permanent solution remains a work in progress.

The development of an induction period for new starters with the view that existing staff will attend to update clinical knowledge and carry out competency reviews. New posts have been introduced to clinical supervisory roles, new starters and TV.

Code: RW165-165LO
Theme: Operational

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable: Yes

Description of the Barrier and/or Challenge:

General Practice enhanced service provision supports GPs looking after patients that are not in their neighbourhoods - attaining patient demographics is challenging to support the configuration of Neighbourhood Nursing teams.

Solution(s) Identified & their Outcomes:

We are working with BI and Public health to quantify neighbourhood populations.

Further Information (E.G. Financial Costs, Suppliers):

Code: RW166-166CBO
Theme: Operational

Country of Origin/Context: UK
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

The role of Heatshield is new in the organisation and there is a lack of understanding about the role and a difficulty to acquire recognition of the role within the organisation.

Solution(s) Identified & their Outcomes:

- We have a heatshield in place, Senior and Corporate managers find the role challenging, heatshields can throw back questions relating to self-managed teams as the role covers a wider remit.
- Heatshields advocate for self-managed teams; they adopt the principles and remind managers of these when required.
- Working with Senior and Corporate managers to approach the heatshield first rather than directly with the teams.
- The heatshield role should form part of the senior management level to remind the organisation of the Buurtzorg principles and how self-managed teams are operating.
- France do not have a heatshield in place as they do not require protection from top level management, if the "C" level is not sharing the same vision it will be difficult to implement.
- The Heatshield is trained by Public World and the model and role introduced to corporate staff.
- The role of the Heatshield can be added to Senior Role JD

Further Information (E.G. Financial Costs, Suppliers):

Code: RW167-167LO
Theme: Operational

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable: Yes

Description of the Barrier and/or Challenge:

Managers approval is required when ordering goods/services from internal teams e.g., estates, telecoms etc.

Solution(s) Identified & their Outcomes:

A workaround is being used by putting co-workers' email as an approver.

A whole system change is needed to allow the team to become an approver/budget holder.

Further Information (E.G. Financial Costs, Suppliers):

Further training for the back-office redesign is needed and on-going discussions with back-office services.

We are still having issues within the systems of the support services (mid office) for example new starters' approval is not required, however for existing staff the organisation is still requiring authorisation from a coach/manager.

Code: RW168-168CBO
Theme: Operational

Country of Origin/Context: UK
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

New concept of the change in expectations of a team and how the organisations will support staff.

Solution(s) Identified & their Outcomes:

A framework is developed for teams which outlines the principles that all teams must work within.

It is noted that an organisational framework is required to share the understanding of the new model with the back-office staff.

Further Information (E.G. Financial Costs, Suppliers):

Our organisational frameworks are in development, and we have on-going meetings and are working with the back office. The team's framework is in place and the teams review it at team meetings to resolve issues they face about this way of working.

Code: RW169-169LO
Theme: Operational

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable: Yes

Description of the Barrier and/or Challenge:

The NHS is a hierarchical organisation.

Solution(s) Identified & their Outcomes:

We need to have the engagement and support of the model by the CEO and senior executive managers.

We need their commitment to organisational change.

Further Information (E.G. Financial Costs, Suppliers):

They are supporting the development of the model.

Code: RW170-170CBO
Theme: Operational

Country of Origin/Context: UK
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

Reviewing processes and requirements is currently being undertaken by teams that could be redirected to back office.

Solution(s) Identified & their Outcomes:

We are working with corporate leads and the teams are identifying functions that could be redirected to the back office.

Our Recruitment and new starter/leavers processes have impact on clinical staff and we are now collaboratively working with HR and the back office to realign these functions away from Neighbourhood Nursing teams.

Further Information (E.G. Financial Costs, Suppliers):

This continues to be work in progress supported by the back office.

We have recruited a HR Business Manager to support teams with recruitment and HR issues within teams.

Our project support officer supports/coaches the teams with new starters and leavers processes.

Code: RW171-171LO
Theme: Operational

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable: Yes

Description of the Barrier and/or Challenge:

It is a challenge to sustain core service provision whilst transforming teams.

Solution(s) Identified & their Outcomes:

We are trialing close/cross working with clinical teams offering support from coaches and line managers.

We have noted that patient care is not compromised.

Further Information (E.G. Financial Costs, Suppliers):

This remains under review with the roll out.

Caseload revalidation is undertaken by coaches.

There is a review of patients and surrounding teams prior to a new team roll out being progressed.

Code: RW172-172CBO
Theme: Operational

Country of Origin/Context: UK
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

The Neighbourhood Nursing teams do not have a dashboard/summary set of indicators that easily highlights their performance.

Solution(s) Identified & their Outcomes:

The solution will be to create performance dashboards for each Neighbourhood Nursing team and one for the Neighbourhoods Nursing Coaches to compare performance across the teams.

This work is labour intensive currently.

Further Information (E.G. Financial Costs, Suppliers):

Oct 2019 – this is to be included in the back-office transition work plan

Oct 2020 – Our requirements have been identified and the information will currently be attained from multiple systems to populate the dashboard for teams.

Sept 2021 - Draft dashboards have now been shared with coaches and they will be tested with Pilot teams for feedback.

Code: RW173-173LO
Theme: Operational

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable: Yes

Description of the Barrier and/or Challenge:

It is a challenge to gain full support from the board for the new way of working.

Solution(s) Identified & their Outcomes:

To support this we have created a "Framework" and there are on-going discussions in place with the Executive team.

Further Information (E.G. Financial Costs, Suppliers):

Draft documents have now gone to the Executive team for ratification and are currently waiting sign off.

These were signed off on the 20th September 2021

There are regular discussions at the Board level and our CEO meets with Jos de Blok for advice and support.

Code: RW174-174CBPR
Theme: Policy and Regulation

Country of Origin/Context: UK
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

A culture change is needed from a policy driven focus to team frameworks and a move from management to a coaching culture.

There needs to be a Team and Organisational Framework

Solution(s) Identified & their Outcomes:

We are working on hosting wider staff engagements and are training on and reviewing policies with key personnel in the organisation. These activities are on-going.

We also ensure that there is active communication both internally and externally and training for teams in place.

Further Information (E.G. Financial Costs, Suppliers):

We have regular updates on TICC and the transformation, we are keeping in touch with the organisation to ensure they are updated on the transformation.

Code: RW175-175LPR
Theme: Policy and Regulations

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable: Yes

Description of the Barrier and/or Challenge:

Monitoring requirements of the Care Quality Commission (CQC) did not fit well with the new way of working, having a set format for inspection and requiring defined evidence, reports, data, ect and that they would "need adapting to better support this model"

Solution(s) Identified & their Outcomes:

We are in dialogue with inspectors, and there are visits planned with team the team, there seems to be a willingness to find solutions.

A policy round table meeting is to be set with CQC with UK Work Package 2 Leads to work on barriers and solutions together.

In some cases CQC processes will need adapting to support the model.

Further Information (E.G. Financial Costs, Suppliers):

We have a round table meeting on 14th January 2020 to gain support for the model and the CQC is interested in the implementation and noting any impact on governance.

