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The Buurtzorg Nederland (home care provider) model

Observations for the United Kingdom (UK)

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Purpose of this briefing

This briefing considers the successes of the Buurtzorg community care programme while also identifying some of the challenges which would need to be addressed if the UK were ever to adopt a similar system approach.

The findings have been updated following a joint Public World¹ / RCN stakeholder seminar in July 2015. This event was attended by Buurtzorg's founder and head - Jos de Blok, who explored in more detail the development of the model, as well as answering more specific questions about how Buurtzorg's approach might be applied in the UK.

The seminar also coincided with news that Guy's and St. Thomas' NHS Foundation Trust is scoping a 'Buurtzorg-style' pilot in London, demonstrating strong interest within the NHS for tapping into the success of this model.

An introduction to Buurtzorg

What is it?

Founded in the Netherlands in 2006/07, **Buurtzorg is a unique district nursing system which has garnered international acclaim for being entirely nurse-led and cost effective.** The latter point has sparked particular interest in the UK where a key challenge is meeting the needs of an ageing population increasingly susceptible to co-morbidity and complex long-term conditions.

Buurtzorg was set-up by Jos de Blok (himself a former nurse) who envisaged a reformed district nursing system in the Netherlands. Prior to Buurtzorg, home care services in the Netherlands were fragmented with patients being cared for by multiple practitioners and providers.

Ongoing financial pressures within the health sector led to home care providers cutting costs by employing a low-paid and poorly skilled workforce who were unable to properly care for patients with co-morbidities, leading to a decline in patient health and satisfaction.

Buurtzorg's answer to this problem was to give its district nurses far greater control over patient care – a factor which it attributes as key for its rapid growth. In 2011, Buurtzorg employed nearly 4,000 district nurses and nurse assistants across 380 teams. By 2013, this had

¹ Public World (2015), <http://www.publicworld.org/projects/>

risen to 6,500 nurses (an increase of 62.5 per cent) across 580 teams.² **Today, Buurtzorg's workforce cares for over 70,000 patients and, according to Mr de Blok, some 50 per cent of these have some form of dementia.**³

How does it work?

Nurses lead the assessment, planning and coordination of patient care with one another. The model consists of small self-managing teams of a maximum of 12 professionals (comprising both nurses and other allied health professionals). These teams provide co-ordinated care for a specific catchment area, typically consisting of between 40 to 60 patients.⁴

The composition of these teams in terms of specialty and level of practice varies according to the needs of each catchment area.

In the Netherlands, integrated care has been cited as easier to deliver because district nurses tend to be well known in the small neighbourhood/community they work in. This has helped them to build good working relationships and strong dialogue with GPs, home doctors, police, paramedics and social care providers.

In terms of revenue, approximately 90 per cent of Buurtzorg's income comes from payments by Dutch health insurance companies. As part of the Health Insurance Act (2006), private health insurers were given a more prominent role in increasing health system efficiency through prudent purchasing of health services on behalf of their customers. **Insurers are regulated under public law and are required to accept all applicants.** More information on the role of insurers in the Dutch health system can be found here: <http://www.commonwealthfund.org/publications/fund-reports/2015/jan/international-profiles-2014>

What services does Buurtzorg provide?

The Buurtzorg model comprises six key services. These are:⁵

1. Holistic assessment of the client's needs which includes medical, long-term conditions and personal/social care needs. Care plans are drafted from this assessment
2. Map networks of informal care and assess ways to involve these carers in the client's treatment plan

² KPMG International (2012), Value walks: Successful habits for improving workforce motivation and productivity. <http://www.kpmg.com/global/en/issuesandinsights/articlespublications/value-walks/pages/improving-workforce-motivation-productivity.aspx>

³ Figure provided by Mr de Blok at Public World/RCN stakeholder seminar in July 2015

⁴ Buurtzorg Nederland (2011), 'A new perspective on elder care in the Netherlands' available at: http://omahasystem.org/AARPTTheJournal_Summer2011_deBlok.pdf (accessed on 12 July 2014)

⁵ Ibid

3. Identify any other formal carers and help to co-ordinate care between providers
4. Care delivery
5. Support the client in his/her social environment
6. Promote self-care and independence.

