# Home care improvement

**Award winning 70:20:10 Project**

70 20 10 INSTITUTE

# Context of the case

The organization provides care and a sheltered environment, mainly for elderly people with physical limitations. To enable these clients to live as independently as possible in their own homes, they provide housework support, home care and various forms of specialized home nursing and treatment. They also provide services for rehabilitation cases. The organization has many different residential locations in which clients receive intensive care and guidance in sheltered surroundings. Clients may stay temporarily at these locations if, for example, they are in a rehabilitation process. This case described here relates to the Home Care Business Unit in the organization.

### Home Care in the Netherlands

***Home Care**, (also referred to as **domiciliary care** or **social care**), is health care or supportive care provided in the patient's home by healthcare professionals (often referred to as home health care or formal care). Often, the term home care is used to distinguish **non-medical care** or **custodial care**, which is care that is provided by persons who are not nurses, doctors, or other licensed medical personnel, as opposed to **home health care** that is provided by licensed personnel.[1]*

*Licensed personnel and other persons who assist the individual may be referred to as caregivers.[2] Caregivers may help the individual with such daily tasks as bathing, eating, cleaning the home and preparing meals.*

*For terminally ill patients, home care may include hospice care. For patients recovering from surgery or illness, home care may include rehabilitative assistance.[*

*The Netherlands has a national social insurance scheme that covers the whole population. The cost of homecare, residential homes for the elderly and nursing homes are covered by this insurance scheme. The premium is financed as part of the incometax. The scheme is, risc free, executed by the insurance companies for the people who have normal health insurance plan with them. Nearly everybody is covered in that way. There are 350 nursing homes with 68,000 beds in the Netherlands.*

*At this moment Independent regional organizations define care-needs and rights on 7 care need levels. The nursing homes and home care organizations get paid based on the care level of the client. So if you need more care, you will get a high care level and therefore an amount of minutes that care personnel can take care of you. The organization should be aware to deliver not more minutes as requested or indicated because of the fact that they will not get paid for these minutes. This is a culture shift in care organizations, especially for care personnel, because not only quantity counts but also quality and they are not used to think in money as they take care for their clients or patients.*

*The quality of care is evaluated once per two years and controlled by the government (Dutch Health care Inspectorate) and is made public. This is the so called CQ index and the Normen verantwoorde zorg Standards of Responsible Care. One of the quality indicators is the care plan. Every client or patient needs to have a care plan where all the professionals around the client is obliged to report about the clients healthcare and also the consent.*

# Performance Detective

Here we briefly describe the outcomes of the Performance Detective. He executed the following tasks:

- Business Analysis: need and business issue;
- Performance Analysis: desired and current performance and the performance gap;
- Root cause analysis.

## Business analysis, performance analysis, root cause analysis

Business analyses, performance analyses and root cause analyses were conducted under the guidance of an external coach with expertise in corporate consultancy and change management. The idea was to look at the actual situation from a fresh perspective. Maximum use was made of the measurement tools that the organization used for management purposes. These tools could then be used again for evaluating the practice. The steering committee validated and prioritized the analyses on organizational level. The organizational factors that were needed to start a cultural change project were first put in place (structure and process redesign).

Later an external partner with learning expertise was hired to determine the tactical and operational learning needs. Tactically the performance check and root-cause analysis were applied with Rummler´s nine boxes model playing a key role to identify causes on corporate, process and professional level. A Plan-Do-Check-Act cycle was constantly applied for each operational care team whereby each part of the team action plan was subjected to an ongoing performance and root-cause analysis (based on the desired corporate results). This was used as a basis for agreeing on and implementing new actions. Accordingly, both managers and personnel were permanently involved in the analyses. The main performance issues and the root causes were discussed in the steering committee every month.