Code: RW176-176CBPR
Theme: Policy and Regulations

Country of Origin/Context: UK
Local or Cross Border: Cross Border
Sustainable: No

Description of the Barrier and/or Challenge:

Policies may have implications on the Neighbourhood Nursing model and self-managed teams.

Solution(s) Identified & their Outcomes:

We are looking to carry out a policy review by the project lead, teams, and coaches as it is deemed appropriate to ensure that they fit with the new model noting any impact and any potential conflicts.

Further Information (E.G. Financial Costs, Suppliers):

It is being considered whether all policies should be reviewed.

We have adopted the sickness policy with HR and no further updates have been undertaken to date. There was a need to adjust the policy for the Neighbourhood Nursing Teams.

Code: RW177-177CBR
Theme: Recruitment Process

Country of Origin/Context: UK
Local or Cross Border: Cross Border
Sustainable: No

Description of the Barrier and/or Challenge:

It appears that there is a demand on clinical time for HR processes undertaken by clinical staff. It is also noted that staff require more support with recruitment and that there is a need to facilitate the development of teams who do not currently possess the required competencies to meet patient care demands.

Team members have little or no experience of recruitment.

There was also the loss of a HR Business Partner to the TICC Project (31/07/20) which resulted in increased workload for the Management team.

Solution(s) Identified & their Outcomes:

A coach is needed to support the team in attaining decision making knowledge and skills to be able to recruit within the framework requirements.

We recruited a HRBP to support recruitment and HR issues within the teams (03/06/19).

HR Business Partner has been reinstated (30/09/20) and role became permanent (16/02/21).

We are utilising the HRBP to support requests for recruits.

The project support officer supports the teams and the coaches with the new starters and leavers processes.

Further Information (E.G. Financial Costs, Suppliers):

This is likely to be a common skill gap in any new team and therefore needs to be part of our inductions and training, etc.

Self-managed teams are a new concept and require intense support to prevent and enable teams to function optimally.

The HRBM provides a training and support programme to self-managing teams and remains available for support.

Code: RW178-178CBR
Theme: Recruitment Process

Country of Origin/Context: UK
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

Our recruitment process is labour intensive.

Permission is required from senior authorisation to recruit.

Solution(s) Identified & their Outcomes:

This has been revised and for a team to recruit it requires the back-office function to support with administration.

Back-office support is being developed to support administrative functions.

We should remove the requirement once a budget for the team is in place.

Further Information (E.G. Financial Costs, Suppliers):

Processes have been reworked and are now simplified and supported by the back office.

Code: RW179-179LR
Theme: Recruitment Process

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable: Yes

Description of the Barrier and/or Challenge:

Recruitment to the new model of self-managed teams has seen increasing applications, including from non-community experienced staff, which creates a challenge. The lower level of exposure to clinical issues means that there is more support needed to ensure the breadth of clinical skills and knowledge to work within the community setting and it is hard attaining the required levels of competence and confidence within a reasonable timeframe.

Solution(s) Identified & their Outcomes:

It has been identified that to facilitate retention we need more robust and supportive inductions of our new staff.

Further Information (E.G. Financial Costs, Suppliers):

This has resulted in increased retention and has supported the facilitation of the transformation.

A new format induction was introduced in Nov 2019.

Code: RW180-180LREP
Theme: Reporting

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable: Yes

Description of the Barrier and/or Challenge:

Reporting and assurance requirements in the NHS are more onerous than in the Netherlands and do not currently compliment the Buurtzorg model and as an example there are some unnecessary reporting requirements which don't support patient care or outcomes.

Solution(s) Identified & their Outcomes:

We have been working with Buurtzorg and Public World to understand and be able to replicate performance requirements to create appropriate dashboards for teams, coaches and commissioners.

We are developing internal performance reporting mechanisms that meet the local measures.

Further Information (E.G. Financial Costs, Suppliers):

Our IT system is to be implemented which will enable data to be extracted without the team's input. For the back office there will be a change of culture and reconfiguration.

Progress has been made with regards to the investment in systems that are provide improved access to data, more timely data and more analytical detail.

We are meeting with local commissioners about changing the focus of their reporting expectations and this has been rescheduled to October.

Our Chief Nurse was due to speak to CQC about some of the report requirements they insist upon and the value of some of the detail they request – we await an update to this.

COVID has been a good example of an added industry of reporting, a lot of which would not appear to add value to local decision making.

Code: RW181-181LW
Theme: Workforce

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable: No

Description of the Barrier and/or Challenge:

We have found for some teams that there is friction between the teams as they are not all able to push back on the external hierarchy.

Our clinical managers are impacting negatively when supporting new teams and they are not facilitating the teams self-management.

Solution(s) Identified & their Outcomes:

There needs to be more awareness about the purpose of this work and intervention from coaches when necessary.

We need further education to embed the TICC model and utilise coaches as support not managers.

Further Information (E.G. Financial Costs, Suppliers):

Code: RW182-182LW
Theme: Workforce

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable: Yes

Description of the Barrier and/or Challenge:

Electronic Staff Records require managers' approval for statutory and mandatory training.

Solution(s) Identified & their Outcomes:

All approval for statutory and mandatory training has been removed from the electronic staff records.

Further Information (E.G. Financial Costs, Suppliers):

Our processes have been changed and the manager's approval is no longer required.

Statutory and mandatory training no longer requires approval.

Code: RW183-183LW
Theme: Workforce

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable: No

Description of the Barrier and/or Challenge:

Tension built between the two teams, and this was due to negativity from senior staff.

Solution(s) Identified & their Outcomes:

It has been helpful engaging and supporting senior staff to better understand the model so that they did not see it as a threat to their own roles.

Further Information (E.G. Financial Costs, Suppliers):

We have found that there is a negative impact if senior staff are not supportive of the model and therefore engagement is needed to gain support from senior staff

This team was dispensed. Team specific recruitment was put in place to recruit to the teams and re transition once they were fully established.

Code: RW184-184LW
Theme: Workforce

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable: No

Description of the Barrier and/or Challenge:

Roll out teams consultation: Professional Identity

Staff not keen on personal care - feel it is not their role.

Negativity around patients self-caring. Will it affect their pin?

Senior staff not happy for junior staff to undertake different non-clinical roles - triage/allocation/rota's.

Communication between substantive teams and neighbourhood nursing teams does not always support facilitating input by the correct team.

Staff negative about model - keen to maintain a hierarchy and not let go off banding and own role.

Solution(s) Identified & their Outcomes:

Talking and discussions relating to role of the nurse, NMC code of code of conduct and understanding changes and impact of separating health and care.

Understanding risk - balance, empowering - time to embed - long term benefits.

Breaking down barriers, understanding individuals strengths - best fit for the team.

Engagement and enhanced communication with substantive teams in understanding model and processes.

Team members not always supportive of the non hierarchical approach and understanding of differences between hierarchy and clinical leadership.

Further Information (E.G. Financial Costs, Suppliers):

Contri to ethos of model - staff engage fully with health and care model.

