Collated Slido Questions from "Neighbourhood Care What Next Event?"

	Question	Suggested for	Response
Top Ten	**How do you shift from management to a coaching model?**	**Mairi Martin (MM)** **Brendan Martin (BM)**	(MM) Cornerstone introduced 7 Coach roles into the organisation. We removed the hierarchical structure from the self-organised teams from the beginning. No managers manage any self- organised teams. Used the GROW model of coaching. Hold 3 day training sessions. Changing the organisation's culture to a coaching approach (BM) Buurtzorg is not a coaching model. It provides person-centred holistic care through self-managed teams of professionals supported by their organisations, including regional coaches. In Buurtzorg there is on average one coach to every 45 teams – a ratio that is sufficient to support freedom and responsibility in the teams without being over-intrusive
	How do we overcome fear of loss of professional identity? This is currently a barrier to joined up care/minimising number of contacts	**Maria McIlgorm (MMc)** **Jane Johnston**	(MMc) It is understanding the contribution and role of all professionals across the whole spectrum of care that helps ensure clarity around professional identity (BM) How much of a barrier is this really? We meet many, many nurses who see their

			role holistically as combining the highest level of clinical intervention with personal care
	Where do people see telecare/telehealth in this approach	**Callum Cockburn (CC)**	(CC)Telehealth/Telecare should be at the forefront of thinking when it comes to delivering the neighbourhood care approach. It ensures that you are keeping the person at the centre, allowing them to manage their own health and wellbeing from their own home or community at their own discretion (BM) The same as any other tools that would help rather than substitute for person-centred care
	How do we link NC with primary care transformation to maximise opportunities and avoid duplication/clashes?	**Fiona Hodgkiss (FH)**	(BM) Start from the perspective of the person needing support and develop the logic from there
	Are some policies actually barriers to working in a self-managed way?	**Maria McIlgorm (MMc)** **Jane Johnston**	(MMc) I don't think it is the policy that is a barrier but sometimes how systems are set-up. The challenge is introducing self-managed teams within current systems which have not been designed to support that way of working (BM) Yes! That is why the framework for self-managed teams needs to be as brief as possible while ensuring the key goals – great care, staff wellbeing

			and sufficient efficiency – and non-negotiable legal and regulatory elements are the frame within which the teams can self-manage
	How has the care inspectorate responded to this approach?	**Claire Drummond (CD)**	Responded to on the day. Awaiting wording.
	What do you think is most important message to senior managers who want to support delivery of neighbourhood care principles in practice?	**All** **Western Isles (WI)** **Stirling (S)** **Highland (H)** **Glasgow City (GC)**	(WI) Be prepared to be flexible and shift or remove any barriers that might get in the way. Empower staff and give them permission to make decisions and work in different ways. (S) Be supportive and directive with your teams. They need to know what your vision is and how you expect them to get there. Without support and direction uncertainty increases and this can be barrier to team development. This support and direction should be applied towards other department leads in your wider partnership organisations as without their buy-in and certainty around what is expected of them, you will face barriers to developing new pathways for collaboration of health and social care workers (H) Involve everyone early on- including staff side- agree a vision and have everyone sign up to it. Keep the vision at the forefront of all you do.

			Project support helps keep momentum and offers objectivity. Don't be afraid to try things and ditch them if they don't work. (BM) Have a mind-set dedicated to providing the frontline professionals with what they say they need to do their jobs, rather than telling them how to do their jbos, and build trust through dialogue (MMc) The importance of recognising and understanding the learning so far from the Neighbourhood care work and other work in Scotland. Recognising the importance of ensuring each member of the team understands their role and contribution within a team context. The importance of culture as an enabler or resistance to change. The importance of recognising the challenges and working to help remove the barriers to change (GC) That staff are empowered to make decisions that improves service users/patient outcomes within their gift. Celebrating effective MDT working and developing relationships. That change takes time and requires

			investment in engagement with all partners
	How do we make better use of the wide range of social care partners in neighbourhood models of care? What about private sector providers? Not just NHS and HSCP?	**All**	(WI) We include them in many of our meetings and they are involved in NHS training and we are included in theirs (S) This is something which the rural west Stirling team aspire to address. However, barriers in terms of current organisational procedures mean we have made little progress in this department. For the time being the team are working on ensuring good verbal communication between services (H) Start with the person being cared for- what do they need? Where can that be sourced? Use all available resources. (BM) Check out the onion model and work with anyone in informal or formal networks that share your values and provides good quality (MMc) I think this is about learning from the work so far (GC) I think you first need to start a dialogue to understand what is available in your neighbourhood, and what the gaps are. We have had good

