When you go to as many meetings as I do, it’s not often you leave feeling genuinely energised and inspired by the encounter. That’s how I felt having met Jos de Blok at the end of June. He combines a deep commitment to care which puts the needs and preferences of each individual first, with a shrewd business knowledge and an entrepreneurial spirit. Heart, head and energy – powerful synergy.

Buurtzorg is the Dutch word for “neighbourhood care.” It’s not a new concept: in 1986, a Community Nursing Review led by Julia Cumberlege recommended the establishment of neighbourhood nursing services in each district. The Queen’s Nurses of Scotland practiced in this way for decades before successive reforms altered the way in which staff were deployed and managed. Jos’s work reminds us of the importance of working with and in neighbourhoods, where meaningful relationships are at the heart of all that we do.

And those relationships bring joy: joy to the clients and the workforce. Through their involvement with Buurtzorg staff, older people had the idea that their rehabilitation would be helped with an incentive – something to train for. So the staff introduced a rollator walking-frame race in the park, which has been repeated and brought to the Olympic stadium. Perhaps that’s part of the reason why Buurtzorg has been rated the best employer in the Netherlands.

Scotland’s Chief Nursing Officer is taking forward a review of District Nursing as part of the initiative Transforming Nursing Roles. This comes at the same time as the renegotiation of the General Medical Services contract for General Practice and the review of Primary Care in the out of hours period. The context we work in calls for working differently and that’s the challenge that Jos de Blok brings to us. Here is a man who has recognised the need for change and made it happen. Let’s see if we can work together, capture that entrepreneurial spirit, be inspired by the commitment to high quality care for people in their neighbourhoods and make a remarkable difference for Scotland.

Clare Cable, Chief Executive and Nurse Director, Queen’s Nursing Institute Scotland
Background to Buurtzorg in Scotland

In June, Andy Lippok of Resolis Associates Ltd. took the initiative to invite Jos de Blok, the innovator of Buurtzorg, to speak in Scotland and bring this work to a wider audience. Two workshops were held and the responses have helped to shape this report. A number of meetings were also held and there is interest in hosting pilots in Scotland.

Jos de Blok is the Director and Founder of Buurtzorg Nederland. Alongside his aim of developing a more person centred model of care, he has also revolutionised the organisational approach to delivering health and social care. Both are an integral part of the success of the model and contribute to the learning of the wider public sector as well.

Introduction to the Model: Buurtzorg meaning Community

To understand the model, you have to understand a little about Jos himself. He started adult life studying economics but realised it didn’t lift his soul. He found, however, that nursing did, especially Community Nursing. Many Community Nurses will recognise the joy he described in being able to provide care that helped people at their most vulnerable and enabled them to return to wellbeing. But in the Netherlands, like here, he saw the impact on healthcare of the imposition of bureaucracy and the breaking up of the care process. The stated purpose of those changes was to improve quality and cost efficiency, but Jos noted the paradoxical effect those changes had. Quality decreased, cost increased exponentially and those at the coal face were pushed to do more and more to bring costs down – a familiar story across western healthcare models.

The nurse’s role and influence on behalf of people diminished too. Alongside that, their sense of fulfilment in their role plummeted. Although he had reached senior positions in traditional care services, Jos decided to set up an alternative approach: working with a small group of like-minded others, he visualised, researched and developed a different model. After two years of planning they launched Buurtzorg, with only four nurses.

They now have over 9,500 nurses in 800 independent teams supported by only 45 backroom staff, 15 coaches and a bespoke IT system. This is a network, not a hierarchy and there are coaches to enable, not managers to manage. Sick leave is low, satisfaction is high, feedback is encouraged so complaints are non-existent, transparency is the norm; these results are transformational. Trust, flexibility and autonomy are the backbone of its success, set in the context of humanistic, person centred care. The approach is relational not transactional and offers 24 hour care in small self managing teams of no more than 12 nurses. The self managing client is at the centre of their vision and model, as is the community in which they live. After those comes the Buurtzorg team and last of all the formal networks.
Buurtzorg at one level is very simple: it is localised, self managed teams where relationships and wellbeing are at the heart of the model. At another level it’s a radical approach to organisation. Both views provide the opportunity for learning.

Creating a person centred approach is very consistent with the integrated organisational model currently being pursued in Scotland. But Buurtzorg is fundamentally about an integrated model of care, not structures. It’s about fostering human connections and holistic care rather than systems. Accountability stops with the practitioner so there is no inspection process; instead Buurtzorg is based on trust and focuses on transparency and simplicity. The model simplifies bureaucracy for care teams but most importantly also for the patient, who no longer has lots of different people coming to the door.

It’s also about organising care for the person within the context of their community and support networks: person centred and not organisation centred care. It’s all about relationships and trust based on the understanding that targets and bureaucracy often work against human relationships.

The integration of health and social care in Scotland provides the opportunity for working differently and putting the person and their community at the centre of care. However, there remains the risk that the focus becomes organisation centred rather than relationship centred. The experience from Buurtzorg is that the use of language is key to changing culture: the talk is ‘back office’ rather than ‘head office’, ‘network’ as opposed to ‘hierarchy’, ‘coaching’ rather than ‘managing’. Small is beautiful for Buurtzorg, with teams of 12 proving the optimum number to enable self management and quality.