Contri to ethos of model - staff less risk adverse, develop confidence in supporting self care.

Contri to ethos of model - when this subject is no longer discussed.

Disruptive to developing self managed teams.

Further education to teams across the whole organisation.

Code: RW185-185CBICT
Theme: ICT

Country of Origin/Context: UK
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

We noted the need for an integrated back-office systems solution to mirror Buurtzorg web benefits.

Solution(s) Identified & their Outcomes:

There are commercial discussions under way with a partner that could deliver integrated ICT.

Further Information (E.G. Financial Costs, Suppliers):

A preferred supplier option has been identified for one of the UK project partners.

We are looking to Incorporate the Omaha approach within new IT systems, simplifying the IT to free up clinician time for patient facing work and there is a commitment from the organisation to be working with an independent company to simply back-office functions with IT.

We are still working on a solution (Zone Standard) and we are not yet in a position to say it could be offered to other possible UK and international partners.

Code: RW186-186LO
Theme: Operational

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable: No

Description of the Barrier and/or Challenge:

Our clinical lead roles need redesigning to fit with supporting self-managed teams including what tools are needed to support them.

Solution(s) Identified & their Outcomes:

There is a meeting planned to review them in line with the transformation to revise Job Description's

The clarity of the roles is not clear, which is creating tension.

Further Information (E.G. Financial Costs, Suppliers):

This remains a work in progress

Code: RW187-187LO
Theme: Operational

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable: No

Description of the Barrier and/or Challenge:

The complexity of hospital discharges is proving a challenge.

Solution(s) Identified & their Outcomes:

This is a national issues which remains a challenge

Further Information (E.G. Financial Costs, Suppliers):

Increased complexity of health needs, demand on community nursing services, not reflected in the investment of workforce – this requires national recognition and review of resources to support.

Raised within local care and supported by QNI

https://www.dailymail.co.uk/health/article-10198323/How-hiring-district-nurses-reduce-pressure-NHS.html?fbclid=IwAR0z5pbgjK6oVfpwfP91gydV5jOSiohK1poBbZ1x2numIdSpPYZUYbLBvFA

Code: RW188-188LO
Theme: Operational

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable: Yes

Description of the Barrier and/or Challenge:

There is a need for low level carer support.

Solution(s) Identified & their Outcomes:

Low level, flexible carer support to reduce risk of patients requiring hospital admission is not available in the UK and we only have standard care packages. As part of the project we are trialing having two Band 2 posts within a Neighbourhood Nursing Team

Further Information (E.G. Financial Costs, Suppliers):

There is not current provision but there is benefit realisation of such model to be trialled

Two Band 2 posts at risk to support a pilot

Code: RW189-189LO
Theme: Operational

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable: No

Description of the Barrier and/or Challenge:

Neighbourhood Nursing team roles need defining to ensure clarity of the roles between the operational back-office functions and the Neighbourhood Nursing team functions.

Solution(s) Identified & their Outcomes:

Initial work is in progress to develop clarity and role proformas to include training and development needs.

Further Information (E.G. Financial Costs, Suppliers):

Clarity of roles is not clear and it creates tension in the team.

Code: RW190-190LO
Theme: Operational

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable: Yes

Description of the Barrier and/or Challenge:

The pilot team is unable to access appropriate office accommodation.

Solution(s) Identified & their Outcomes:

We will develop a checklist for consideration of the appropriateness of premises for teams.

Further Information (E.G. Financial Costs, Suppliers):

The team have now re-located to WBC, but it is need that we create a long term process requires establishing and this was requested by estates team.

Code: RW191-191LPR
Theme: Policy and Regulations

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable: No

Description of the Barrier and/or Challenge:

Nurses are unable to remove or deliver medication to and from a patients home.

Solution(s) Identified & their Outcomes:

A policy review is needed.

Further Information (E.G. Financial Costs, Suppliers):

under review

Code: RW192-192LICT
Theme: ICT

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable: Yes

Description of the Barrier and/or Challenge:

HR

Solution(s) Identified & their Outcomes:

We have recruited a HR business manager to support with recruitment and HR issues within teams.

Further Information (E.G. Financial Costs, Suppliers):

We are utilising the HR Business Manager to support requests for recruits.

The project support officer supports teams and coaches with the new starters and leavers processes.

Code: RW193-193LR
Theme: Recruitment

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable: Yes

Description of the Barrier and/or Challenge:

The traditional skill mix and recruitment of community nursing supports hierarchical structures and is contrary to the ethos of self-managed teams.

Solution(s) Identified & their Outcomes:

We see the solution is to focus on skills and knowledge as opposed to pay bandings when recruiting, by limiting advertisements to Neighbourhood Nurse and Neighbourhood assistant nurse with pay and not a title reflecting breadth of qualifications, skills and knowledge.

The job descriptions delineate qualifications and broad roles in line with relevant codes of conduct.

Further Information (E.G. Financial Costs, Suppliers):

The job descriptions for the Neighbourhood Nurse and Assistant have been redesigned.

Code: RW194-194REF
Theme: Referrals

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable: Yes

Description of the Barrier and/or Challenge:

New referrals being added to caseload despite numerous requests from the coaching team for this not to happen.

Solution(s) Identified & their Outcomes:

Processes are being created to protect new teams from new referrals.

Further Information (E.G. Financial Costs, Suppliers):

Code: RW195-195LW
Theme: Workforce

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable: Yes

Description of the Barrier and/or Challenge:

There has been the loss of our HR Business Partner to the TICC Project which is resulting in increased workload for Management.

Solution(s) Identified & their Outcomes:

HR Business Partner has been reinstated

Further Information (E.G. Financial Costs, Suppliers):

Code: RW196-196LW
Theme: Workforce

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable: Yes

Description of the Barrier and/or Challenge:

A palliative patient called Medocc for a palliative injection over the weekend but the call was not put through to the Neighbourhood Nursing team phone instead the community nurse went out to the patient without contacting the team as they saw on the rota a Nurse Associate was on duty.

The team had a buddy system for this event so if the community nurse had called the team, they would have been able to visit but instead the community nurse visited.

Solution(s) Identified & their Outcomes:

As a result, we are revisiting the communication about the Neighbourhood Nursing teams processes with other substantive teams.

Further Information (E.G. Financial Costs, Suppliers):

We need further education for the teams across the whole organisation.

There are challenges of transforming substantive teams from community nursing to neighbourhood nursing.

Code: RW197-197LC
Theme: Contracts

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable: Yes

Description of the Barrier and/or Challenge:

NHS Contracts: there are multiple requirements on reporting.

Solution(s) Identified & their Outcomes:

We are working with BI to capture the needed data in the background for the clinicians on the new system.

Further Information (E.G. Financial Costs, Suppliers):

Our initial discussions were about understanding the scope.

There is a block in the number of licenses available to staff.

We are working on the Neighbourhood Nursing Dashboard development.

Code: RW198-198LF
Theme: Funding

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable: No

Description of the Barrier and/or Challenge:

This model supports qualified nurses who are providing health and care and there is a challenge that the roll out proposed will cause increases in the budgetary requirements.