The assessment approaches are shown in the table below.

| Assessment approaches | To identify | Who (external coach in association with support departments) |
|---|---|---|
| Source studies (policy government, internal)<br>(business analyses) | Image, strategy issues | Internet, local and national government |
| Interviews with senior management of the home-care organization (business analyses, performance analyses, root cause analyses, learning needs) | Management problems, structure | Senior management, including CEO, Home Care Director, Financial Controller, regional management |
| Interviews with external stakeholders<br>(business analyses) | Image | Representation municipalities, family doctors |
| Interviews with the client panel (business analyses, performance analyses, root cause analyses) | Image, client satisfaction, collaboration with management | Client representation |
| Interviews with support staff (performance analyses, root cause analyses, culture analyses) | Employee satisfaction, process analyses, cooperation between support staff and management | Support staff, communication, HR, finance, training, quality |
| Focus groups / team meetings (performance analyses, root cause analyses, culture analyses, learning needs via Plan-Do-Check-Act method) | Employee satisfaction, identify factors that block performance Need for support (informal/formal learning), cooperation with management | All teams |
| Measurement/financial reports/ client satisfaction surveys/employee satisfaction surveys/ICT systems | Productivity, production, costs, turnover, absenteeism, client satisfaction, employee satisfaction, number of medical and other errors, use of systems, spreading knowledge | Documentation, validation HR/Finance/ICT |

# Business needs

The organization is in the process of developing from a traditionally structured to a future-proof home-care operation that serves its market in a professional manner. It works with referees and stakeholders in an atmosphere of professionalism and trust. Clients can expect an integrated approach if necessary. The organization will do everything necessary to enable people to retain optimal independence and their accustomed lifestyle.

- The Home Care project aims within a two-year timescale:
- to make home care at least cover its own costs;
- to improve the result by 1-1.5 million;
- to utilize growth opportunities in the region;
- to increase the number of satisfied clients;
- to increase employee satisfaction;
- to improve the image among referees / stakeholders.

At the start of the project there was pressure on the financial results which threatened to jeopardize continuity. It was also important to become attractive as an employer in the region to prevent outflow to competing organizations and to increase the appeal of this labor market as a whole. A stronger regional presence in relation to the chain partners (hospitals and municipalities) was crucially important in order to make up for the dwindling government funding, to safeguard the continuity of the organization, and to play a meaningful role in the regional first line care.

- Gaps at organizational level:
- Turnover and productivity too low;
- Negative contribution to the budgetary result of the concern;
- Productivity too low to survive, top-down management nearing its end;
- Concern costs are too high;
- Sickness absenteeism 8.7 %;
- Customer satisfaction 80%;
- Insufficient local strength and integration;
- High levels of dissatisfaction among personnel, breakdown of trust in the management;
- Poor image among stakeholders and family doctors.

## Report analysis

The decision was made together with the steering committee (including the CEO, the Home Care Director and management representatives) that an approach was needed that would provide support for both managers and personnel and which would enable more knowledge-sharing and interventions in order to achieve sustainable improvements. An approach that addressed every aspect throughout the organization seemed the only way to realize the desired cultural change and organizational development. The organization was convinced that traditional means such as workshops for the various target groups would not deliver the required results. Furthermore, it was clear that structural changes were needed and a process redesign on corporate level before interventions could be started at team level. The design was linked to the root causes which had been validated with internal and external stakeholders. In addition, after being approved by the CEO and the steering committee, the design was discussed with the project group and the work group), so all levels of the organization committed to the design.

At first, root causes were found at three levels:

- Organization
    - The vision of the future of home care with external and internal stakeholders lacked clarity, incomplete idea of the activities in the coming years;
    - This was leading to inadequate steering by the management;
    - Top-down management based on one-sided financial results was undermining the relationship of trust between senior executives and personnel;
    - Insufficient information supply for results on every level;
    - Very low alignment in organization due to post-merger period.
- Process
    - Unclear processes, not enough clarity on connection with clients;
    - White spaces between the support service processes and the primary process.
- Performer
    - Corporate results not properly translated into team performance and team action plans; actions to optimize business operations were insufficiently followed through in the workplace;
    - The system of 'That's how we do things here' (shared values) was underdeveloped and not generally accessible;
    - Personnel felt they did not get enough support and that the registration process was too complicated (which caused irritation); the personnel also felt they did not get enough time to provide proper care.

