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Third sector contributions to Buurtzorg

Learning for UK social prescribing (with a focus on England) from the Netherlands and Sweden

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Executive summary

Background: Buurtzorg is a community-based healthcare organisation that originated in the Netherlands and has gained prominence within health and care communities around the world, including in the UK and with regard to approaches known as 'social prescribing'.

Aims: To gain insight into the Buurtzorg models of care and organisation, including how they interface with third sector organisations and groups in the Netherlands and Sweden; and to consider the implications of this learning, particularly with regard to 'social prescribing' in the UK (with a focus on England), including whether it is desirable to adopt the Buurtzorg models of care and organisation, whether it is feasible, and what this might mean for third sector organisations and groups.

Methods: Mixed, using: desktop research; direct observation of Buurtzorg service delivery; informal interviews with people using Buurtzorg services (referred to as 'clients' within those services); and semi-structured interviews with people working within health and care communities – both practitioners and non-practitioners – including for Buurtzorg and in the third sector.

Key findings: Buurtzorg, and organisations like Amstelring Wijkzorg that have followed its approach, are delivering results for clients, staff and the system in the Netherlands and Sweden that are desirable within the UK. The Buurtzorg model of care aligns with the English policy agenda, especially in terms of delivering person-centred care. Self-organising teams have the power to give their clients choice and control over their treatment, care and support – *"but almost self-organised doesn't work"*. [continued…]

Executive summary

Key findings [continued]: The Buurtzorg model of organisation is necessary for the model of care, but is counter-normative to UK models, including within the public sector. It appears to be in direct conflict with some frameworks, including regulatory, but work in Scotland suggests this is surmountable. Social behaviour (*"blunt communication*" and 'speakability' in the Netherlands), social attitudes (the promotion of independence in Sweden) and decision-making behaviour (consensus rather than democracy in both countries) seem to particularly benefit the Buurtzorg approach – variation in these may affect the feasibility of transferring it from one health and care community to another. The third sectors have differing portfolios of health and care roles and services, and some areas are better-funded and cultivated than others – just as in the UK. Third sector interviewees reported concern about the lack of funding that transfers into the sector in parallel with clients. Concern for sector sustainability was stronger in the Netherlands than in Sweden, where interviewees spoke of being asked to *"do more for less"*, including provide public services.

Conclusion: Buurtzorg is delivering the person-centred care and associated results sought in the UK, including by the third sector. There is currently strong concern within the English third sector that social prescribing schemes must either provide plans for or be developed alongside plans for sustainable funding of third sector infrastructure – addressing this is the priority. This recognised, there is nonetheless an emerging sense that the English third sector's portfolio, presence and way of working – particularly its courage, flexibility and agility – may mean organisations are better-placed than public bodies to lead work to implement a Buurtzorg approach to social prescribing.

Executive summary

Recommendations:

1. **People working in the third sector** (at national, regional and local level) should keep exploring, sharing learning and talking about the Buurtzorg approach, including how to realise its models of care and organisation in the UK.
2. **People working in the public sector** (at national, regional and local level) should recognise people, groups and organisations in the third sector as essential partners in Buurtzorg-type approaches, and collaborate with them on both the theory and practice of implementing them in the UK. This includes addressing the priority that funding transfers in parallel with people between the sectors.
3. **Third sector provider organisations that are in a position to do so**, working with **organisations that can ensure people are partners in the design of services**, should consider 'showing and telling' what a Buurtzorg approach could look like in the UK.
4. **Buurtzorg in Britain & Ireland** should continue to invest time and energy into collaborating with the UK's third sector.
5. **Funders**, including Big Lottery, Nesta and the Health Foundation, should be invited to join these conversations, and will hopefully be glad to do so.
6. **There is much cause for optimism**, but **everyone in the health and care community** should be pragmatic about Buurtzorg-type approaches.

About the author

Hello, I'm Chloë. I'm the Director of London Road Policy & Projects – a charity and public sector consultancy with a particular focus on health and social care.

I've led research projects and advocacy campaigns, including 'Prevention in Action' for the British Red Cross, which secured amendments to primary legislation. I'm especially experienced in delivering programmes that bring together people and organisations with different perspectives and ways of working, including the Richmond Group of Charities' Doing the Right Thing.

I have an MA in the Philosophy, Politics and Economics of Health, and was an Honorary Research Associate at UCL's Crucible Centre for Lifelong Health and Wellbeing. I'm a Trustee of Irise International and an RSA Fellow.

I've chosen a career in health and social care because of my experiences as a carer. Some of my experiences have been good, but others have been poor. Most of the stories aren't mine to tell, but I believe health and care can and should be better than they are.

I enjoy video gaming, wildlife photography and exploring historic pubs. I live by the sea with my husband Greg and daughter Alice, the latter of whom caused nausea and back ache throughout my travels and then delayed the publication of this report. She's pretty cool though, so I'm not holding it against her.

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Acknowledgements

I would like to thank the Winston Churchill Memorial Trust (WCMT), not only for funding my Fellowship, but for their support before, during and after my travels. I've only been able to fit this research into the busyness and unpredictability of life because WCMT favours trust and flexibility over bureaucracy and arbitrary deadlines. They've offered genuine fellowship as well as a Fellowship. It's been cathartic to have the time and headspace to explore ideas that I've been mulling for some time, and it's been motivating to discover new ones. **It's been fun.**

I want to thank all of the **people in the Netherlands, Sweden and UK who gave up their time** to share their knowledge, expertise and passion with me, including those at Buurtzorg, Amstelring Wijkzorg and Grannvård. I hope I've done it and them justice. I'm especially **grateful to the Buurtzorg clients** who so generously welcomed me into their homes and shared their experiences and reflections with me.