Solution(s) Identified & their Outcomes:

It is therefore going to be important to work collaboratively with social care and commissioners so that we can find a way to demonstrate the positive outcomes on the wider health and social care economies.

Further Information (E.G. Financial Costs, Suppliers):

The financials of working in this way will need to support clinical demand.

We will keep this under review with the roll out across the organisation.

Code: RW199-199LF
Theme: Funding

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable: No

Description of the Barrier and/or Challenge:

There is a challenge with new teams requiring office space, but they are being advised that there is no space and no funding available to find alternatives.

Solution(s) Identified & their Outcomes:

The Neighbourhood Nursing team have identified an office being used as storage and they are happy to share with tambour storage if it could be moved to enable an effective working space around the storage.

The alternative was external office space which was found but the cost was to high.

Further Information (E.G. Financial Costs, Suppliers):

We currently have a lack of back-office support in relation to this challenge.

We need to identify what we would consider reasonable costs and look at the long-term plan for re-deploying staff out of centralised offices.

Following further discussions and explanations with the estates department about the impact this has on the teams, space has now been agreed. This provides further evidence that there is a need for communication with all relevant stakeholders.

We will arrange discussions to determine the financial envelope for any new premises, giving teams more flexibility and choice and improving the speed at which they can make decisions.

Code: RW200-200LF
Theme: Funding

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable: Yes

Description of the Barrier and/or Challenge:

In one of our new office spaces there were challenges around the suitability of the room, the team had raised issues with things like needing blinds to replace frosted glass, which was difficult to work with, the printers do not work, etc.

Despite raising their issues for over a year nothing was being done. The team were not being heard.

Solution(s) Identified & their Outcomes:

IT has now been in to sort the challenges with the printers.

The teams need to have someone to raise these things with and the development of the back office can play an important role in this.

Further Information (E.G. Financial Costs, Suppliers):

Code: RW201-201LO
Theme: Operational

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable: Yes

Description of the Barrier and/or Challenge:

There have been challenges with two separate teams trying to work from the same building.

Solution(s) Identified & their Outcomes:

Further Information (E.G. Financial Costs, Suppliers):

Code: RW202-202LO
Theme: Operational

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable: Yes

Description of the Barrier and/or Challenge:

A challenge we noted was the need for a manager to sign off on mileage claims.

Solution(s) Identified & their Outcomes:

We have asked ourselves does it have to be a manager that signs off on mileage claims and we have decided that the team should be able to sign off and monitor mileage claims for the team.

A workaround is currently in place to reduce the burden of the extra administrative work on clinical staff and a long-term solution is being developed by the back office.

Further Information (E.G. Financial Costs, Suppliers):

The team informer is now responsible for the approval of the whole team's mileage and expense claims.

Code: RW203-203LO
Theme: Operational

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable: No

Description of the Barrier and/or Challenge:

There was a challenge with the provision of Neighbourhood Nursing team dashboards.

Solution(s) Identified & their Outcomes:

We have spent time working on what the requirements are and how the information can be attained from the multiple systems. We have managed to pull this together now for the dashboards.

Further Information (E.G. Financial Costs, Suppliers):

This is a labour-intensive task.

We have included this in the back-office transition work plan.

Code: RW204-204LPR
Theme: Policy and Regulations

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable: Yes

Description of the Barrier and/or Challenge:

There is a whole system understanding of the medication administration challenges for patients who are discharged from hospital.

Solution(s) Identified & their Outcomes:

We have instigated a cross-organisation work stream whose role will be to identify solutions to facilitate better medication management for this group of patients.

Further Information (E.G. Financial Costs, Suppliers):

As a result of this work there is improved medication management for patients in their own homes.

A meeting was held on the 25th of November 2019 to discuss and make arrangements however this work was halted by the pandemic.

Code: RW205-205CBREF
Theme: Referrals

Country of Origin/Context: UK
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

There are three different pathways that patients can be on with regards to hospital discharge which is complex. We have started some initial work taking patients from hospital and then engaging with other services who need to be involved and this crosses both organisational and service provision. The patient ends up across a multitude of teams across health and care.

Solution(s) Identified & their Outcomes:

We need to simplify referral pathways to the team.

This is a work in progress.

In France a patient coordinator deals with families and the hospitals.

We are looking to work with patients to contact the teams to let them know they are ready to be discharged and they can then help coordinate the discharge with the different formal networks.

Further Information (E.G. Financial Costs, Suppliers):

Whilst we are in the transformation process moving from one model to the other, we have dual processes, however the goal is that the Neighbourhood Nursing teams will enable direct contact for patients and the GP's.

Patients and families will have contact numbers of the Neighbourhood Nursing teams who are based in the GP surgery.

There is a requirement to review the process of hospital discharges.

Code: RW206-206LSM
Theme: Self Management

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable: Yes

Description of the Barrier and/or Challenge:

Team unable to develop self-managing model due to increase demand / number of patient visits

Solution(s) Identified & their Outcomes:

Our solution has been to ensure new teams gradually build their caseload whilst they are in the set-up phase and traditional teams understand the requirements for them to build up their case load in a more measured way to enable them to embed this new way of working.

Further Information (E.G. Financial Costs, Suppliers):

We have re-aligned coaches and there is a process in place to support a team that is newly transitioning.

Code: RW207-207LW
Theme: Workforce

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable: Yes

Description of the Barrier and/or Challenge:

Due to Covid 19 the requirement for staff to shield at home if positive to covid19 or has they were highly vulnerable impacted on the resource/capacity within the smaller teams.

Solution(s) Identified & their Outcomes:

We are looking at ways to support shielding staff that were keen to be at work, they were able to find support to facilitate care to patients with smaller team levels.

Further Information (E.G. Financial Costs, Suppliers):

There was an impact on small teams in maintaining service delivery during the pandemic.

We incorporated a home triage service for shielding staff to carry out. The team handovers and team meetings were completed virtually to enable open communication within teams.

We needed to incorporate business continuity to enable service coverage.

The development of leaflets and care plans were carried out by TVN to support patients to self-care.

Code: RW208-208LW
Theme: Workforce

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable: No

Description of the Barrier and/or Challenge:

The caseload was transferred over from our traditional community nursing team to the new neighbourhood nursing team too quickly which resulted in missed visits, and an inability to review patients effectively due to the high levels of visits.

This has resulted in a possible SI investigation due to the deterioration of pressure damage as a result of the skill mix and there being no treatment plans in place.

We also found that patients being discharged from the caseload by non-team members resulted in missed visits.

The low staffing due to the induction training of some members of the team meant that there was an increase in visits for team members not on training resulting in nursing to the old model due to the high caseload numbers.

Solution(s) Identified & their Outcomes:

It was important to reinforce that the new team's caseloads would require drip feeding whilst teams settle and develop skills for new ways of working.

With regards to the process issue this was corrected with renewed communications across teams.

We have recognised the risks of balancing competing demands and we looked at the mutual support from substantive teams.

Further Information (E.G. Financial Costs, Suppliers):

This could prevent the effective transition to the new way of working.

A system review and education that the teams are responsible for the caseloads and should only discharge from this as and when required.