The care teams were not systematic enough in making improvements to their work. They did not share improvements with the rest of the organization.

These causes needed to be addressed on system level; the structure needed to be redesigned (more small-scale teams). Managers would have to be supported for longer and the care teams had to be able to operate independently.

More traditional interventions such as workshops or roadshows would not work because of the time required to reach everyone. Also, it was clear pretty soon that a smarter, more modern approach to knowledge-sharing was required, as the spread of personnel across a large swathe of North Holland and the individual character of the work (clients are visited individually) had led to many performance leakages.

# Performance Architect

The Architect designed the '100': a mixture of 70, 20 and 10 solutions. In this paragraph we describe the process of cocreation, de design itself

## Design the '100'

The most important stakeholders were involved from the start in the phased shaping of the design in co-creation. Eventually, the final design was determined by all relevant stakeholders, including the CEO and the Home Care Director.

The design is described as a learning and performance landscape in which care professional networks cooperate, communicate, develop and share knowledge, and learn from and through each other, with as features:

- *Performance (HPI method)*

Assessments are consistently performed to determine whether any performance problems are caused by a deficit in competence or organizational barriers. The structure and processes and the output-based steering were, for example, redesigned to facilitate the changeover to a new organizational format. This was a major precondition for the further development of the organization.

- *Continuous co-creation*

The starting point is that co-creation continuously enriches the learning and performance landscape with current and relevant best practices and nice-to-know and need-to-know information.

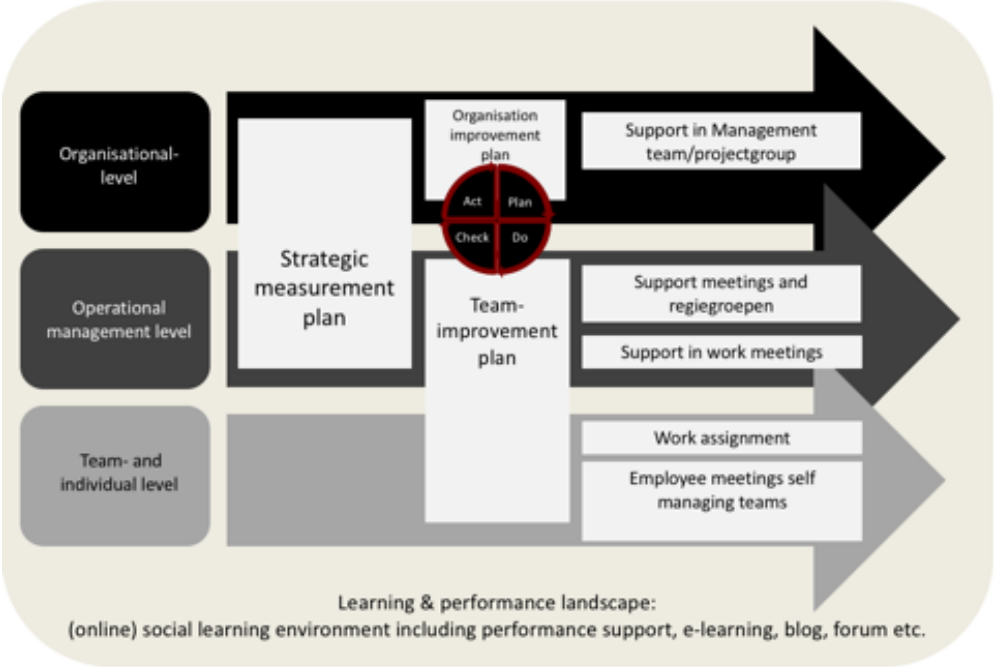
- *Informal learning with social software*

*Social software* was used to strengthen informal/formal learning by making effective use of a virtual environment containing contemporary social media tools.