While the author is grateful to Buurtzorg, Amstelring Wijkzorg, Grannvård and Buurtzorg in Britain & Ireland for their help undertaking this research, the views and opinions expressed in this report and its content are those of the author. The author is independent of these organisations, was not paid by them for this research and did not receive any gifts in kind.

About this report: A coffee or a pint…

One of the most enjoyable things about my Fellowship has been the opportunity to be flexible and unencumbered by a strict specification. Rather than cram interviews, meetings and reading into an incredibly tight window, **WCMT gave me the time and headspace to do things a little differently.** I enjoyed visits to the Museum Tot Zover (Dutch Funeral Museum) and Swedish Parliament. These experiences proved more instructive than hours of reading. You can learn a lot about a society, its cultures and its attitudes to life, health and care by understanding its approaches to death and dying. And differences in how people approach decision-making are role-modeled by their governments.

As I read the first draft of this report, I realised I'd written something acceptably traditional. It was fine, but it was formal and stripped of personality. WCMT hadn't asked me to write in such a way. In fact, they'd encouraged me to **use the Fellowship to rediscover the things that motivate me and talk about them in my own way**: Fellowships "are not academic research grants. They are practical inquiries into real-world issues".

Undertaking this research also reminded me that you learn more through a candid chat than reading a report. I've wanted to reflect that here, so I've included a few **asides with the things I would tell you if we went for a coffee or a pint**. Hopefully this makes for a better report. Either way, it's been pleasingly cathartic to get everything out of my head and onto paper.

While I've tried to make this report as readable as possible, I know how busy we all are. If it's likely to be an unread open tab on your phone or desktop for a while, then please send me the briefest of emails or tweets, and **we can have a chat** instead (and maybe even a real coffee or pint).

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About this research

Introduction

Research aims

Methodology

Terminology

If we were chatting over a coffee or pint…

I've worked in health and social care for 15 years. During this time there's been **a lot of talk about 'person-centred care'** – about giving people choice and control over their treatment, care and support. It's been a heck of a lot of talk, coupled with occasional funding, but it **hasn't translated into commensurate change**.

I've observed **part of the problem, probably a large part, to be about power**. The people who hold power within health and care tend to be senior managers. They usually hold the purse strings. They're working in hierarchical structures, bogged down by governance. Perhaps they're reluctant to give their power over to the frontline, but the structures make it difficult anyway. Whatever the cause, it's very difficult for frontline staff to 'enable', 'empower', 'support' (pick your buzzword) people to have choice and control over their treatment, care and support when they don't have it themselves.

As well as challenges within organisations, there's **an external context of suspicion**, driven by mainstream media. Allow someone to buy an iPad so they can benefit from online peer support, or take a cookery class to learn how to prepare food that positively interacts with their medication, and the press denounces this use of public money. This is despite it being better for people and cost-efficient (sometimes cheaper). **It would be good to see some strong riposte** from Parliament, Whitehall and Skipton House.

Health and care are full of good people wanting to make things better, but they are stuck in a system and culture that doesn't always allow them to do so. It's **a problem that Buurtzorg seems to be overcoming.**

Introduction

Buurtzorg is a **community-based healthcare** organisation that originated in the Netherlands and has expanded to countries including Sweden, the United States and Japan.

It has been **gaining prominence** within UK health and social care communities, particularly **in relation to approaches known as 'social prescribing'**.

The King's Fund, Royal College of Nursing, NHS Confederation, mainstream media, trade press and others have all been exploring how the Buurtzorg models of care and organisation might be implemented in England.

However, there is a **perspective rarely considered... those within the third sector** who work in partnership with Buurtzorg services, its clients and staff.

Within England, **third sector groups and organisations take on a number of health and social care roles**. Some of these roles involve working with people (such as helping people to understand long-term conditions, navigate the NHS and connect with peers) and some of these roles involve working with 'the system' (such as integrating and coordinating care and redesigning how the system works).

If England is going to implement and scale Buurtzorg, which there seems to be some appetite for, then **the potential role(s) of third sector organisations and groups need(s) to be understood**, not least so that they can be equal and active partners in making it happen.

This is the issue – the **gap in the literature and discussion** – that I wanted to investigate.

Research aims

Funded by WCMT, my research aimed:

1. To **gain insight into the Buurtzorg models of care and organisation**, including how they interface with third sector organisations and groups:
   - in The Netherlands (where the model originated); and
   - in Sweden (as an example of transferring the Buurtzorg approach from one health and social care context to another).
2. To consider the **implications of this learning, particularly with regard to 'social prescribing'** in the UK, with a focus on England:
   - Is it **desirable** to adopt the Buurtzorg models of care and organisation?
   - Is it **feasible** to adopt the Buurtzorg models of care and organisation?
   - What might this mean for **third sector** organisations and groups?
3. To **share this learning with colleagues in the UK health and social care community, especially those within the third sector**, in order to support informed and collaborative conversations about Buurtzorg, particularly with regard to social prescribing.

Methodology

Mixed method design, using:

- desktop research, including grey literature;
- direct observation of Buurtzorg service delivery;
- informal interviews with people using Buurtzorg services (referred to as 'clients' within those services);
- semi-structured interviews with people working within health and care communities – in both practitioner and non-practitioner roles – including for Buurtzorg and in the third sector.

The majority of this work was undertaken in the Netherlands and Sweden, where interviews were held face-to-face.

Some semi-structured interviews were also undertaken with professionals in the UK, which were primarily held by telephone or video call.

The majority of findings are derived from interviews and direct observation. Interview quotes are italicised, but are not attributed to particular interviewees or organisations. WCMT holds a record of my research itinerary.