The aim of this approach is to engage three key national health priorities:

- **Health promotion,**
- **Management of conditions,** and
- **Disease prevention.**

Buurtzorg cares for patients who are terminally ill, suffer from long-term conditions, dementia or require home care following major surgery. Most of the nurses who join Buurtzorg are trained at a 'generalist' level – similar but not directly equivalent to a UK Registered Nurse in Adult Care. This allows them to deliver treatments from wound care and diabetes monitoring to IV infusion therapy and end-of-life care. **Importantly, unlike in the UK, there is no formal district nursing qualification in the Netherlands.**

Buurtzorg's successes

Buurtzorg has achieved some notable breakthroughs, particularly in the following three areas (each of which is explored in more detail in this paper):^{6, 7}

- **Higher levels of patient satisfaction**
- **Significant reductions in the cost of care provision,** and
- **The development of a self-management structure for nurses.**

Importantly, it's not just nurses who have noted the positive impacts of Buurtzorg. While better patient outcomes are the most notable of its successes, Buurtzorg has also drawn attention from politicians and other health workers as a money-saving model. To take one example, Buurtzorg is currently working with Dutch hospitals to apply the model's principles in acute care settings. Mr Blok estimates that up to 50 per cent of care provided in the Dutch hospital system could be done more effectively and cheaply in the community nursing sector.⁸

⁶ Ibid

⁷ Ibid

⁸ Figure provided by Mr de Blok at Public World/RCN stakeholder seminar in July 2015

On higher levels of patient satisfaction:

- **Buurtzorg has delivered improved quality of patient care through 24/7 access to a district nursing team via phone or a home visit service.** Results have shown a correlated decrease in unplanned care and hospital admissions, as well as better patient satisfaction when compared to other home care providers in the Netherlands
- **In 2009, the Netherlands Institute for Health Services Research (NIVEL) found that Buurtzorg had the highest satisfaction rates among patients in the country⁹**
- As of June 2014, the University of Minnesota is finalising a design for a Buurtzorg pilot model with funding being provided both by the university and by state/federal health authorities as part of the Affordable Health Care roll-out.¹⁰ Buurtzorg's patient satisfaction rates were a key incentive for this project being undertaken
- During the Public World / RCN seminar in July 2015, Mr de Blok revealed that Buurtzorg uses the Omaha system to help measure good patient outcomes. The Omaha method is a research-based taxonomy (classification) designed to enhance practice, documentation, and information management across settings. It is especially popular in home care, hospice and assisted living case-management settings. More information on the Omaha system can be found here: <http://www.omahasystem.org/problemratingscaleforoutcomes.html>

On reducing the costs of care:

- By limiting managerial structure and bureaucracy, **Buurtzorg's nurses have greater autonomy to organise their own client visits and day-to-day nursing interventions.** This has reduced administrative costs and time spent on paperwork
- **A 40 per cent reduction in client costs when compared to other homecare organisations, indicating potential national savings of €2 billion euros (£1.9 billion) per year.¹¹**
- **A 50 per cent reduction in hours of care** due to health promotion initiatives and promotion of self-care and patient independence¹²

⁹ AARP (2013), 'Buurtzorg Nederland: Nurses Leading the Way!', available at: <http://journal.aarpinternational.org/a/b/2013/06/buurtzorg-nederland-nurses-leading-the-way> (accessed on 02 July 2014)

¹⁰ Buurtzorg USA (2013), 'About', available at: <http://buurtzorgusa.com/about.html> (accessed on 02 July 2014)

¹¹ AARP (2013), 'Buurtzorg Nederland: Nurses Leading the Way!', available at: <http://journal.aarpinternational.org/a/b/2013/06/buurtzorg-nederland-nurses-leading-the-way> (accessed on 02 July 2014)

¹² Ibid

- Buurtzorg's overhead costs are estimated at eight percent, compared to a competitor average of 25 per cent¹³
- Despite being a not-for-profit organisation, Buurtzorg registered a four per cent profit margin in 2014¹⁴
- In terms of staff efficiency, sickness rates for 2014 was four per cent, compared to a competitor average of six per cent¹⁵

On promoting self-management for nurses:

- Buurtzorg has consistently been ranked as number one among all home care organisations according to a national quality of care assessment survey. In 2011 and 2012, Buurtzorg was named Dutch employer of the year¹⁶
- Approximately 70 per cent per cent of Buurtzorg's nurses are Registered Nurses (RNs) and 40 per cent hold a bachelor's degree level, compared to a 10 per cent average for other Dutch home care organisations¹⁷
- Buurtzorg's approach to continuing professional development/education (CPD) also reflects its ethos of professional autonomy, with each nurse able to decide their own educational needs. According to Mr de Blok, each nurse has their own education budget and is supported with adequate time in order to undertake whatever learning activity they choose. Cumulatively, the total education budget is 3 per cent of Buurtzorg's income¹⁸
- Registration of patients' information, time registration and communication are supported by a web application called the 'Buurtzorgweb' which nurses are able to access directly in order to deliver better care and share information and best practice with each other
- This technological advantage also extends to practical equipment with all Buurtzorg nurses given an iPad and training to help them update patient records instantaneously¹⁹

¹³ King's Fund (2013), 'Buurtzorg Nederland presentation', available at: <http://www.kingsfund.org.uk/sites/files/kf/media/jos-de-blok-buurtzorg-home-healthcare-nov13.pdf> (accessed on 02 July 2014)

¹⁴ Figure provided by Mr de Blok at Public World/RCN stakeholder seminar in July 2015

¹⁵ Ibid

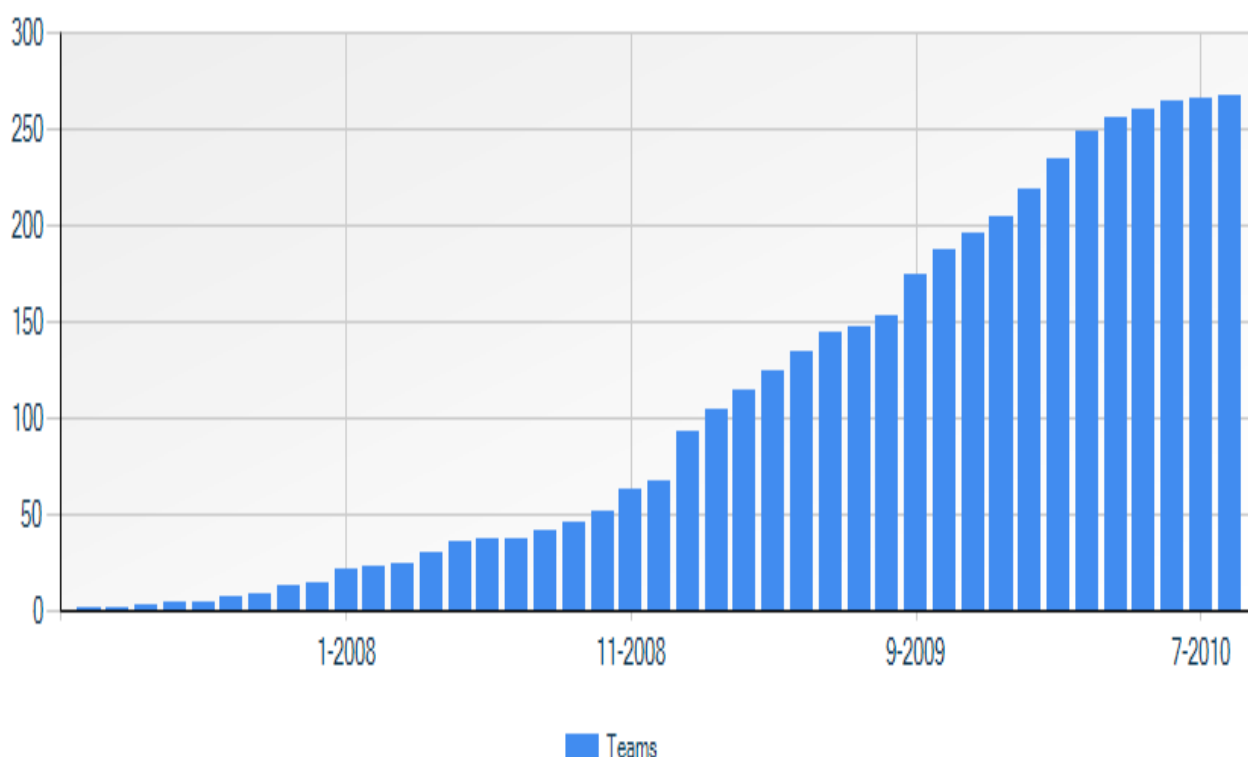
¹⁶ AARP (2013), 'Buurtzorg Nederland: Nurses Leading the Way!', available at: <http://journal.aarpinternational.org/a/b/2013/06/buurtzorg-nederland-nurses-leading-the-way> (accessed on 02 July 2014)