			engagement with a variety of partners in Glasgow and have been supported by them to work in a variety of ways
	There are so many models for keeping people in the community longer, does this add to the complexity or can they be complimentary?	**All**	(WI) I feel if it works and incorporates some of the principles then surely they must complement (S) I think at the core of all community based models of care there is the same value of working together to support the person to maintain their independence, health and wellbeing. Everyone is trying to achieve the same thing, what matters is how health and social care workers/teams connect with each other and work together to support the person. In this respect I feel that different models can be complimentary of each other (H) Use a model that fits with your area's requirements, location, infrastructure. (BM) Thinking again about the onion model, work to draw on as much expertise and commitment as available for a common purpose, but someone must take the co-ordination role, and in Buurtzorg that is the neighbourhood team

			(MMc) I would challenge back and say how do we use the learning to develop a one team approach for Scotland and how do we ensure this is closely linked to our community assets? How do we make neighbourhoods small enough to really engage with communities, reduce fragmentation, promote continuity and ensure better outcomes (GC) I think you should aim for a range of complimentary models as one size does not fit all – this means about understanding what is needed and what is available
	How do you overcome existing management hierarchies?	**All**	(H) If you work it out tell me (BM) By creating a 'bubble' within which you create and grow your greenfield operation and protect it from the hierarchical norms – grow the new organically within the old until it is the norm (MMc) Work with teams to co-design new models of care.

Other questions/Specific for presenter(s)	**- How do we spread the principles of Neighbourhood care across Scotland?** **- How do we harness the hope and positivity we've heard describes today and share, at pace, across Scotland?**	**All** **Chris Sutton**	(WI) There must be a unified message from the highest level in Scotland that these are the principles we are all aspiring to and should be incorporating into our work places. Hope is infectious –so sharing not only on line but networking shadowing between sites etc etc— share the learning and the dream (MMc) The learning from Neighbourhood care is crucial to supporting integration at the point of care. This now needs lifted to a strategic level incorporating learning from across country and linked to pathways of care especially for the older population (BM) Create the organisational environment in which the teams can flourish, enable them to learn from each other in their own ways, and let it grow at its own (not a forced) pace.
	How are teams working with 3rd sector does anyone have any good examples of this?	**All** **Neighbourhood Care Sites**	(MMc) There are variations however, this has been one of the complexities in embedding the model that my understanding is that teams are still working through (S) The rural west Stirling team is connecting with the 3rd sector through their Community Reference Group and the Resource Worker. 3rd sector representatives participate in the community reference group, generating partnerships between the team, the community and themselves. The resource worker supports the development of these partnerships. Some of the work going on is; Linking with Strathcarron Hospice to generate wider social supports for people with palliative care needs and their carers/families;

			Working with Trossachs Search and Rescue to create faster response times for people who have fallen; Linking Strathendrick Care home with Alzheimer's Scotland to generate more dementia friendly services (H) Living well project in Oban- supporting people with frailty to improve their wellbeing and function. NHS/LA/3rd Sector
	How does NC link with local authority housing departments? Feedback from our recent consultation flagged up a challenge around availability/house type/adaptations	**Ruth Robin (RR), Portfolio Lead (Place, Home & Housing) Improvement Hub (ihub)** **All**	(RR) ihub has a programme based on brining housing and health together. In relation to adaptations we have a programme named 'Housing Solutions' information and modules are hyperlinked below. The 'Housing Solutions' training programme applies the principles of Adapting for Change, and supports strategic service change and improvement across partnerships. It focuses on encouraging wider responsibility across our housing, health and social care services for the much earlier identification and discussion of housing needs and solutions. https://ihub.scot/improvement-programmes/place-home-and-housing/adapting-for-change/housing-solutions-training/ (WI) I guess it's about relationships and involvement in the team to an extent. (S) Availability/ house type/adaptations has been a focus of our team's Community Reference Group and also a community consultation on the HSCP priorities. While the team are trying to improve the delivery of adaptations with our OT's role in integration, it seems that this is really a wider partnership issues to address. The report from our community consultation on the partnership priorities suggests that more integrated working is needed