Additional references are provided where relevant and available, with a full bibliography available at the end of this report. If the content of a page is drawn from a single source, then the relevant reference is given at the bottom of that page rather than repeated throughout the text.

List of meetings, interviews and visits

Due to the number of interviewees who asked to remain anonymous, this is an overview rather than a detailed itinerary (which WCMT holds a copy of). However, I think it helps to show that Churchill Fellowships provide an opportunity to explore an issue in a more creative way than say, academic research grants do. As I mentioned earlier, this can lead to unexpectedly helpful discoveries. I learnt about consensus decision-making at The Riksdag, the 'poldermodel' approach to Dutch decision-making at Molen Van Sloten, and Dutch attitudes to death, end-of-life care and dignity in older age at the Museum Tot Zover – all of which inform my findings.

Meetings and interviews in the Netherlands: Representatives from Buurtzorg, Amstelring Wijkzorg, De Regenboog Groep and Netherlands Institute for Social Research. Individuals working for a third sector infrastructure body, charity providing services to reduce loneliness and social isolation, social prescribing.

Direct observation and educational visits in the Netherlands: Buurtzorg service provision with clients from different socioeconomic backgrounds. Museum Tot Zover (Dutch Funeral Museum). Ons' Lieve Heer op Solder (Museum Our Lord in the Attic). Molen Van Sloten (working windmill).

Meetings and interviews in Sweden: Representatives from Grannvård Sverige, Röda Korsets Högskola, Karolinska Institutet. An individual working in occupational therapy with a specialist focus on reablement. Individuals working for a third sector infrastructure body, charity addressing homelessness, pendant alarm service for older people.

Educational visits in Sweden: The Riksdag (Swedish Parliament). Stockholm City Hall. Archipelago tour with guide.

Terminology: ‘Buurtzorg’

Buurtzorg is a community-based healthcare organisation with a “**nurse-led model of holistic care**”.

Dutch for ‘neighbourhood care’, Buurtzorg was **founded in the Netherlands** by Jos de Blok and a small team of professional nurses in 2006.

Nurses work in **small self-organising teams** that are responsible for all aspects of care, including planning, coordination and delivery.

Nurses are supported by a **very small back office** of 50 staff (supporting 10,000 nurses and nursing assistants).

It can be helpful to think of Buurtzorg as having two essential and related elements:

- A **model of care** focused on promoting self-management, building trusting relationships and networks of support, and providing care in a person-centred way.
- A **model of organisation** focused on empowering nurses, keeping bureaucracy to an absolute minimum, using technology in a way that supports practice (and actually works), and only changing something or doing something new if it helps nurses to do their jobs better.

Buurtzorg now provides more than half of homecare in the Netherlands and **has influenced change in neighbourhood care in 25 countries**.

Buurtzorg, Amstelring and Grannvård

Buurtzorg started in 2006 with a team of four nurses working closely with GPs and delivering community care services. It has grown to over 10,000 nurses and nursing assistants working in 900 teams of up to 12 professionals. The frontline is supported by 20 regional coaches and just 50 back office staff. Buurtzorg works with 100,000 clients in a one-year period. Buurtzorg is a non-profit organisation.

Amstelring Wijkzorg used to be a traditional, hierarchy-based community nursing and homecare provider in the Netherlands. It remodelled itself on Buurtzorg's example about six years ago. It has around 600 employees and 60 teams, with 16 people in the back office, including two coaches. Amstelring Wijkzorg is a non-profit organisation.

Grannvård Sverige is the Swedish branch of Buurtzorg (Grannvård means 'neighbourhood care' in Swedish, just as Buurtzorg does in Dutch). The first team was established in 2011, in Bålsta, and the service has grown both within the municipality and into neighbouring municipalities. Grannvård is a non-profit organisation.

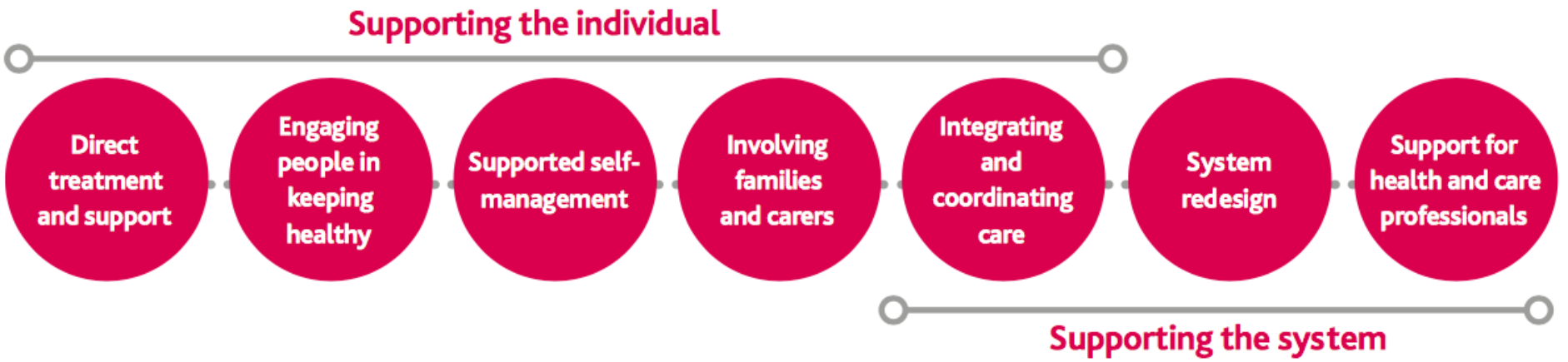
[NB. I did not undertake an assessment of clients' needs, nor would it have been appropriate for me to do so, but I think some context is probably helpful. I would describe the needs of the clients I met as Substantial according to the old Fair Access to Care approach to assessing the social care needs of adults in England (as opposed to Low, Moderate or Critical). I have not worked in an Adult Social Services Department since the Care Act came into force, but my understanding is the Substantial banding more or less correlates with the national eligibility threshold (though I recognise its application is subject to local interpretation)].