¹⁷ Buurtzorg (2014), 'Buurtzorg Nederland', available at: <http://buurtzorgusa.com/PDF/AJN.pdf> (accessed on 12 July 2014)

¹⁸ Figure provided by Mr de Blok at Public World/RCN stakeholder seminar in July 2015

¹⁹ Ibid

- **Buurtzorg prides itself on its non-hierarchical structure.** There are no leaders within the teams and individuals work on the basis of consent. This is helped by the use of a tailored coaching system. How this works is that when a new team begins, a coach is appointed to help them to recruit new colleagues, learn to use the Buurtzorgweb, divide the different roles in the team and build their network with other caregivers, both on a formal and informal basis
- Thanks to the Buurtzorgweb patient database and self-supporting teams, no managers are needed and the back office function is comparatively small, although growing – 47 employees was the figure quoted by Mr de Blok in 2015, compared to 20 in 2011. The focus on simple, accessible IT systems has helped to reduce the bureaucratic workload and Buurtzorg's back office function provides any assistance for what remains to be done in this area in order to minimise non-patient facing time by nurses.^{20, 21}
- Buurtzorg has grown rapidly - the below graph shows expansion in total team numbers up until 2010.²² **The organisation's ability to facilitate this rapid expansion evidences an integral structural foundation, as well as a strong recruitment appeal**



²⁰ Buurtzorg Nederland (2011), 'A new perspective on elder care in the Netherlands' available at: http://omahasystem.org/AARPTheJournal_Summer2011_deBlok.pdf (accessed on 12 July 2014)

²¹ King's Fund (2013), 'Buurtzorg Nederland presentation', available at: <http://www.kingsfund.org.uk/sites/files/kf/media/jos-de-blok-buurtzorg-home-healthcare-nov13.pdf> (accessed on 02 July 2014)

²² King's Fund (2014), 'Buurtzorg Nederland model', available at: <http://www.kingsfund.org.uk/sites/files/kf/media/jos-de-blok-buurtzorg-home-healthcare-nov> (accessed on 12 July 2014)

Observations on the Buurtzorg model and its applicability in the UK

Without a doubt, the Buurtzorg model has demonstrated considerable successes – especially in its demonstration of nursing capability and self-management in delivering better patient care. This was reinforced at the Public World / RCN seminar and from the news that Guy's and St Thomas' Trust is looking to emulate the Buurtzorg model in London.

Areas which the UK should be focusing on for implementation include:

- **Fostering a strong entrepreneurial innovation among nurses, supporting them to present tangible solutions to many of the significant challenges facing district care in the UK.** This approach has enabled Buurtzorg to win the endorsement of key observers both within and outside of the Netherlands.
- **Bolstering district nursing services, including: increasing district nurses' autonomy, allowing them to deliver patient-centred care, and by increasing funding for placements and training.** A 2013 report by the Royal College of Physicians concluded that, in their current state, health services for the elderly and vulnerable are variable, inconsistent and do not meet key needs. The report proposes that community-based health working, similar to that found in the Buurtzorg approach, should play a central role in future service deployment.²³
- **The Buurtzorg model works well in both urban and more sparsely populated areas – a factor which the UK can learn from.** According to the World Bank, the percentage of the national population located in towns or cities for the UK was 82 per cent in 2013, only slightly less than the Netherlands at 89 per cent.²⁴ This indicates that large numbers of patients are easily accessible to well-organised catchment teams, although care does need to be taken to ensure that rural populations in the UK are also integrated into any such model.

Challenges

Invariably, any effort to “lift” the Buurtzorg model and assume that it would immediately work in the UK is problematic. This is not to dismiss the importance of learning lessons from Buurtzorg's successes, but **it must be remembered that systems such as Buurtzorg have developed over time. Consequently, these models are suited to the unique nursing landscape, long-term care needs and funding systems of the host country.** In the case of Buurtzorg, some of the challenges which the UK would need to consider are:

²³ Royal College of Physicians (2014), 'The Future Hospital Commission: caring for medical patients', available at: <https://www.rcplondon.ac.uk/projects/future-hospital-commission> (accessed 18 July 2014)

²⁴ World Bank, Urban population (% of total), <http://data.worldbank.org/indicator/SP.URB.TOTL.IN.ZS> (accessed 25 March 2015)