			between HSCPs and local authority housing departments to address this issue (MMc) Needs to be engaged at a local level (BM) See earlier points about onion model and formal and informal networks. (GC) In Glasgow City HSCP, we have established good links with a wide a range of housing providers (our City Council does not provide housing) We need to understand the requirements of all parties and aim for a win win situation. Housing providers have the interests of their tenants at the centre of how they work
	S Lanarkshire's presentation. Saved £35k but how much did care at home resource cost council?	**South Lanarkshire**	Difficult to quantify as the Home Carers are based in ICST and are utilised for other Home care roles across the patch, both facilitating earlier discharge for up to 72 hours pre a core POC and also supporting acutely unwell patients to remain at home. Calculation for the £35k included cost of medical bed days for 18 patients / 5 days stay in hospital.
	Is there an ideal population size for a neighbourhood care team to serve. If so, who needs to be "in" the team?	**All**	(WI) I think this depends on geography demographics etc. The core team are those closest to the "individual" The wider team can be more fluid as needed. (S) Buurtzorg recommend a population of around 14,000 having care delivered by a team of up to 12 nurses. However, Scottish Models have a lot more variety in team and population size alongside an integrated focus. So really it's up to you and what you want to achieve by developing Neighbourhood Care. Although larger teams can make the self-organising principle more complex to implement.

			Also, Neighbourhood care is as much about connecting with other community health and social care services as it is about how teams work together. So even if you decide to not have, for example, OT's on your core team that doesn't mean that your team can't work with the local OTs (H) Teams and populations of varying sizes. Hard to say which is better. (MMc) In Buurtzorg – teams usually cover a population of 10,000 and the teams size is no more than 10 – 12. The teams in Scotland have not been aligned in this way. Buurtzorg teams can as it is an insurance based scheme can select their referrals. This is not the case for example district nurses within Scotland who do not operate a waiting list and receive referrals as they come into the system (BM) In Buurtzorg it is 5 – 10k population size, but many are larger to begin with and reduce as teams expand and divide over time. (GC) I don't think you can set an ideal size, it's so variable ie geography, population etc. This is the same with the team, I would recommend as broad a skill mix as possible underpinned by key best practice principals.
	Impressed by removing the need for referral, multiple assessments and reducing time for support - was the capacity readily available to make this happen?	**South Lanarkshire**	Additionality in resource to the Integrated Community support Teams initially was to cover overnight nursing and Homecare for 7 nights. Occupational Therapy and physiotherapy hours were added to the nursing teams for in hours. Being one whole integrated team enabled person centred approach with no addition referrals thereafter.

	For South Lanarkshire is the nursing component of your icst a district Nurse of is district nursing a service that sits alone but alongside icst	**South Lanarkshire**	Pre ICST there was a standalone District Nursing Service. Separate from this was an Occupational Therapy and Physiotherapy service. Once we moved to ICST– Integrated Community Support Team it now includes District / Community Nursing, Occupational Therapy / Physiotherapy – Registered staff and Support / Assistant Practitioner staff and our day time test includes Home Care staff in one of our ICSTs. Our overnight team have had Home care integrated since 2015.
	For South Lanarkshire I understood that NHS Lanarkshire has of had a hospital at home service is your act service an extension of this??	**South Lanarkshire**	Hospital at Home is in the other three localities in South Lanarkshire. Clydesdale being predominantly rural does not have H@H. It was desirable for Clydesdale to configure a model which would meet the needs of a dispersed population over a 24 hour / 7 days / week as opposed to a service model delivering core hours over 6 days. H@H has consultant medial component, ACT has GP responsible MO.
	What is a 'heat shield'?	**Brendan Martin**	We are reconsidering this term, but the role is to be the guardian of the bubble mentioned in answer to an earlier question. The role is a transitional one and acts as a liaison point between the team and the wider organisation to protect the team from the normal processes and convey information in both directions
	In Angus, apart from ACP, were there other interventions that the ECS team carry-out to support people live at home for longer?	**Angus**	
	Angus, are all these staff co-located?	**Angus**	