Terminology: ‘Third sector’

‘Third sector’ describes the range of organisations that are **neither public sector nor private sector**. It includes voluntary and community organisations (both registered charities and other organisations such as associations and community groups), social enterprises, mutuals and co-operatives.

Third sector organisations are generally **independent of government**, **motivated by the desire to achieve social goals** rather than to distribute profit, and they reinvest any surpluses generated in the pursuit of their goals (and are therefore sometimes known as ‘**not-for-profit**’) (National Audit Office 2018).

Within England, **third sector groups and organisations take on a number of health and social care roles**:



(Diagram taken from Bull et al 2016)

Terminology: ‘Social prescribing’

‘Social prescribing’ **links people into personal networks as well as practical and emotional support** within communities and the voluntary sector. This is often via their GP, nurse or other primary care professional.

The aim of social prescribing is to **help people live their lives as well as possible**, with a focus on supporting them to take control of and to improve their health, wellbeing and social welfare.

Services are normally **time-limited**, but with some flexibility.

Social prescribing can empower people to look for solutions to social problems **before a crisis occurs** that might affect their physical or mental health (secondary prevention). It can also support people with one or more long-term condition to **build self-management and coping skills** and to maintain independence (tertiary prevention)

There are a wide range of needs that social prescribing is unlikely to prevent or de-escalate. Social prescribing is **not an alternative to social work, social care or occupational therapy**. Nor is it an alternative to properly funding and supporting these essential eligibility-based services.

Social prescribing is **not the same as providing information, advice and signposting**. Nor is it an alternative to properly funding and supporting these essential universal services.

Social prescribing is not **a panacea** to system and funding pressures within health and social care.

Terminology: ‘Social prescribing’

There is **no definitive model** of developing and implementing social prescribing. Each area has different infrastructure, assets and relationships upon which to build. However, there is emerging consensus, especially within the third sector, that there are some essential components:

Reference: Reeves & Cole 2019

Terminology: ‘The system’

‘The system’ is a term that’s been used for some years* to describe **all of the people, groups, organisations, supra-organisations and networks** involved with designing, implementing and delivering health and care.

- This includes providers and commissioners.
- It encompasses the local, regional and national.
- It usually includes the people and organisations within the third sector and the private sector involved with health and care.
- As the components and their interactions are constantly in flux, it offers a non-time-specific term.

Since devolution in the late 1990s, the NHS is no longer one large body, responsible for the UK. Health and social care are organised and receive their funding from the devolved governments in Wales, Northern Ireland and Scotland.

This research primarily considers the system in England, but is informed by a knowledge of the devolved systems, as well as interviews with health and care professionals in Scotland.

If you are unfamiliar with health and care in England, then I recommend looking at The King’s Fund’s series of ‘explainer videos’. They also offer a free online course, *The NHS explained: How the health system in England really works*. This is a valuable resource, but at eight hours it also demonstrates how complicated things are.

*See for example this, from 2013: https://bit.ly/1n4B4F0

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Three health and care contexts

Even a general introduction to each of the health and care contexts could be a tome, and one that would quickly be out-of-date. I've assumed readers will have some knowledge of English health and care, but I've sketched the context in terms of current pressures. I've provided a general sketch of Dutch and Swedish health and care, focusing on the things I found particularly interesting while thinking about Buurtzorg, social prescribing and the third sector. (Like Marie Kondo, but with an "ooh" of interest rather than a "ting" of joy).

England

The Netherlands

Sweden

English health and care

Our **population is ageing** rapidly. When the NHS was founded and the National Assistance Act (within which the current adult social system has its origins) enacted 70 years ago, one-in-two people died before they reached 65. Now a 65-year-old man can expect to live at least another 18 years, and a 65-year-old woman can expect to live at least another 20 (ONS 2018). This is **the single most significant driver for changing health and care needs** within our society.

The NHS budget was around £125 billion in 2017/18 (King's Fund 2018a), with a further £3 billion spent on public health (primarily through local authorities) (King's Fund 2018b). The **NHS spends the vast majority of its budget on secondary care** services. Despite commitments to shift care away from hospitalisation and closer to people's homes, spending on hospitals has increased, while **spending on primary care has only just begun to rise from a plateau and has fallen in real terms since 2010** (Charlesworth & Johnson 2018).

Waiting times are increasing and **targets are being missed.** Public satisfaction levels are starting to fall. However, many experts, including Health Foundation, King's Fund and Nuffield Trust now consider the **precarious workforce challenges in the NHS in England to present a greater threat to health services than the funding challenges** (King's Fund et al 2018). If the challenges continue, then we could see growing waiting lists, reducing quality of care, and – despite the projected shortfall in funding – a risk that the multi-year settlement of increased funding cannot be fully spent because there are insufficient staff to deliver the services commissioned with it.

English health and care

Public spending on local authority provided and/or arranged care is much smaller than public spending on health. The ratio is about one to seven, with **£18 billion spent** on adult social care in 2017/18 (ADASS 2018).

Local authorities provide and arrange adult social care, primarily funded through three types of income: 1) council tax, government grants and business rates, 2) means-tested user contributions, and 3) transfers from the NHS and other joint arrangements.