What can we learn from this in Scotland?
Quality does matter, but the system focuses on outcomes not processes, using the Omaha model\footnote{1}, which is linked to clinical outcomes. This system provides a structure to document clients’ needs and strengths, describe multidisciplinary practitioner interventions and measure outcomes in a simple yet comprehensive manner. In addition to this, a bespoke IT system acts as a support mechanism for the teams and feedback is the focus for improvement, not scrutiny. Trust is reported to be a fundamental component of the success of the model.

The focus on networks rather than hierarchy frees up the skills and the personal accountability of the people in the teams. The answer does not lie within the hierarchy, it lies within them. Where knotty problems exist, coaches are drawn on rather than managers. Coaching comes from the belief in people’s own capacity to find answers, but also supports them with information and challenge to enable people to work at the edge of their comfort zone. There are few meetings; instead people are encouraged to get out and connect with people. The norm in the Scottish system is to focus development and responsibility for change only on leaders; Buurtzorg supports leaderful behaviours at all levels and develops all of the team not just those at the top.

More of the nurses are qualified, with 40% having a bachelor degree, compared to the focus in Scotland on skill mix and the reduction of qualified staff. In spite of this, the cost per client is cheaper than standard approaches in the Netherlands as there is less need for visits. Perhaps this reflects the impact of focussing on holistic needs and not just on one part of the system. The Buurtzorg model has resulted in a reduction in hospital admission rates alongside a high level of satisfaction with the care provided.

These achievements did not happen overnight. Buurtzorg was built up incrementally, focussing on people and relationships, listening to people and building services and support around the individual person. This needs wide commitment from politicians, service leaders, the teams themselves and the public. Moving from control to trust requires significant buy-in and an ability to stay with the process of transition. The experience of Buurtzorg would suggest that the results make this very worthwhile but that it can’t be half done; it needs commitment and trust at all levels.
Where do the challenges to implementation lie?

Understanding what we are trying to fix

At some level there is a question of whether this challenges the concept of the NHS itself as it’s a self managed concept which puts the person not the organisation at its centre. The NHS is such an important institution within our society that there is a fundamental resistance to anything that seems to challenge its foundations; politically this would be untenable. Therefore the question in Scotland would be: how do we utilise the principles of Buurtzorg in the system of a National Health Service?

Recent health and social care policy documents express a commitment in their language of seeking person centred, community-based approaches. The concept developed by Buurtzorg offers a potential approach to this radical change. The challenge is that Buurtzorg’s transformation model took place within one profession at a time, when in Scotland we are trying to bring cross organisational and professional teams together. Interestingly Buurtzorg started with nursing and is now working across other professions such as AHPs. The uni-professional model which was originally tested it now being widened. The challenge will be how to widen the scope whilst still focussing on an organisational approach that favours small and simple.

Bureaucracy: trust vs control

The main factor in Buurtzorg’s success seems to be trusting more, controlling less and focussing on clinical and personal outcomes as the main measure of quality. This has delivered a high quality service with no complaints, a very different situation to the norm within most Western systems of healthcare. To successfully implement this way of working differently there would need to be a commitment across all stakeholders, including the public and politicians. Moving from a management system to a coaching model needs different skill sets or different people. Therefore any transition would need to build the skills of coaching and enabling change, as well as building trust in the people and the new system.
Moving from leaders to being leaderful

Empowered and confident people and teams will enable the shift to happen. Again, support to make that shift will be important; giving up power and taking up power are two sides of the same process. The role of the back office becomes one of creating the right conditions for the people to provide the right service and the right time. It could be argued that the level of bureaucracy that currently exits has deskilled professionals and fostered a learned helplessness. Therefore preparation for the shift should take account of the need to support and develop the teams and perhaps most importantly ensure that they are at the centre of leading the change.

Applying the critical success factors in the success of Buurtzorg to Scotland?

A shared and compelling understanding of the need for change is a key component for the motivation to change and seek a new model. In Jos’s own words, ‘people know the current way is finished.’

The new way of working makes sense to both patients and nurses. The model needs to be both simple and easily scalable. The new way of working can be clearly described and understood and there is consistency in how that’s done; simplicity is key.

The new way of working and need for change becomes part of the collective consciousness. The experience of Buurtzorg suggests that once it’s started it builds its own momentum. Success and experience feeds the sense of “rightness” of the model, and the shared benefits are so powerful, they tell their own story. ‘If you have the possibility of doing much better work that costs less why would you not do it?’ as Jos himself frames it.
Shift from a focus on policy to one of professional practice. The current system of focussing on process has tended to disconnect nurses and others from their professional knowledge and instinct or experience, so by shifting the focus back, it unleashes the teams’ full potential to work for the best outcomes.

The nurses should stand behind the patient and not the organisation. Nurses can be strong advocates for the people they work with and provide support and care to and the new way of working enables that to be a powerful lever for people in the system.