There is a need for further education to teams across the whole organisation.

Code: RW209-209LRR
Theme: Recruitment and retention

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable: Yes

Description of the Barrier and/or Challenge:

Community nursing, historically, has been a sponge taking everything and anything that is not supported elsewhere in the community, this has meant that there is a challenge in managing the demand on the service.

Code: Solution(s) Identified & Their Outcomes:

There is a need to realign all mobile patients that are historically supported although not commissioned into clinics. This creates resources available from the vacancies created within community nursing which is necessary as commissioners appear to be unwilling to invest in these service gaps.

Further Information (E.G. Financial Costs, Suppliers):

Code: RW210-210CBO
Theme: Operational

Country of Origin/Context: UK
Local or Cross Border: Cross Border
Sustainable: No

Description of the Barrier and/or Challenge:

Staff find it difficult to be open and honest and have difficult conversations with each other

Solution(s) Identified & their Outcomes:

The solution to this is to continue with the team-building exercises and support from the coach and project lead to help facilitate open and honest conversations.

Further Information (E.G. Financial Costs, Suppliers):

Self-managed teams is a new concept for partner organisations and it requires intense support to prevent and enable teams to function optimally during the set up phase.

Teams utilise the Solution Driven Method of Interaction approach to their conversations, but it takes time to learn. Coaches will revisit teams six weeks after they have gone live to support where needed.

One organisation have also set up “Keeping it blue” days to re-embed the principles to TICC and SDMI once every six months or when it seems to be required.

Code: RW211-211LW
Theme: Workforce

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable: Yes

Description of the Barrier and/or Challenge:

The demographics of Neighbourhood Nursing teams impacts on local need provision.

Solution(s) Identified & their Outcomes:

We are working with Public health to provide neighbourhood demographic profiles to support identification and allocation of appropriate workforce capabilities.

Pilot team demographics including morbidity and mortality have been identified ensuring that the Neighbourhood Nursing team workforce plan will include training and identification of support service requirements and this method is to be applied to roll out all teams.

Further Information (E.G. Financial Costs, Suppliers):

This method was not used with roll out of other teams, as we were utilising MVA and our social prescribing teams and those others who are connecting with local communities.

Code: RW212-212CBW
Theme: Workforce

Country of Origin/Context: UK
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

There is difficulty in the differentiation between hierarchical and clinical expertise.

Solution(s) Identified & their Outcomes:

The change of culture, coaching and training makes a difference to this challenge.

Embedding the framework, coaching and learning as an organisation what is being expected from the team, embedding that everyone is equal. The organisation has to set and give the right example, they need to demonstrate that they are not acting like there is a hierarchy.

There is more work to do on supporting critical thinking and positive challenge between team members using Solution Driven Method of Interaction.

Further Information (E.G. Financial Costs, Suppliers):

We need to challenge the agenda for change and ensure the scope of practice.

The use of SDMI in everyday practice will become the norm for teams and coaches

We have developed an understanding that as a team, they are responsible for decision making and as clinicians there is a difference in education levels i.e., registered/unregistered but this does not affect the equality of the voices in the team.

Governance overarches us all and adherence to NMC Code of conduct/ HCA Code of conduct is all our responsibility and this should be captured in the organisational framework.

Self-managed teams are a new concept and have required intense support to prevent and enable teams to function optimally.

Code: RW213-213LICT
Theme: ICT

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable:

Description of the Barrier and/or Challenge:

There is difficulty in implementing an integrated back office IT solution that will give comparable benefits and time savings as the BZ Web solution does.

Solution(s) Identified & their Outcomes:

The benchmark for IT that supports the Buurtzorg model of care and maximises time saving is to have a single IT system capable of capturing electronic patient record information and all relevant back office IT functions (e.g. HR, finance, procurement).

The 'Buurtzorg Web' IT solution serves this need for Dutch organisations and 'Buurtzorg Web International' caters for language alternatives.

Each organisation will start from a different position. Some organisations may already have an integrated electronic patient record and enterprise resource planning system whilst others may have several different solutions each providing a specialist function.

Organisations should have a demonstration of the Buurtzorg Web solution as the standard to aim for.

Organisations should then compare this to their existing IT solution(s) to evaluate the differences and what change is required. It may be that existing systems can be adapted or that a single or combination of systems need to be procured. In the case of procuring alternative IT systems, care must be taken to identify the existing contract lengths and exit clauses to determine how quickly the change to alternative IT suppliers could be made. Determining how much user training will be required will also be a key part of the planning when implementing this aspect of the programme of changes that the Buurtzorg model requires.

Further Information (E.G. Financial Costs, Suppliers):

Code: RW214-214LO
Theme: Organisational

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable: Yes

Description of the Barrier and/or Challenge:

Nail Cutting has not previously been provided which causes delays in care provision.

Solution(s) Identified & their Outcomes:

As a result of the identification of the challenge team training has now been provided.

Further Information (E.G. Financial Costs, Suppliers):

Code: RW215-215LR
Theme: Recruitment

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable: Yes

Description of the Barrier and/or Challenge:

Our new starter process is currently complicated, and it is time consuming for clinicians to attain baseline equipment including mobile phone and IT access.

Solution(s) Identified & their Outcomes:

We have plans to provide enhanced back-office support and remove these tasks from clinicians.

Our project support officer completes our newly created Welcome Day Requirement Form to ensure the new starter has everything they need to get started.

Further Information (E.G. Financial Costs, Suppliers):

There are also plans to provide enhanced back-office support and remove unnecessary tasks from clinicians. Our project support officer organises the new starters equipment, forms and documents which are added to PF and a point of contact aligned within the team to contact.

Code: RW216-216LPR
Theme: Policy and Regulation

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable: Yes

Description of the Barrier and/or Challenge:

We have found it a challenge during the pandemic to ensure access to PPE and provide guidance for staff.

Solution(s) Identified & their Outcomes:

Staff created a WhatsApp chat for the Neighbourhood Nursing team to quickly disseminate information to teams and update them on where to source PPE.

Further Information (E.G. Financial Costs, Suppliers):

This was discussed with all Neighbourhood Nursing Teams about what the best way to cascade information might be. The process is being added to Zone standard to simplify the process and it will be kept under review.

Code: RW217-217LO
Theme: Operational

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable: Yes

Description of the Barrier and/or Challenge:

Teams were unable to order from non-catalogue for SBS Ordering and early on staff are unsure what best to purchase from NHS supplies.

Solution(s) Identified & their Outcomes:

We have developed a catalogue with the Procurement Team for Neighbourhood Nursing Teams. We are also arranging refresher training on the ordering system.

SBS training has been given to those carrying out the Housekeepers role and on ordering on the system.

Further Information (E.G. Financial Costs, Suppliers):

An initial meeting was held on 16/11/20 and this resulted in a decision being made to ideally produce a catalogue for consumable items making it a more user-friendly system - meetings are in progress.

Code: RW218-218LO
Theme: Operational

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable: Yes

Description of the Barrier and/or Challenge:

There is a challenge to review Senior Staff Job Descriptions in the Transformation of Local Care.