Two-thirds of recipients of local authority provided or arranged adult social care in England are older people (aged 65 and over), and one-third are younger adults (aged 18 to 64 years). This ratio is not reflected in terms of public spending on adult social care, with older people accounting for half and younger adults for half (Charlesworth & Johnson 2018).

Despite 44% of people thinking social care is provided by the NHS and 28% believing it to be free at the point of access (LGA 2018), **the majority of people who need care do not receive state-funded care,** which is both eligibility-assessed and means-tested. An estimated 21% of older people in England receive the majority of their help with care needs from their local authority, 37.5% from family and friends, and 12.5% from privately funded sources. An estimated 30% of older people receive no help with their care needs (Triggle 2018).*

Adult social care services are facing significant funding pressures due to the combination of a growing and ageing population, increasingly complex care needs, reductions in government funding to local authorities and increases in care costs.

*Percentages may not total 100 due to rounding.

Background to social prescribing

Social prescribing **could make a positive difference to people:**

People go to see their GP when they "don't feel well" in the broadest sense, e.g. due to bereavement, feeling stressed about a work situation, or feeling lonely. They recognise they are "probably asking the wrong person for help", but they don't know where else to go.

People want a long-term relationship with their GP: Someone who knows them well and who they can open up to. But they usually see a variety of doctors, have to repeat themselves, and are not able to build a trusting relationship. They want to discuss things that can be quite difficult to articulate – that they may not have said out loud before – with someone they feel comfortable with and have confidence in.

People want appointments that are long enough to discuss multiple issues and to allow problems that are harder to talk about to come to the surface. But they usually get 5-10 minute appointments that leave them feeling rushed and unable to get through everything. Some are explicitly told to bring single issues to appointments.

The idea of social prescribing has immediate resonance with people, who see it as a **sensible way to meet needs unfulfilled by the current system**. They recognise health services are under pressure and are open to new ways of doing things.

Reference: BritainThinks, 2017 cited within Reeves & Cole 2019

Background to social prescribing

Social prescribing **could make a positive difference to the system:**

Around 90% of patient interaction with the NHS is with primary care, including GP practices, dental services and community pharmacies (Powell and Parkin 2016).

Demand for primary care is increasing (Baird et al 2016).

GP workload is growing in complexity (Hobbs et al 2016; Dayan et al 2014).

The **number of GPs has increased, but is insufficient** to meet demand (Hobbs et al 2016).

An estimated 20% of patients consult their GP for what is primarily a social problem (The Law Commission, 2015). **Non-medical demand on GPs is rising** (Citizens Advice 2015). This costs the equivalent of 3,750 GP salaries a year (Citizens Advice 2015).

It is **difficult for GPs to give people the non-medical advice and support they need.** They don't always know about the range of practical and emotional support available from the third sector in their area (BritainThinks 2017).

Social prescribing offers a way of interfacing the public and third sectors, giving GPs and other health and care professionals a general and consistent route into a service that is highly personalised for patients.

If we were chatting over a coffee or pint…

Yes, ‘social prescribing’ is a clunky term. It’s not ideal and I wish there were an alternative, but it’s a term that’s now used and recognised across the system. And no, social prescribing is not new, despite the NHS often proclaiming it to be “innovative”, “ground-breaking” and part of a “radical transformation” – schemes have been successfully running in the UK (especially Scotland) and around the world for a number of years. But I think *it is* fair to say that **schemes have grown in recognition, number and scale** over the past five years. And – while there’s a risk their achievements are overclaimed in the endless pursuit of cost savings and reduced hospital pressures – many of the schemes do seem to be doing good things and people seem to be benefiting from them.

Personalisation is at the heart of social prescribing, which is why I find it so interesting. Over the years, health and social care have accumulated many layers of management, but in my experience this reduces the power of the frontline to give people choice and control over their treatment, care and support. I can’t imagine a council or health trust making their managers redundant, shifting the savings into enhanced frontline salaries and supporting frontline staff to self-organise.

But social prescribing is relatively fresh. The power dynamics are still being worked out. Maybe, just maybe, there will be **people at the helm who have the vision and courage to give over power to the frontline and not have any managers** in the first place…

Dutch health and care

Health insurance is compulsory for everyone who lives or works in the Netherlands. The system is one of private health plans with social conditions built on the principles of solidarity, efficiency and value for the patient. Healthcare is funded through this mandatory health insurance as well as taxation on income. There are 60 insurers, but four (carrying various brands) cover almost 90% of the market.

The **Dutch government is responsible for the accessibility and quality** of the health system, but is not in charge of its management. It sets the basic package that is compulsory, though people may buy additional cover for things like adult dental care, hearing aids and contraception. The government also acts as a supervisor of the health insurance, purchasing and provision markets, aided by various watchdog agencies.

People are increasingly living with multiple long-term conditions. The Dutch care landscape is changing, with a **push for people to remain at home** rather than move to care homes or residential hospitals. This means some treatment and care tasks that were usually provided by specialists and/or in hospitals, are now being handled by GPs and district nurses. Long-term care was reformed in 2015, with municipalities taking on responsibility, but with reduced budgets. There is now "**a tendency toward personalisation**" (IGJ 2018).

The **care inspectorate has recognised that people have "care networks" around them**, which might include unpaid carers, paid carers, GPs, pharmacists, district nurses, specialist consultants and help with domestic tasks. They have therefore revised their approach to regulation and inspection, looking at both the quality of care provided by individual organisations *and* the collaboration within a person's care network.

References: IGJ 2018; OECD 2017b

Dutch health and care

The Dutch long-term care sector is the largest in Europe. The 2015 reforms were intended to temper growth, but discussion continues about the sustainability of the sector and the expectations of unpaid carers. There is particular concern that new governance responsibilities, particularly those of municipalities and health insurers, "run **the risk of encouraging different actors to push care on to each other**" (OECD 2017b) undermining efficiency and potentially adversely affecting people.