- *Formal and informal learning solutions*

Formal training courses, meetings for informal learning at the workplace to strengthen the organizational development program.

| **More specifically, the following solutions, clustered into four lines, are planned.** | | |
|---|---|---|
| **Line** | **Solutions** | **Results** |
| 1. Visible from nearby | - Strategic reorientation;<br>- Formulate strategic goals;<br>- Process design, define strategy with regions. | - *Clearer focus on the future of the organization in consensus.* |
| 2. Preconditions strategic work/creation of learning environment | - Redesign structure and processes<br>- Set up autonomous, local teams<br>- Overall mix of functions per team<br>- Reduce management<br>- Local ICT support<br>- Translate analysis results to performance | - *Clearer organizational design and management agreements*<br>- *Uniformly organized local teams*<br>- *Concordance role/extent management*<br>- *Local access to harmonized ICT systems* |
| 3. Pulling together for a healthy business | - Analyses of business operations in regions;<br>- Bring into line with strategic program;<br>- Improve activities for business operations. | - *Brings speed to the problem-solving capacity of managers and personnel.* |
| 4. Leadership program and employee participation | - Digital working and learning landscape. | - *Improved problem-solving capacity in the regions;*<br>- *More autonomy among personnel;*<br>- *Management based on improvement processes.* |




## The solution fits the interest of the organization, employees and clients

- Interests of the organization
    - The solution meets the criteria co-created by the organization for the design.
    - The solution is efficient and cost-effective, reflected in the design by the emphasis on workplace learning.
    - The educational function is reinforced by linking formal and informal learning. Traditionally, the learning function is geared primarily to formal learning. This reaches only 10% to 20% of all personnel on a regular basis. Though this practice has increased penetration, the educational offerings have been expanded and learning in the organization is no longer limited to the controlled supply of formal training and coaching.
    - All information, experiences, and best practices are available via the virtual platform. Accordingly, learning is not an isolated but a continuous activity which individuals or groups can keep using as long as it serves a function.
    - The solution will be integrated into the core business of the organization. This is a sustainable intervention.

- The redesign fits in with the local tasks and the embedment that is needed to make the income and market position of the home-care organization future-proof;
- The professional-client relationship as the axis in the management of care, quality, work, and turnover is thus made possible in the design and can be used in the learning program;
- The subsequent savings in management and support will enhance cost-effectiveness;
- Consistent steering is realized on the basis of quantifiable performance in order to facilitate local autonomy.

- Employee interests
  - Participation in a formal intermediate vocal education program with the prospect of formal qualifications. This is good for the employee's personal and professional development and his/her mobility potential;
  - Practice-based training has led to greater acceptance and improved the effectiveness of the training courses;
  - The major advantage of context-specific workplace learning is that custom-made work is realized per department;
  - Less theoretical instruction in the classroom. This links up with the learning style of the professionals: they are the doers who need the context in order to learn. Theoretical instruction has less effect;
  - Optimal deployment of best practices and best performers and existing and developing practical knowledge (tips and pitfalls);
  - Employees report more involvement and a deeper mutual understanding and appreciation of one another's qualities. Teamwork is very important to employees who work individually. It enhances job satisfaction.

- Client interests
  - Home care will continue as a service in an area with growing numbers of older people and declining numbers of younger people;
  - Fewer different faces in the home;
  - Better quality care;
  - Opportunities for more customized care, local coordination, because personnel concentrated solely on the district;
  - Faster and more direct contact with the care provider.


70:20:10 Solutions

# Performance Game Changer

The game changer has a very important role in this case. She executed the following tasks:

- Align with stakeholders
- Organize communication
- Team

We describe most interesting activities in this paragraph.