Solution(s) Identified & their Outcomes:

We need to devise specific job descriptions which reduce hierarchal structure but we also need to continue to utilise senior knowledge. (Clinical nurse managers band 7's sit within the historical structure)

The transformation to a new model requires redesigning of the senior roles within the service.

We have also recruited to the roles of Infection Control & Prevention, Clinical Supervision and Induction Facilitator.

Further Information (E.G. Financial Costs, Suppliers):

We needed to have open and honest discussions with the senior team and job descriptions are to be developed as the roll out progresses.

Initial discussions have taken place and we have the ICP lead now in place for service.

Code: RW219-219LO
Theme: Operational

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable: No

Description of the Barrier and/or Challenge:

There are a number of link roles such as dementia, IC, safeguarding, IG, asset etc. all of which require clinical engagement.

Solution(s) Identified & their Outcomes:

This is unsustainable with the new model. We need to review our back-office processes to support clinicians and to be able to disseminate updates as per the requirements across teams.

Further Information (E.G. Financial Costs, Suppliers):

This is a work in progress. The team informer/developer is responsible for liaising with the wider organisation to disseminate information. The recruitment of an IC nurse will support teams with infection control audits/training/governance. We need to consider how we communicate this with teams.

Code: RW220-220CBO
Theme: Operational

Country of Origin/Context: UK
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

The role of a coach is a new role in the service, understanding the role, provision of appropriate training, writing appropriate JD and evaluating/approval for banding in pay structure is all a part of this challenge.

Solution(s) Identified & their Outcomes:

We are working with Buurtzorg coaches and Public World and this will require access to training being developed by Buurtzorg and Public World, the model does not fit with traditional coach training. We must write job descriptions and put these forward for evaluation, approval and ratification.

Further Information (E.G. Financial Costs, Suppliers):

We are actively engaged with training and support.

Coach training has been implemented and undertaken with Public World and Buurtzorg. We have also completed the writing of the job description.

We then need to review our training plan for the additional coaches.

Code: RW221-221LW
Theme: Workforce

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable: Yes

Description of the Barrier and/or Challenge:

The On-call payment structure is a barrier.

Solution(s) Identified & their Outcomes:

We are discussing different models rather than sticking to traditional payment tiers etc.

Self-managed teams is a new concept and requires intense support to enable teams to function optimally.

Further Information (E.G. Financial Costs, Suppliers):

Teams are required by the framework to provide a 7am – 7pm service which requires flexibility in rotas and scheduling. The Neighbourhood nursing MNNT has been re-designed to cover Out of Hours.

Code: RW222-222LW
Theme: Workforce

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable: Yes

Description of the Barrier and/or Challenge:

The team roll out and the need to adapt training for the new teams.

Solution(s) Identified & their Outcomes:

We have created virtual training and delivered this to teams instead of face-to-face training and we have offered virtual 121's as extra support.

Further Information (E.G. Financial Costs, Suppliers):

We have changed training delivery to a virtual set up and to touch base virtually with individuals as well as teams.

Code: RW223-223LO
Theme: Operational

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable: Yes

Description of the Barrier and/or Challenge:

Teams within one organisation were challenged with the scope of their remit which may have a potential impact on the workforce.

Solution(s) Identified & their Outcomes:

Our solutions will be to work with internal teams collaboratively to develop solutions.

Further Information (E.G. Financial Costs, Suppliers):

Discussions and training with Community Nursing teams to educate them further on the principles of TICC and offering shadowing within a TICC team.

Code: RW224-224LPR
Theme: Policy and Regulation

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable: Yes

Description of the Barrier and/or Challenge:

There are complex and high levels of reporting that are currently required to provide the required level of clinical governance oversight.

Solution(s) Identified & their Outcomes:

We do however need to review the governance requirements and ask ourselves whether they can be simplified, where can we best capture the data from, what is the simplest way to capture information from the required clinical documentation, how do we best review those requirements, how can we create this information in a less clinically labour intensive way.

We need to review Clinical Governance.

We have also thought about the implementation of a new role, a lead for the service in the Integrated Care Partnership.

Further Information (E.G. Financial Costs, Suppliers):

The relevant meetings and workshops are in progress.

Code: RW225-225LPR
Theme: Policy and Regulations

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable: No

Description of the Barrier and/or Challenge:

Medication Administration in Social Care: Social Care colleagues can prompt about the administration of medication, but they do not administer it themselves.

Solution(s) Identified & their Outcomes:

UK partners are reviewing the practices locally.

Further Information (E.G. Financial Costs, Suppliers):

Code: RW226-226LO
Theme: Operational

Country of Origin/Context: UK
Local or Cross Border: Local
Sustainable:

Description of the Barrier and/or Challenge:

Unnecessary bureaucracy is said to destroy value in innumerable ways, including slowing problem solving, discouraging innovation, and diverting huge amounts of time into politicking and "working the system."

The NHS as it is currently organised is overly complex, over-regulated and generates substantial transaction costs. Current moves to streamline and simplify the organisation of the NHS in England should continue and may require changes in legislation in due course.

There are some big issues for wider challenge but in order to implement Buurtzorg principles within community teams -- we focused on areas of organisational bureaucracy that were unnecessarily burdensome on clinicians, slowed desired outcomes, used unnecessary clinical managerial resource and corporate resource.

Solution(s) Identified & their Outcomes:

Various solutions were identified using technology enablers such as single sign on systems, easier catalogue system for ordering sundries, new online forms to replace multiple paper forms. See word document for additional info.

Further Information (E.G. Financial Costs, Suppliers):

See word doc 'D2.2.4 PP5 Tackling Hierarchical Bureaucracy within organisations'

Code: RW227-227CBR
Theme: Recruitment

Country of Origin/Context: France
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

Teams have the responsibility for hiring new colleagues with the Buurtzorg model, but it is difficult to guess who will or will not be a good colleague. There have been recruitment errors that have had heavy consequences. Once an error has been made, it is not easy to dismiss the person and the result is that the next time the team will be more reluctant to hire a new colleague.

Sometimes we have found that teams prefer to refuse new clients than to take the risk of hiring a bad colleague.

Solution(s) Identified & their Outcomes:

We needed to clarify a few simple steps to follow to minimise recruitment errors.

We need to anticipate more on the recruiting needs, when there are time pressures, we need to remember it is a risk to hire the wrong people and we shouldn't just recruit because we need someone.

Further Information (E.G. Financial Costs, Suppliers):

Code: RW228-228CBSM
Theme: Self Management

Country of Origin/Context: France
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

The team members have never been used to direct communication between colleagues.

Solution(s) Identified & their Outcomes:

It takes time, training, and coaching interventions to raise the level of communication maturity. We learn by our errors, which can cause pain but will pass with time and practice.

Further Information (E.G. Financial Costs, Suppliers):

Code: RW229-229LF
Theme: Funding

Country of Origin/Context: France
Local or Cross Border: Local
Sustainable: No

Description of the Barrier and/or Challenge:

The current "per act" pricing scheme does not support holistic care. The nurses must speed up their interventions to financially break even, hence they cannot do all the prevention activities that would be necessary because they are not paid for by the health insurer.