There has been a **push to primary care over secondary care**, particularly with regard to management of long-term conditions. Primary care professionals increasingly work in larger organisational settings, such as primary health care centres and multidisciplinary teams. Task shifting has led to new and more primary care and community-based occupations, including practice nurses, nurse practitioners and physician assistants.

Alongside the reform of long-term care in 2015, **health insurers were made responsible for contracting community nursing** through the inclusion of this benefit in the mandatory health insurance scheme. The aim was to improve the coordination of primary, secondary and community care, while driving efficiencies.

Despite the reforms aimed at better coordination, long-term care as a whole falls into **three distinct funding regimes**: social care (covered by the Social Support Act), community nursing (covered by the Health Insurance Act) and intensive home healthcare or institutional care (covered by the Long-term Care Act). But people's needs don't neatly fit within these categories and there are 'quirks' within the system, including the **financial disincentivisation of preventative measures** to help people remain independent at home for as long as possible.

References: OECD 2017b; Alders & Schut 2019

Swedish health and care

The national **government establishes principles and guidelines**, and sets the overall political agenda for Swedish health and care.

Sweden is divided into 290 municipalities and 20 county councils / regions (plus the island of Gotland, which is a municipality with county council responsibilities), all governed by democratically elected politicians.

Swedish **healthcare is universal, largely tax-funded and is decentralised** – responsibility for financing, purchasing and providing health services primarily **lies with the regions**.

The system's decentralisation "contributes to **regional variation in service access and outcomes**", despite an equal access principle expressed in law (OECDc 2017). A national redistribution scheme is designed to equalise the capacity to provide health services across the country, with additional funding available for targeted programmes. A relatively small share of the Swedish population reports unmet needs for medical care, and the difference between high and low incomes is among the lowest in the EU.

Responsibility for care lies with the municipalities. This includes care for older people, people with disabilities, people with mental health conditions, and support to people who have completed therapy and been discharged from hospital. Care is primarily funded through municipal taxes and grants from the state to the municipalities, though a small part is financed through user charges.

References: Swedish Institute 2019; OECDc 2017

Swedish health and care

Assessments of care need are undertaken by municipality assessors. Identified needs must be met with the provision of relevant services. If a person has both community-based health needs and personal care needs, then the nurse attached to the healthcare will delegate the care tasks that do not require nursing input.

In 2009 the **Freedom of Choice Act** was introduced (passed in 2008 and amended in 2010), which built upon existing policy moves to open up the market. [I found a useful background to and analysis of this in Dahlgren's Why public health services? Experiences from profit-driven health care reforms in Sweden].

The Freedom of Choice Act made Sweden the **first country in Europe to adopt a law on the right of citizens to choose their welfare service provider** from either the public, the private or the non-profit sector. This legislation extends to health and care. Costs of provision are still picked up by the state. All providers are treated equally. Swedish municipalities must **certify all service providers that fulfil basic criteria** and then inform the public about the full range of available providers. Providers cannot refuse a person who chooses them and must commence delivery of care within 24 hours. There is a lot of **discussion about moving from a focus on activity, unit costs and time, to a focus with more value**.

However, while it is mandatory to have choice plans in primary care, regions and municipalities can **decide if they want to implement the law** with regard to health and social care. Around half of regions and just over half of municipalities offer choice plans. This has implications for the coordination of combined health and care packages, as well as for providers working across regional and municipal borders.

Headline comparisons

Area of comparison	UK	Netherlands	Sweden
Spending on health as a share of GDP	9.9% (10th highest)	10.7% (4th highest)	11.0% (3rd highest)
Amenable mortality rates*	94.4 women per 100,000 population 139.1 men per 100,000 population	79.7 women per 100,000 population 96.4 men per 100,000 population	79.4 women per 100,000 population 117.2 men per 100,000 population
Ratio of hospital beds to population	2.6 per 1,000 population	3.6 per 1,000 population	2.3 beds per 1,000 population
Average length of hospital stay	7.0 days	6.2 days	5.9 days
Avoidable hospitalisation for chronic conditions	Lower than EU average (4th lowest)	Lower than EU average (3rd lowest)	Lower than EU average (7th lowest)
Spend on inpatient care as a percentage of total health expenditure	29%	26%	22% (lowest)
Self-reported levels of unmet need for medical care (due to cost, distance and waiting times)	Lower than EU average (17th lowest)	Lower than EU average (3rd lowest)	Lower than EU average (9th lowest)
Ratio of practicing doctors to population	2.8 doctors per 1,000 population	3.5 doctors per 1,000 population	4.2 doctors per 1,000 population
Ratio of practicing nurses and midwives to population	8.4 nurses and midwives per 1,000 population	10.5 nurses and midwives per 1,000 population	11.1 nurses and midwives per 1,000 population

*Premature deaths that could have been avoided through timely and effective healthcare

References: OECD 2017a; OECD 2017b; OECD 2017c

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POLICY & PROJECTS

WINSTON CHURCHILL MEMORIAL TRUST

Is it **desirable** to adopt the Buurtzorg models of care and organisation?

Buurtzorg, and organisations like Amstelring Wijkzorg that have followed its approach, are delivering results for people, staff and the system in the Netherlands and Sweden that are desirable within the UK

Desirable results for clients

Responding to individual needs.