## Alignment

The chosen method of improvement affects the whole organization. This system approach enables senior operational management and employees who collaborate in structuring all the activities, ensuring alignment with the implementation of the organizational strategy. Previously, different types of training, learning and other activities would have been organized separately – which hinders alignment on system level. Now, all activities are closely linked.

It was clear that the causes existed at different levels in the organization. This led to interventions at these levels. It began with a redesign on corporate level and was followed by parallel support for the teams to improve team performance, to learn together, and to share best practices with support from the social learning platform. The ultimate aim was to bring about a total cultural change.

First, the strategic and tactical corporate goals and the positioning were aligned. This led automatically to the redesign, which binds the strategic goals with the structure and culture. The entire project was geared to improving the corporate results, so the connection more or less went without saying and monthly monitoring took place through a dashboard on corporate and team level.

Snapshot presentation of the connection:

- Quality of care
- Cost reduction
- Productivity
- Client satisfaction

- Absenteeism
- Employee satisfaction

The innovative approach to learning in this practice makes a concrete contribution to the strategic development of the organization, in which innovative forms of learning are seen as a necessity.

# Collaboration

| | |
|---|---|
| ***Phase 1**: Work group:* | |
| *Roles* | *Tasks* |
| - CEO, CFO, CO-HR, Operational Director Home Care Controller<br>- Senior management home care (COO, Home Care Director)<br>- Employees (selection)<br>- External partner (coach change-management process).<br>- Concern management team members | - Redesign strategy, corporate structure and processes; development and decision-making processes in collaborations with Works Council, the Client Panel and the Supervisory Board;<br>- Needs assessment, cause analyses, design practice;<br>- This collaboration was useful because the direct connection between corporate results and practice was guaranteed. |
| ***Phase 2:** Home care steering committee (strategic level)* | |
| *Roles* | *Tasks* |
| - Executive Board (concern level), Home Care Director, HR Director, CFO, expert in redesign & change management coach (partner);<br>- Financial controller;<br>- Formal decision-making by Executive Board (concern level). | The steering committee was initially responsible for the redesign of the strategy and organization, for the setup of the working/learning environment and the decision-making in the organization on every level. In the implementation phase this role shifted toward reviewing the proposals, monitoring progress and management of the entire process. As chair of the steering committee the CEO was responsible for unity within the Executive Board of the organization. The Home Care Director took care of the agenda. |
| ***Phase 2:** Home care project group* | |
| *Roles* | *Tasks* |
| - Home Care Director;<br>- COO;<br>- HR Director, (technical chair);<br>- Business Control consultant;<br>- Home Care financial controller;<br>- Project worker;<br>- External partner (expert in redesign & change management coach);<br>- Personnel from marketing, communication, HR and ICT. | • Prepare and implement the action plan and program and coordinate the parts and the whole;<br>- Prepare discussions steering committee and decision-making by the Executive Board;<br>- Bundling the tactical home-care responsibilities in this group enabled the balance between implementation, policy formation, adjustment, progress and decision-making to be monitored. |
| ***Phase 3**: Working group for learning and performance* | |
| *Roles* | *Tasks* |
| - CO –HR;<br>- Staff services communication;<br>- Training manager;<br>- Project manager;<br>- Operational management;<br>- External partner.<br>- | - Monitor learning and performance progress in the teams. With the aid of this group the learning materials were continuously improved and adjusted. The operational management was also responsible for making and monitoring the improvement plans drawn up by the teams (team action plans). This created a direct connection between the management, the teams and the team performance targets, which were based on the corporate results. |

| ***Phase 1, 2 and 3**: Sounding board group, personnel and client panel* | |
|---|---|
| Roles | Tasks |
| Employees and clients:<br><br>Direct impact on employee satisfaction and client satisfaction. | Employee sounding board group:<br>- Raise employee commitment, develop and secure the policy with a support base;<br>- Test plans against the actual situation in the organization from the start;<br>- Learning workplace for employees and (senior) management to engage in dialog and then achieve results together;<br>- Share information and knowledge. Sharing the debate and knowledge, gives form and substance to collective learning. |
| | The client panel:<br>- External testing;<br>- External communication to strengthen and sharpen the image. |