- **Buurtzorg's dependence on insurer payments reinforces the need for a considered view as to how the UK can build the right incentives system in order to replicate its success in delivering good patient care and financial sustainability.**
- **The differing requirements regarding CPD for nurses in the Netherlands and the UK is a major challenge.** In the Netherlands, there is no system of regulation or mandatory learning requirements, whereas in the UK the Nursing & Midwifery Council (NMC) is planning to strengthen the minimum hour's requirement, along with tighter rules about how this time can be divided between participatory learning, as opposed to other methods.
- **Buurtzorg's stringently non-hierarchical approach might sometimes be counter-productive from an operational perspective.** For example, once a team has completed its coaching stage, it will not receive any additional support unless it requests this directly. Consequently, it is arguable that having a managerial position – even if this were elected from within each team – could help to identify key support needs, as well as helping to resolve disputes among staff which, at the present time, rely either on internal resolution, or on an intervention by Jos de Blok.
- **The absence of a managerial structure also raises questions about career progression opportunities.** Buurtzorg has undoubtedly been incredibly successful in recruiting more nurses into the community model. However, it would be interesting to gauge more about Buurtzorg's incentives system for bolstering retention, as well as recruitment. Without any managerial grades based on experience or time served, it is not entirely clear how Buurtzorg keeps its more established employees.
- **It is also important to note that self-directing teams need to be mindful of equality and diversity issues in the absence of a more centralised policy approach, and that their composition should reflect the communities which they serve.** During the Public World/RCN seminar, Mr de Blok highlighted specific examples of where team diversity within Buurtzorg was more in evidence, but also accepted that more could be done in this area.
- **Concerns have been raised that Buurtzorg's 24/7 care commitment could lead to work patterns which infringe on the EU Working Times Directive.** This has been cited in cases where a patient requires a visit or is in distress late at night and the responding team has already worked a full day attending patients.
- **There has also been concern around new legislation in the Netherlands which requires that insurance companies only pay for care hours worked.** Payments do not include any time spent by the nurse in planning care interventions or travel time to the patient's home, which can be difficult for more remote catchment areas.
- From a professional perspective, the Buurtzorgweb function has been a key innovation, enabling nurses to access and update patient information quickly and equitably (i.e. there are no systems

of restricted access according to seniority for example). Again, this is a very positive development which has reduced bureaucracy and improved patient care. **However, it has been noted that Buurtzorg teams often maintain paper records and documentation at the patient's home, raising issues around data security.**

- It has also been noted that **significant disparities in service provision can occur, especially depending on the time of day.** Night-time services for example tend to perform less well which indicates a significant patient risk, as many of Buurtzorg's patients are elderly or terminally ill and are therefore likely to need good night time care.
- **Buurtzorg's focus on reducing hours of care (about 50 per cent compared to other providers)²⁵ has raised concern that too little time may be given to patients.** Given that Buurtzorg's patient population is often frail with multiple conditions including dementia, there may be a risk that this approach limits critical patient-facing time.

View of the RCN

The RCN welcomes the remarkable success of the Buurtzorg model. Its demonstration of nursing capability and self-management in delivering ever better patient care is a great boost to the profession's morale, both in the UK and internationally and this was in evidence at the Public World/RCN seminar in July 2015. The RCN hopes that by learning from Buurtzorg's approach, the critical process of nurse-led innovation for patients – which was so important in forging Buurtzorg in the first place – can be strengthened in the UK.

However, the RCN also recognises that no model which seeks to address the incredible complexity of 'joined-up' community care, especially in times of tightened financial budgets and changing patient needs is ever going to be perfect.

In addition, while the challenges of care provision (especially for older people) across countries may be similar in terms of broad-brush description, they are rarely completely identical. **Consequently, lifting the Buurtzorg model as it is without considering the significant differences between the UK and the Netherlands in terms of funding structures, demographics and patient needs etc. will invariably present challenges.**

The King's Fund in its analysis of Buurtzorg has reached a similar conclusion. While extolling the model's virtues, it recognises that Buurtzorg's approach 'may not be right for all health systems but it highlights the potential benefits of taking a fresh look at professional roles.'²⁶ It is the view of the

²⁵ King's Fund, 'The Future is Now', available at <http://www.kingsfund.org.uk/reports/thefutureisnow/> (accessed 24 March 2015)

²⁶ Ibid.

RCN that this 'fresh look' can only achieve meaningful results if the central plank of the Buurtzorg model – its emphasis on nurses as self-managing agents of change – is maintained throughout.

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