- Clients have **choice and control** over their treatment, care and support.
  - *"We have quite complex people with complex needs – we don't expect them to fit into scheduling and rostering"*.
- There is **continuity of care** with a small team of nurses and nursing assistants.
  - Clients don't have to repeat their stories, needs or care plans.
  - Clients were observed to have comfortable, open and good humoured relationships with staff.
  - Staff are able to monitor and respond to aspects of care such as skin integrity, medication adherence and low mood.
- The Buurtzorg approach and the system it's operating in have evolved, so that **nurses now undertake their own assessments** [in the Netherlands plus some other countries].
  - When they started, they were picking up others' assessments. *"Most of the time there was too much care indicated, or too less [sic]"*, and the discussion about ambitions, goals and lifestyle is as important as a functional assessment.
  - It took years to convince the Dutch system that nurses should do their own assessment. **There was an assumption that it would take longer and cost more, but the reverse was found to be true.** Nurses are confident and highly skilled, and are able to focus on maintaining and regaining independence – *"they will not give care that isn't needed".*
- *"We encourage staff to sort of break the rules, like helping people to keep their pets rather than putting them down. Who is going to say "I don't agree with that"? We waste time asking – if it's the right thing for the client, then do it".*

Desirable results for clients

Responding to group needs.

- The IT system, Buurtzorg Web, allows teams to **see the different populations they're working** with and understand if and how they compare to those of other teams, e.g. a larger cohort of clients with a particular condition or who follow a particular religion.
- Teams **can then respond**, e.g. up-skilling in dementia care, hiring a specialist oncology nurse, or adjusting work patterns to respond to the demands of religious practice, such as Shabbat and Ramadan.
- Teams have an educational budget, but there is also a **culture of seeking out experts within the organisation**. *"Organisations usually have so many experts, including experts-by-experience, yet you see them buying in the expertise that's under their nose. Why? It's expensive and unmotivating [sic]".*
- The lack of bureaucracy makes it **easy to facilitate this exchange of information**, with no internal invoices, service level agreements or other burdensome process. Teams can also **recruit new members quickly**. *"There are no HR hoops [to jump through] – if you need a new member and will have work for them, then get on with it and recruit them".* [This is easier within a system where actual work can be billed for, than in a system where services are block contracted].
- *"A lot that happens in organisations happens because of **goodwill** – staff develop relationships and then help each other out. Why not **recognise and respect it as an organisation**? It's better for morale, which is better for clients and for the organisation. Everyone wins".*

Desirable results for clients

Achieving good outcomes.

- **High client satisfaction.**
  - Sweden undertakes an annual national survey to ascertain older people's satisfaction with care. Results are published in the press. Grannvård has only had one client report being unsatisfied in six years and the client chose to continue receiving care from them (Buurtzorg 2017 and others).
  - Dutch Buurtzorg reports the highest client satisfaction rates of any healthcare provider – 30% above the national average (Ćirković 2018).
- **Maintaining and building independence**.
  - Clients have open and communicative relationships with staff. They problem-solve together. Being bought into the solutions they come up with seems to encourage persistence.
  - Clients work with the same staff over prolonged periods. Staff were observed to have the flexibility to give clients the time they need to implement person-centred plans. This might include trialling different ways of managing incontinence, changing diet to better interact with medication, attending new community groups and getting used to these, or preparing for meaningful events like family visits.
  - Clients receive care and support for an average of 5.5 months, against a system average of 7.5 months (Ćirković 2018).

If we were chatting over a coffee or pint…

I've worked in and with a number of organisations that claim to focus on working with people to maintain and regain their independence. The intentions are usually genuine – no one is proactively trying to provide bad care – but they are modelled on traditional approaches to homecare, with staff who are used to working in a particular (usually task-based) way. Pushes to achieve person-centred care seem to be characterised by **hard-working staff being asked to work in new ways by organisations that produce processes, targets and e-learning, but make little attempt to change structures and cultures.**

I've also seen services, functions and sometimes **whole organisations stay afloat thanks to the goodwill of staff.** This might be OK for a happy team at a time of genuine organisational turmoil, but it cannot be a long-term strategy. Low morale, high turnover and the associated loss of organisational memory do not result in person-centred care. Clients and staff **need continuity of care, as well as the motivation and headspace to creatively solve problems.**

It was especially refreshing to see an organisation recognise how valuable it can be to pick up the phone to a colleague and say something like "I have a client with Parkinson's and I understand you're something of an expert, please could we have a chat?", and **rewarding (through decent salaries rather than gimmicks) that expertise that staff bring to the table**.

Desirable results for staff

Trusted staff.

- *"You don't want to have a manager saying "I see that this week you spent five minutes extra with X client, what did you do?" because that's not helpful. You end up spending time talking about it, and it uses up your energy and motivation. It's not constructive. And it's even more useless if you're asked why you spent five minutes less than usual with X client. But of course, you can't just spend two hours drinking coffee – you have to be sensible. But this is how you work outside of work, with personal admin and life. We make sensible judgements outside of work – why not be trusted to do that at work?"*

Improved morale.

- While it's difficult to genuinely gauge staff morale through this kind of observational visit, staff spoke warmly about the autonomy they are given and how it enables them to be *"proper nurses"*.
- Staff consistently spoke of having professional careers rather than jobs, and of a fulfilling sense of purpose.
- More than one member of staff (including one who had spent decades in the NHS) spoke warmly of Call the Midwife's depiction of community nursing and care, which they identified as being similar to the Buurtzorg approach. Those who had studied or worked in England reflected that *"nursing is very task-based and can be single issue there. We're holistic and do things with clients rather than to them".*

Desirable results for staff

A focus on staff health and wellbeing.

- Amstelring Wijkzorg makes a point of encouraging staff to think of creative things to make their work fun, just as they are meant to be thinking of creative ways to help their clients maintain and regain independence. Their support of this might include paying half the cost of things like gardening equipment, bicycles or running shoes.
- The collection and use of good data enables the detection of and response to things like frozen shoulder.