# Performance Tracker

The Performance tracker executed the following tasks:

- Describe a measurement plan
- Collect data
- Report to client

## Measurement plan

At the beginning of the project, an measurement plan was made. Here is an overview of the planned evaluation per level of Kirkpatrick/Phillips. We chose to have the evaluation take place as much as possible during the planned intervention.

| Level | Method of data collection | Source |
|---|---|---|
| **5: ROI / financial impact** | Data collected from Finance and Control, Quality Management, HR | Quality Reports<br>Production figures 2010/2011<br>Management Control |
| **4: Impact on organization** | Quantitative analysis of achieved results<br>Qualitative analysis of achieved results<br>Interviews audit | Quality reports and surveys<br>Production figures 2010/2011<br>Management Control<br>Benchmark, team dashboard<br>Internal audit (customized tool developed for this organization) |
| **3: Application of material learned** | Feedback collected from trainers/coaches/ Survey<br>Interviews with and observation of managers and specific team members<br>Analysis of team improvement plans<br>Analysis of platform content | Employees<br>Managers and employees<br><br>Improvement plans<br>Platform |
| **2: Learned knowledge and skills** | Feedback collected from trainers/ Survey<br>Interviews with and observations of managers and specific team members<br>Analysis of team improvement plans<br>Analysis of platform content | Employees<br>Managers<br>Platform |
| **1: Response and satisfaction process** | Feedback collected from trainers/ Survey<br>Interviews with and observations of managers and specific team members | Managers and employees |

The project was evaluated:

- Once per 2-4 months in the steering committee
- Once per month in the control group/teams using the team dashboards
- On an ongoing basis via the social media platform

## Evidence and metrics

**Financial metrics:**

- Production/turnover figures
- Productivity figures
- Overhead figures
- Net result

**HR metrics:**

- Employee satisfaction score
- Employee absenteeism figures

**Quality metrics**:

- Client satisfaction score (CQ index, national indicator of quality of care)
- Number of error reports ("MIT reports")

The priorities shifted in the course of the process. Initially they were geared to finance and survival; once these had been achieved, they were replaced by quality and satisfaction. As a result, the corporate design measurements, and application and maintenance increased in importance.

**Costs**

| Costs | | Fiscal revenues&subsidies | | |
|---|---|---|---|---|
| Externe partner (coach verandermanagement, redesign) | € 197,627 | Support program Dutch government, European subsidies social innovation. | € 197,627- | |
| Externe partner (leren en presteren, interventies managers, medewerkers) | € 804,000.- | Fiscal compensation | € 804.000,- | |
| Social learning platform | € 341.530 | | | |
| Internal costs (including absenteeism due to activities project) | € 525,000 | Internship fund Dutch Ministry of Healthcare (to support organizations) | € 94.800,- | |
| Totale costs | €1,868,150 | Total revenues | € 1,098,00 | €770,150 |
| | | | | |

**Because of the chosen design and the innovative character of the organizational development practice the organization was able to make use of subsidies of European and Dutch government and to make use of fiscal compensation for the support meetings and learning and performance program for managers and employees.**

# RESULTS

**Business impact**

To get an overview of the results see a table with KPI and the results of year 1. The financial revenue was 2,002,00 for this year. The expectation is that this is just the beginning. Because of the design of the solution, the results will be sustainable.