	How do we embrace transformational change as exemplified by cornerstone in the statutory sector?	**Chris Sutton** **Chris Bruce** **All**	(H) Would welcome it (BM) Through organisational leaders with the vision to repurpose their whole organisation to providing the frontline self-managed professionals with what they say they need to do their jobs, rather than telling them how to do their jobs, and by tackling the many detailed organisational issues arising from that
	Cornerstone : do we have feedback from the people who are receiving the care. Was feedback sought regularly as the concept rolled out	**Mairi Martin**	
	Does Neighbourhood Care only work in rural areas?	**Mairi Martin** **Brendan Martin** **All**	(BM) No. Both in the Netherlands and in England we have seen how it can work in urban areas too (GC) For me Neighbourhood Care is not a 'noun' rather a series of principles that should reflect your organisation and place the patient at the centre.
	South Lanarkshire has hospital@home, is this an alternative to H@H? A replacement?	**South Lanarkshire**	As above
	Are the Glasgow teams a single team per neighbourhood or is it several teams that work well together?	**Glasgow City HSCP**	Our neighbourhoods function at a Service Manager / Team leader level. We are clustering a range of service and teams at neighbourhood level. it is actually both a neighbourhood leadership team and individual teams
	South Lanarkshire are carers employees of South Lanarkshire or independent care companies	**South Lanarkshire**	South Lanarkshire Council carers have supported our Test of Change and are partners in our overnight team.

	There seems to be a variety of available supportive IT out there. How can we address this variance and make it a level playing field?	**Callum Cockburn**	Work is underway through the National Digital Maturity Assessment to understand the current level of variation in use of IT across Scotland https://www.digihealthcare.scot/ Our national Digital Health and Care Strategy https://www.digihealthcare.scot/wp-content/uploads/2018/04/25-April-2018-SCOTLANDS-DIGITAL-HEALTH-AND-CARE-STRATEGY-published.pdf also recognises the need to improve the current IT infrastructure. The NES Digital Service https://nds.nes.digital/ has been created to take forward the development of a National Digital Platform which will ensure the secure movement of data for those who need it when they need and in a way that is suitable to the person whose data it is
	Are we too obsessed with team and management structure rather than function? Have we started at wrong end of spectrum- what about users needs and experiences?	**Maria McIlgorm All**	(H) Need to start with the person and build the team around them. Structures get in the way but that is what is important to staff and is a common reaction to change- best to find something in the middle. (BM) Yes! The logic of self-managed teams in Buurtzorg, and of the organisational changes required to support them, starts from the needs of the person requiring support. As Jos de Blok 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."*** (GC) You need to operate at both ends of the spectrum to effect real organisational change you need 'buy in' and support from the management level but need to identify what is required both from a 'front line staff' as well as a service user's needs and experiences.

	How do we capture and share the evidence created by all the wonderful work? In other words, how do we know and learn from the experience of integration?	**Alec Murray (AM) Chris Sutton (CS)**	(AM) Capturing and evidencing impact on integrated care is always challenging. During the 3rd year of the collaborative teams have helped to develop a set of 10 common measures that will help with this in phase 2. Three sites have been supported to carryout local evaluation (available if you join the Neighbourhood Care KHub website) and the three year pilot is also undergoing national evaluation (due April 2019 on the LWiC website).
	Does Glasgow city have a plan for aligning homecare to neighbourhoods?	**Glasgow City HSCP**	There is already some alignment between Homecare and Neighbourhoods but further development is required.
	Did Clydesdale need to create a single point referral system once became integrated team?	**Greater Glasgow & Clyde**	
	How is Professional Governance and working to standards within of scope of practice assured in Buurtzorg approach	**Brendan Martin**	Not easily answered briefly, but essentially the peer support and challenge within self-managed teams is the first (and most important) safeguarding line, complemented by the vigilance of the coach, of the support centre (spotting indicators), and all further supported by regular patient feedback (both informal and formal) and external inspection. The most recent Buurtzorg inspection was in 2018 and Buurtzorg scored top marks in all categories
	What were the challenges with overnight support being provided by LA home support	**All Neighbourhood Care Sites**	(WI) Our test was around end of life care and we struggle on the island with overnight care/ support generally. Any care was carried out by CNurse however I think we will be looking at this again in more detail (H) Overnight support v limited and is contracted out.
	Does the regular huddle in Monifeith include	**Angus**	

	the extended team if they can make it?		
	For cornerstone did you have questions from staff that you couldn't answer and how did you respond to these	**Mairi Martin**	
	Cornerstone are inspiring! Well done		
General Questions	**Why do we have such misgivings about self-managed teams?**	**All**	(WI) I personally think it's a culture thing but it's also about career structure (S) There are really so many factors here. Organisational structures and procedures make it difficult for teams to have the autonomy they need to self-manage, in turn creating anxiety for workers around what is expected of them vs what they can realistically achieve. Also, especially within social care, workers have been conditioned to need permission/approval from managers before they can act. Meaning there is a need to support workers to develop confidence to self-manage. However, where the rural west Stirling team do self-manage they are being successful and demonstrating how much simpler delivering care is when it is managed directly between the necessary workers (BM) Great question! Many aspects to the answer, but most fundamental because we have allowed low trust cultures to develop in organisations and systems that make rules for the exception rather than empowering professionals to