Solution(s) Identified & their Outcomes:

We are working with the government to obtain the right to experiment with a per hour pricing scheme instead of per act.

Further Information (E.G. Financial Costs, Suppliers):

The experiment will end in October 2022. We succeeded in getting the right to overcome the per act pricing, for a three-year period until October 2022.

Code: RW230-230LICT
Theme: ICT

Country of Origin/Context: France
Local or Cross Border: Local
Sustainable: Yes

Description of the Barrier and/or Challenge:

In the market there is not a French version of Omaha referential

Solution(s) Identified & their Outcomes:

We have engaged software specialists to review potential vendors.

Further Information (E.G. Financial Costs, Suppliers):

We have found a Swiss IT company able to provide a French version of Omaha.

We have now implemented a fully operating version of the Omaha system in French, that is connected to the nurses' daily operations and patient records.

Code: RW231-231LLB
Theme: Language Barrier

Country of Origin/Context: France
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

Training or knowledge materials are in English or in Dutch (ex: the book from Astrid Vermeer), but our nurses don't speak English. The staff do not speak English. It's difficult for them to follow the training by Buurtzorg in Holland. Sometimes when we work in small groups there isn't any translator.

Solution(s) Identified & their Outcomes:

We need to translate the documents into French and then engage French speaking Buurtzorg nurses in the training activities.

We have also had the Solution Driven Methods of Interactions book translated into French.

Further Information (E.G. Financial Costs, Suppliers):

Code: RW232-232CBO
Theme: Operational

Country of Origin/Context: France
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

We in the team feel insecure and stressed about money/revenues of our team. This is a psychological burden; we fear that we might lose our job if we get it wrong. We also feel pressure to serve more patients (sometimes more than we would like to).

Solution(s) Identified & their Outcomes:

By now the financial balance is the only KPI that the team can use to check “what good looks like”. We would need to implement regular evaluations about team interaction quality and patient quality, so that teams also focus on those 2 important aspects of their outcome.

Management should also communicate differently about economics, to mitigate the risk of excessive pressure on the relevance of finance.

Further Information (E.G. Financial Costs, Suppliers):

Code: RW233-233LR
Theme: Recruitment Process

Country of Origin/Context: France
Local or Cross Border: Local
Sustainable: Yes

Description of the Barrier and/or Challenge:

We have found that the teams tend to recruit "young and easy to manage" colleagues. Especially if they themselves are young. They tend to recruit people like themselves, instead of reflecting on what their needs might be, and looking for the best experience/competence possible. They seem to fear recruiting more experienced, competent colleagues, maybe thinking it will be a possible source of conflict/difficulty managing the person if she is older or experienced than they are.

Solution(s) Identified & their Outcomes:

The solution in the long run is team coaching and training, to let the team have open and honest discussions about the outcomes for patients and tackle the "fears", before launching a recruitment.

Also connect the various teams between them, so that they can experience the benefits of working with better skilled, more experienced colleagues for them and for the quality of care.

Identify a "recruitment role" within the team that would receive specific support from a coach to help improve the recruitment skills of the team.

Further Information (E.G. Financial Costs, Suppliers):

In the long term the team will always benefit from some coaching

Code: RW234-234CBREF
Theme: Referrals

Country of Origin/Context: France
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

The team receives mainly “difficult patients”, that self-employed nurses don’t want to get. Then the job is difficult for the team because they mainly deal with difficult clients.

Solution(s) Identified & their Outcomes:

The teams will meet with hospitals, doctors, and partners to inform/explain the value the teams can bring to a wider range of patients.

Further Information (E.G. Financial Costs, Suppliers):

Code: RW235-235LPR
Theme: Policy and Regulation

Country of Origin/Context: France
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

The President of the National Nurses Order has raised a concern that this "system" or approach could lead to an end of the "private self-employed" status and believes that it would lead to the Nurses Union fighting against it.

Solution(s) Identified & their Outcomes:

We need to meet with the Nurses Union to have an open discussion about the project, the vision, and agree upon vision/strategy for the future.

Further Information (E.G. Financial Costs, Suppliers):

In the longer term there is a risk that the Nurses Union will communicate negatively towards their members which could lead to no Nurses wanting to join.

Code: RW236-236CBPR
Theme: Policy and Regulation

Country of Origin/Context: France
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

The law does not allow us to hire nurse assistants, and we get paid per act. This is a barrier to implement a fully “integrated care” vision, including social care and case management.

Solution(s) Identified & their Outcomes:

We are working now on a new request for experimentation, to get the right to include nurse assistants with the care team. Return expected by summer 2020.

Further Information (E.G. Financial Costs, Suppliers):

This new experiment was not accepted.

Code: RW237-237LR
Theme: Recruitment

Country of Origin/Context: France
Local or Cross Border: Local
Sustainable: Yes

Description of the Barrier and/or Challenge:

In France we are not allowed to do any kind of publicity, hence it is difficult to grow awareness amongst care professionals. The Nurses Union believe our aim is to "kill" the self-employed nurse system and they then refuse to communicate about the project

Solution(s) Identified & their Outcomes:

Further Information (E.G. Financial Costs, Suppliers):

Code: RW238-238LCOMP
Theme: Competition

Country of Origin/Context: France
Local or Cross Border: Local
Sustainable: No

Description of the Barrier and/or Challenge:

In France the competition from self-employed nurses is tough. In one city they joined together to ask the mayor to block the creation of a TICC team.

When we start new teams in a new city, there are lot of partners to see before being able to start work. Sometimes it's hard work starting new teams, sometimes it takes a very long time, sometimes it doesn't work at all.

Solution(s) Identified & their Outcomes:

Identify sectors with less competition, go into the bigger cities where a new team is more acceptable.

We start new teams near teams that are already accepted and established and not in an area too far away where it can be difficult to stand alone.

Further Information (E.G. Financial Costs, Suppliers):

In the midterm, we have more and more homecare workers asking to work on self-managed teams.

Code: RW239-239LE
Theme: Evaluation

Country of Origin/Context: France
Local or Cross Border: Local
Sustainable: No

Description of the Barrier and/or Challenge:

It is not possible to set up a control group, to compare interventions from TICC nurses to “regular self-employed nurses”.

Solution(s) Identified & their Outcomes:

We have therefore looked to set up a research program to extract data from the health insurer’s databases.

Further Information (E.G. Financial Costs, Suppliers):

The Evaluation partners will work with the French partners to resolve this issue without it there is a risk that the project fails.

Code: RW240-240CBSM
Theme: Self management

Country of Origin/Context: France
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

Running a self-managing team requires more/efficient internal communications.

Solution(s) Identified & their Outcomes:

All our team members establish a set of self-managing team golden rules or charter in which they have created their own 'DNA' or identity and set out their own rules and describe how they as a team will deliver the home care service.

They now talk and listen to each other and participate in regular supervision sessions. This mirrors the team agreements that other partners have set up or are used by Buurtzorg.

Further Information (E.G. Financial Costs, Suppliers):

'Communication' was set as golden rule #1 by our team members. This has strengthened the 'team spirit' and today our coach can confirm that the team has stabilized since they have set and followed their own 'golden rules'.