| KPI | Result | | | Remark |
|---|---|---|---|---|
| | Year 1 | 2011 | | |
| A positive result In Q4 2011 after cost allocation: turnover | €27,587,000 | €29,607,000 | €2,020,000 (positive) | The product mix was changed. The care was more complex and more intensive;<br>A higher volume was generated (more hours of care delivered). |
| After cost allocation the budget made a positive contribution to the concern | €- 1,389,000 | €+ 592,000 | €1,981,000 (positive) | Increased volume and product mix;<br>Increased employee productivity;<br>Decrease in absenteeism;<br>Lower cost allocation internal overhead. |
| Productivity rise of at least 4% | 60.4% | 63.4% | 3% (positive) | The other non-productive hours (not vacation, absenteeism, travel time) decreased by approx. 1%. These hours included administration, work meetings, training etc.;<br>Absenteeism was reduced by approx. 2%. |

| | | | | |
|---|---|---|---|---|
| A decrease of at least €750 in concern costs | €4,051,000 | €2,969,000 | €1,082,000 (positive) | There was a limited decrease in overhead components (after indexation);<br>Various regulation tasks were assigned to the self-managed care teams;<br><br>Follow-up actions drawn up to realize a further decrease in the coming years. |
| Client satisfaction | 80% | 94.2% | 10.1% (positive) | The care teams have been made smaller to ensure that the clients do not get many different care-givers;<br>Growing influence of frontline workers on client rosters (they are better acquainted with the clients' needs). |
| Employee satisfaction | 6.9* | 7.2 | 0.3 (positive) | More attention paid to the care professional, more autonomy (experienced influence) in the work;<br>Decline in absenteeism since the introduction of local, small-scale care teams;<br>More autonomy in personnel and client rosters;<br>Attention to working conditions. |
| Decrease of at least 1.2% in absenteeism | 7.6% | 5.7% | 1.9% positive €350,000 | |
| Error reports | 234 (medication-related incidents)<br>157 (non-medication-related) | 231<br><br>116 | -3<br><br>-41 | In 2010 there was enormous under-registration in one part of the working area. This explains the wide differences in the figures;<br>A strong focus among the personnel on good medication safety as a result of the medication safety program.<br>There was a greater willingness to report incidents. |

## Participant behaviors

The intervention changed the behavior of the personnel, the managers and the support staff. Care is now being increasingly provided in small-scale, self-managed teams and delivered in a more demand-driven setting.

- A different management format is increasing output and creating space for co-creation, bottom-up initiatives and hence more self-management in the organization;
- Self-managed local teams are resulting in new forms of cooperation with the management and the workers (redesign);
- As a result of the intervention, 70-90% of the personnel are working on primary care tasks and on preconditions so that they can operate as self-managed teams (redesign);

- 90-100% of the teams have adopted a more systematic approach to work meetings and client discussions. This raises efficiency levels and generates initiatives for quantifiable improvements.
- The digital platform has led to more efficient and effective internal coordination (e.g. digital transfer of client information and changes in the rosters);
- 90-100% of the teams have learned to work with the Plan-Do-Check-Act improvement methodology with quantifiable results for the organization;
- 90-100% of managers have reported a significant improvement in internal communication: more feedback, an increase in problem-solving capacity and self-management among the personnel and teams;
- The action plans show a shift from internal team business to coordination with other teams and support services in the region;
- Support departments are more focused on providing direct support for the teams;
- HR offers concrete tools such as competence management and team assessment and development systems;
- Managers are steering more clearly on an output basis. The 'what' is more clearly defined, so that the teams can give form and content to the 'how';
- Managers are facilitating the teams more effectively in terms of organization and preconditions;
- Managers are giving the teams more effective feedback on performance and are using the team dashboard in order to provide them with consistent support in the realization of sustainable improvement.
- Dissemination and production of knowledge via the social learning platform (see the attachment nr 5 to this proposal for examples). Note:

These figures show that the platform is visited frequently. The platform was used very regularly in employee meetings as a tool for exchanging information and knowledge and was consulted as a source of information for the project. The employees and the managers are very enthusiastic about the possibilities of the platform. This appears to be creating entirely new opportunities for the development of KPIs to measure the effectiveness of educational efforts.