Advice for making it happen in Scotland:

Find and recruit the motivated stakeholders, have people involved who understand the need for change and keep it small and practical. Get the people who see the solutions to lead it. And finally have open conversations that get change to happen.
What might we do here in Scotland and who needs to be involved?

It is likely a couple of pilots, as have been proposed, of a Scottish Buurtzorg could enable Scotland to test and learn from the approach. This would fit with the advice to stay small and work with those who see the solutions. In order to ensure that learning is shared, there is an equal need to ensure these pilots sit within a wider movement of transformational change. Many pilots have great results but change nothing in the longer run, so setting this experience within the context of a learning community may help to create that shift in consciousness spoken of by Jos de Blok. This community should have not only professionals and leaders in the current system but also those with lived experience of healthcare. The Health and Social Care Alliance Scotland (the ALLIANCE) could provide the setting for this and the encouragement to approach learning in different ways across the whole system.

What’s the wider learning for us?

This approach has been developed for Community Nurses but is also a transformational approach to organisations and care. Jos de Blok now advises many public services in the Netherlands and beyond. As we see a recruitment crisis build in General Practice is there something to learn from this approach in that setting too? Could we apply all we know around modern General Practice to this very different context where GPs are self managing but employed by a back office whose role is to enable them to excel in the work? Could GPs be measured by clinical and personal quality outcomes only, with coaches providing the support they need to stay focused and resilient?

As services integrate around Scotland, could this be the ideal time to move towards some of these key principles? Could self managing teams work with self-determining individuals in care systems whose key focus is the person and their community? It’s absolutely in keeping with health and wellbeing outcomes, but instead questions and challenges how we currently seek to deliver them.
The Buurtzorg Model: caring for each other with mutuality at the core.

Following on from the visit of Jos de Blok to Scotland in the summer, a small Scottish delegation recently visited the Netherlands to see the Buurtzorg model of care in action. The delegation accompanied the community nurses on home visits; spoke to the Buurtzorg coaches; examined the enabling IT system; and visited the headquarters. Colleagues have returned from the trip enthused and impressed by what they have seen on what has been a successful and informative visit.

Early thoughts and reflections are around the true person centred nature of Buurtzorg and have highlighted how, with the right community connections, with anticipatory care and highly motivated professionals, people are encouraged to self manage their conditions, knowing that support is available to them if and when it is needed. The Buurtzorg model of self managed teams, with trust in highly trained professionals to deliver care and resolve issues at a local level, was also of considerable interest.

The visit was an important supplement to the positive articles and literature surrounding Buurtzorg and has given us much to think about. Of course there are some legitimate questions to think through, not least the engagement of other professional disciplines who provide social care. Is it possible to take the Buurtzorg model and place it into a Scottish context, either in full or in part? What changes, if any, might this require and how do we ensure that our integration agenda works seamlessly with any test of change that may be taken forward? It will also be important that we do not simply view models of care in isolation but – alongside other reviews and proposals, for example the District Nursing review – make sure that they add to the quality of experience for those needing care.

There is no doubt however that the principles around Buurtzorg are worthy of serious consideration and should be given this.

Ian Mitchell, (Deputy Director, Health and Social Care Integration, Scottish Government) led the visit and you can read his own blog by visiting the link below.

What’s the learning from other transformational change work in Scotland?

Perhaps the Fife Shine Project offers the best opportunity for aligned learning. It was funded through the Health Foundation Shine programme, which focussed on investing to save. The primary purpose of this work was ‘to help older people thrive, not just survive, in their own homes.’ Responding to the systemic need to reduce hospital admissions, the work took time but led to older people reporting they felt human again, happier in themselves and more actively engaged in life. The staff too expressed that their work felt more meaningful and satisfying for them. This work, like Buurtzorg, resulted in a profound culture change: ‘in the economy of wellbeing, money is on the margins not the centre’.

Dr Margaret Hannah describes some key learning from this work in her book ‘Humanising Healthcare’:

- *Take a broader aspirational view*; point the compass where you want to go not to where you have travelled from.

- *Configure around commitment*; give people space to step out of role and into themselves thus releasing their capacity and resources to enable the shift to happen.

- *Grow the new in the presence of the old*; this is a process of cultural leadership and needs sensitivity to the context and people whilst applying the skills and tenacity to enable it to come to fruition.

And fundamentally change comes from within us too, so any change programme requires self-awareness alongside an understanding of transitions and the psychological process of change if it is likely to succeed.
Conclusion

Buurtzorg offers a rich seam of learning, a sense of hope in the face of a current system under huge pressure and a tangible way of working that at its heart is simple and absolutely person centred. And its cost effective too. Providers of care in Scotland are being given an opportunity to pilot this work and to be brave and ambitious enough to put people at the centre. The ALLIANCE’s Health and Social Care Academy, like Buurtzorg, has a history of enabling the transformation of health and care and of bringing an attitude of ‘let’s do this’!

And so in conclusion we suggest let’s do this and let’s work together to achieve it.

‘If not now when; if not us who?’

1. References http://www.omahasystem.org/overview.html