Adhering to their rules is also a prerequisite for applicants to join their team.

Code: RW241-241CBW
Theme: Workforce

Country of Origin/Context: France
Local or Cross Border: Cross Border
Sustainable: Yes

Description of the Barrier and/or Challenge:

The team members have never been used to direct communication between colleagues. Running a self-managing team requires more/efficient internal communication.

Solution(s) Identified & their Outcomes:

It takes time, training and coaching intervention to raise the level of communication maturity. We learn by our errors, which can cause pains.

All our team members establish a set of self-managing team golden rules' or charter in which they create their own 'DNA' or identity and set out their own rules / describing how they will deliver the home care service. They organise their own internal communication training for the team members.

Further Information (E.G. Financial Costs, Suppliers):

This has resulted in more work training in collective intelligence.

There is a need for more initial training to ensure future professionals are aware of the importance of personal development in the exercise of the profession.

Appendix B Glossary of Terms TICC Project

ADDENDUM TO THE WORLD HEALTH ORGANISATION GLOSSARY OF TERMS FOR COMMUNITY HEALTH CARE AND SERVICES FOR OLDER PERSONS

items addendum	describtion
(omaha) Assessment	The Omaha System is a standardized taxonomy used for planning, documenting, and analyzing client care. It includes a problem classification system (42 environmental, psychosocial, physiological, and health-related behavioral problems), an intervention scheme that covers different services, and an outcome-rating scale for knowledge, behavior, and health status. It is used not only for planning and documenting care but also for billing and analyses of patterns of services.
Bachelor nurse	A bachelor educated nurse
Back Office	The internal operations of an organization that are not accessible or visible to the general public, providing functions s.a.reception staff, rental office administration, payroll, personnel, accounting, client administration, logistics, assessment and intake, and Ecare Helpdesk
Care plans	Care created by a health or social care professional fo clients as a result of structured and standarized assessment of clients needs
Community care areas	Defined geographical areas of service delivery
Community health care (UK definition)	Focuses on the delivery of clinical/medical care only, in or close to the patient's home, as opposed to WHO definition ("Includes health services and integrates social care. It promotes self care, independence and family support networks"). Commissioned and provided by the NHS or on its behalf.
Community dwelling	Old people who live in the community (= the local community) on their own (= without anybody's help) in their own private homes, as opposed to those (who are) taken care of in nursing homes.
Community health and welfare service	Community based services that deliver a wide range of services, from public health and preventive services in the community, to primary health care.
Community nurse (UK definition)	Working in a variety of environments, from clinics and health centres to residential accommodation and patients' own homes, community nurses help meet the needs of elderly, disabled or vulnerable patients who may not be able to easily visit the hospital. Community nurses are trained to perform a variety of nursing procedures which may include: • basic care - such as checking temperature, blood pressure and breathing • administering injections • assisting doctors with examinations and medical procedures • cleaning and dressing wounds • setting up intravenous drips and monitoring ongoing care source = https://www.nursingtimesjobs.com/article/the-role-of-a-community-nurse/

items addendum	describtion
Domiciliary care (UK definition)	Supportive care provided in the home, usually by professional caregivers who provide daily assistance to ensure the activities of daily living are met. It generally involves non-medical care, custodial care, or private-duty care which refers to assistance and services provided by persons who are not nurses, doctors, or other licensed medical personnel. Note the broader definition of the WHO ("Care provided in an individual's own home"). Commissioned by local authories and provided by a mix of private, public and not-for-profit sector organisations. Source= https://en.wikipedia.org/wiki/Home_care
Diploma nurse	A professional educated (diploma-degree) nurse
District nurse (UK definition)	See Community nurse (UK definition). Sometimes a District Nurse is understood to be a more senior community nurse, who leads a team of nurses and support workers. Source = https://www.qni.org.uk/nursing- in-the-community/work-of-community-nurses/district-nurses/
Employment based worker	Health or social care professional that work for an employer and are paid directly by that employer.
Entrepreneur	Health or social care professional who starts and runs a business and is responsible for all the risks and rewards of his or her business venture
Federal health care administration	A public social security institution that manages and supervises the compulsory health care and benefits insurance
Fixed fee	A fixed amount specified in a contract including all services required to complete the care
Formal networks	The net of supportive formal caregivers
General practitioner	A physician whose practice is not oriented to a specific medical specialty but instead covers a variety of medical problems in patients of all ages. Also called family doctor.
Group practice	Community-based practice run by several health or social care professionals
Health care insurance	Insurance that covers the whole or a part of the risk of a person incurring medical expenses, spreading the risk over a large number of persons.
Heat shield	Will enable the nurses to develop the model in a protected environment, leaving them free to care for their patients without being drawn into the processes of the existing and complex system.
Home care (UK definition)	See Domiciliary care (UK definition)
Informal networks	The net of supportive informal caregivers
Integrated care in community	Integrated care is concerned with improving patient care through better coordination. A decision about the intensity of integration is essential, starting with links across services, coordinating teams or pooling resources.

items addendum	describtion
Non-group practice	Community-based practice run by a single health or social care professional
Nurse-led community care	A nurse-led, nurse-run organization of self-managed teams that provide home care to patients in their neighborhoods.
Patient-centered care	In patient-centered care, an individual's specific health needs and desired health outcomes are the driving force behind all health care decisions and quality measurements. Patients are partners with their health care providers, and providers treat patients not only from a clinical perspective, but also from an emotional, mental, spiritual, social, and financial perspective.
Planned care	The care is scheduled in advance, and thus not an emergency
Professional competences	A cluster of knowledge, skills and attitude that enable a person to to act effectively in a professional situation
Regional care areas	Regional defined geographical areas of service delivery
Regional coach	Supports self-managed teams in their performance, decision-making and team processes, leaves initiative with the teams, supports up to 50 teams in a region.
Regional coordinator	Supports self-managed teams, is involved in recruitment and absences, manages contacts with municipalities and other partners.(Role applies to Buurtdiensten and Familiehulp only). Are employed at headquarters, tend to have been nurses and support about 30 to 50 local teams.
SDMI	Solution Driven Method of Interaction – a communication tool used by Buurtzorg professionals to efficiently and effectively reach decisions by consensus
Self-management	Being in control of how core responsibilities are fulfilled and organised, and of the essential processes that support this core process, within the boundaries of a defined framework.
Self management client	Self-management relates to the tasks that an individual must undertake to live well with one or more chronic conditions. These tasks include gaining confidence to deal with medical management, role management, and emotional management
Self-managed teams	Small, local teams of 8-12 professionals who deliver care to people in their homes and manage all the processes surrounding this, including care co-ordination with other professionals and organisations, rostering, appointments, referrals, assessments, performance management, recruitment, office, admin, etc.
Small scale normalised living	Home-like, holistic and person-centred approach. Where participation in daily activities is stimulated. Groups are relatively small (usually 6 – 8). Day schedule according to resident's preferences. Environment is familiar and home-like. Staff tasks are integrated. More individual decision making by staff members.