**KPI: Platform statistics**

Definition: Penetration via the platform

| | September | December | April |
|---|---|---|---|
| **Visits** | 1,338 | 4,344 | 6,619 |
| **Visits per day (average)** | 45 | 141 | 221 |
| **Unique visitors (IP addresses)** | 607 | 1,473 | 2,013 |
| **Average visit time (minutes)** | 6:28 | 6:20 | 5:56 |
| **Page views** | 13,665 | 42,411 | 58,019 |
| **Page views per visit** | 10.21 | 9.76 | 8.77 |
| | | | |
| | | | |
| | September 2011 | December 2011 | April 2012 |
| **Blogs** | 163 | 421 | 623 |
| **Forum** | 838 | 7,076 | 9,308 |
| **My profile** | 152 | 1,403 | 1,624 |

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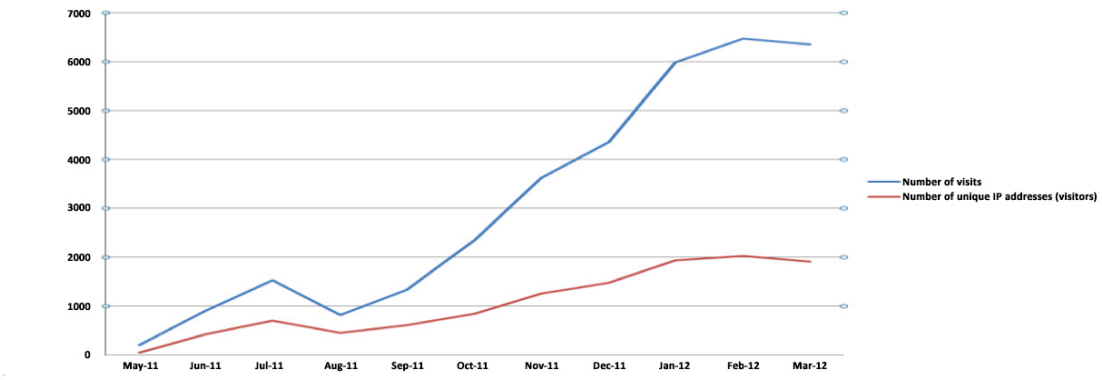


- The Executive Board has said that it has made a huge turnaround during the project. An important place has been accorded to a vision of management that is executed from a perspective of personal leadership. Decisions to establish and build consistently on principles of local autonomy call for regular reassessment and testing. This is accomplished by performing regular external audits.
- The managers say that they find it difficult to think consistently in terms of output and to formulate systematic goals that can be passed on to the teams. A series of six development meetings has been

scheduled for the second project year to address this problem. These will consolidate what has been learned in the first project year.

- The teams, managers and support services agree that the Social Learning Platform is extremely effective and efficient as a channel of communication and information. Vertical coordination is being replaced more and more by horizontal coordination. The platform will have to be developed further in order to optimize the effects of this turnaround. A separate working group has been set up for this purpose.

## Other results

- The support services and senior management are taking a greater and more direct interest in what the employees do and how they contribute to the corporate results.
- Mutual trust has improved on every level in the organization.
- External partners and stakeholders such as municipalities and family doctors are more satisfied with the organization.
- Innovation in the primary process is developing and is spreading through the organization in a simple, uncomplicated fashion.
- Both managers and team members report more employee involvement in giving a concrete form to district-based work.
- The digital learning and performance environment has made the management and support services more visible.
- Client feedback conveyed by the personnel confirms that the teams are organizing the services more and more around the client.
- The project has encouraged the personnel to make more use of modern information and communication technology. Information is permanently available and is being shared more efficiently. It is no longer possible to circumvent the digital world. The project has more or less forced everyone to find out more about ICT and to connect with modern working methods. Knowledge and information that used to be buried deep in the organization have become more generally available (democratization).

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