			act with freedom and responsibility and support and challenge each other to do so. No doubt the challenges associated with organisational disruption at times of stress and with reorganisation that can reduce and change management and administrative roles also play their part (GC) We have unfounded concerns about 'letting go'. We have many teams who self-manage workloads on a daily basis
	Can we include other social support to combat loneliness? Gyms, classes etc	**All**	(WI) A great idea. Nurses here have had some involvement with the schools and exercise in care homes along with third sector (S) Definitely. This is part of the Resource Worker's role in the rural west Stirling team. The resource worker helps to identify and address informal support needs of the people in our NCT's care. So far he has connected people to local lunch clubs, volunteer opportunities, support groups and is also working with local partners to increase this informal resource for the people in rural west Stirling. The resource worker also works within the team to promote community supports which has resulted in team members actively considering informal support when planning care for people (H) Essential to include (BM) Absolutely fundamental to the Buurtzorg model. That is what mobilising and developing informal networks and building capacities for self-care is all about.
	How do the carers, GP's, social work carers	**All**	(WI) As nurses we have a regular weekly meeting with carers in each area. Sometimes OT, SW or anyone who might want to pass on

	etc all communicate?		information will come to that meeting. We have a regular H&SC Team meeting with all others including third sector in attendance. They also attend discharge planning meeting at the hospital weekly (S) The best way to do this is making people aware of one another and enabling good conversations and collaborative working between NHS and LA services (H) With difficulty (BM) The best way is by building strong relationships with each other face to face and individuals and using that strong foundation for ad hoc communication as and when required. Of course IT also helps, but is necessary rather than sufficient
	Is changing talking about services and 'social work' and 'health' to just teams of people with distinct professional skills what we needs to scale up NhdC?	**All**	(S) This is idea is quite ambitious. Health and social care workers have a very strong identity around their roles, roles are important for the public to understand what a worker is there to deliver/help them with (managing expectations of health and social care) and there are a lot of competing social factors between health and social care workers, both historic, and more recent. As health and social care partnerships develop it is likely that social factors and, potentially managing public expectations, will become less of a barrier to this but the identity a specific role gives to a worker is important to the pride and passion they have in doing their job, so the importance of role identity to workers is unlikely to disappear any time soon. At this stage I think the focus should be on developing a joined up language between health and social care workers. Such as, instead of saying "patient" or "service user," we could just talk about the "person." This seems like the first,

			achievable, step towards a joint identify for health and social care workers. (BM) Of course language shapes meaning, so the more we can develop a vocabulary suited to the fundamental purpose the better. (GC) The language and how we communicate is a really key element in the move to Integration but you cannot underestimate the power of a 'professional identity' has for individuals , for Glasgow it's about emphasising the benefits to the service user
	How do we change patient/public expectation of care?	**All**	(S) This is difficult to solve and is something that all HSCP in Scotland are trying to address. In Stirling the following has been especially useful in beginning to address the public perceptions of Health and Social Care Services; Good conversations and meaningful engagement with communities when developing health and social care. Clear and accessible communication about health and social care services for the public. Have effective signposting and support to access informal supports in the community. Developing greater inter-role understanding and knowledge between health and social services to ensure appropriate referrals and to support effective communication with a person using a service (H) Public health campaign- media advertising (BM) By enabling the frontline to build the relationships required and reinforcing this with public messages in an honest way. (GC) I think we need support from Scottish Government level to do this, there are many pieces to this jigsaw

			underway: ACP/ Power of Attorney/ GP contract etc all heading in a similar direction but not brought together under the one banner….
	Could multiple teams, although of benefit to patients and service users, be streamlined by increasing resource and therefore capacity to DN teams	**All**	(WI) I think you have to look at different areas and see what needs there are locally. Sometimes in very remote areas you are wearing several different hats and there is very little third sector groups etc—so it's important to know your own "Neighbourhood" (GC) You need to understand the needs and demands of the service users and then identify the most appropriate ranges of skills and professionals to deliver or meet this demand. It's not about redirecting resource to one group, it should be about a broad review