Increased job satisfaction.

- Buurtzorg has such high satisfaction (between 8.7 and 9 out of 10) that it has won Dutch Employer of the Year five times between 2010 and 2016.

Reduced absenteeism and turnover.

- Absenteeism halved at Amstelring Wijkzorg when they switched from a traditional hierarchy-based nursing and care organisation to a Buurtzorg model (Kamphorst 2016).
- Buurtzorg's sickness absence is about half the industry average (Ćirković 2018).
- Retention rates are 50% higher than the industry average (Gray et al 2015).

Desirable results for staff

Increased productivity.

- Staff are asked to meet a productivity target of 61% at Buurtzorg and 63% at Amstelring Wijkzorg. This is the percentage of their contracted hours that must be spent with clients, and the billable time within an insurance-based system. The Dutch industry average is 51% (Ćirković 2018).
- Team productivity is visible to other teams, and teams are encouraged to ask each other how they're achieving their results. *"Buurtzorg is actively stimulating you to look around you, ask advice and share".*
- *"There might be a legitimate reason for someone not achieving the target, such as illness, With good team morale you find people flex around each other. But it's obvious if someone isn't pulling their weight or if they need help with skills or confidence".*
- *"In other organisations you can spend hours of management time looking at and discussing figures, without the teams being involved. It means you don't understand what is behind the data and the teams don't actually know how they're performing".*

"It's not perfect… There are challenges and we're not all happy all the time, but I had an image when I trained to be a nurse, and this is like my imagination. I can do good here. I go home and think 'Today I did more good than anything else'. In some jobs I would go home and think 'Today I did more forms and talking with managers than anything else'. This is better".

Desirable results for the system

Reduced demand for community-based care.

- Clients receive care and support for an average of 5.5 months, against a system average of 7.5 months (Ćirković 2018).
- Clients use 40% of the care that they are entitled to (KPMG study cited in Public World Consulting 2016), compared to a system standard of 70% (Ćirković 2018).

Reduced demand for hospital-based care.

- Hospital admissions are reduced by one third (Ernst & Young study cited in Public World Consulting 2016).
- When a client does need to be admitted to hospital, the average stay is shorter than that of non-Buurtzorg-clients (Ernst & Young study cited in Public World Consulting 2016).

Reduced costs.

- Higher unit costs, but lower overall costs due to aspects including clients' reduced demand for care (multiple sources, including Buurtzorg 2018).
- Overheads of 3.7% at Amstelring Wijkzorg and 8% at Buurtzorg (self-reported figures), against a Dutch average of 25% (Public World Consulting 2016).

If we were chatting over a coffee or pint…

It's difficult within this climate of ridiculously squeezed health and care budgets to attract investment into new ways of working. We all lament the 'prevention challenge' of working out how to invest now to save later. I've sat in meetings with HM Treasury officials, trying to convince them that an intervention that's good for people, good for the system, cost-efficient and likely to release cashable savings down the line, justifies investment. These attributes should be sufficient, but they rarely seem to be – **there's too much of a push for interventions that release *in-year cashable* savings**. I have sympathy with the civil servants and local leaders trying to find these savings. They have an unenviable task and, as I've said above, I don't think anyone is proactively trying to provide bad care, but it's still a bizarre situation to be in.

We seem to pile fantasy onto fantasy that loads of these interventions exist, just waiting to be discovered. We're awash with 'digital solutions' seeking a problem. I've seen funding go to apps that are essentially a poor imitation of Google Maps, using static instead of live data. **It can feel like the more complicated or less defined something is, the more likely it is to attract investment**.

Sure, Buurtzorg has developed an IT platform that helps nurses do their jobs well. It's an important element of the model, and yes, it feels more notable than it should within a community only just letting go of Windows XP. But the main reason Buurtzorg achieves desirable results, including financial, is that it **invests in frontline staff** rather than managers. It's **simple, intuitive and everyone can understand it**. These *should* be things we look for when deciding what to invest in. Yet the cynic in me, shaped by years of trying to make person-centred care happen, suspects a 'digital solution' described as a 'person-centred app' is still more likely to be green-lit by investors on their quest for 'innovation'. Come on funders. Please. Prove me wrong.

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Is it **feasible** to adopt the Buurtzorg models of care and organisation?

The model of care aligns with England's policy agenda; the model of organisation is necessary for the model of care, but is counter-normative to UK approaches

Aligns with England's policy agenda

The Buurtzorg model of care **delivers the personalised care** that UK health and care communities have been pursuing for many years, including its focus on self-management, see for example:

- Putting People First (Department of Health 2007)
- Think Local, Act Personal (Department of Health 2010)
- Care Act 2014 (section 26, among others)
- Understanding Personal Health Budgets (Department of Health 2012)
- Comprehensive Model of Personalised Care (NHS England 2019)

The Buurtzorg model of care **delivers the blended medical and non-medical approach** that UK health and care communities are pursuing. There is a particular focus on scaling social prescribing to bridge the divide between primary and community care, see for example:

- NHS Long Term Plan (NHS England 2018)
- A connected society: A strategy for tackling loneliness (Department for Digital, Culture, Media and Sport 2018)
- RCGP calls for social prescriber in every practice to tackle 'epidemic of loneliness' (Pulse 2018)
- The power of the arts and social activities to improve the nation's health (Health and Social Care Secretary 2018)
- Social prescribing and community-based support (NHS England 2019)

However, Buurtzorg is a **provider of long-term care, while UK social prescribing services are usually time-limited**. This **may affect the feasibility of transferring** the Buurtzorg approach to social prescribing.

If we were chatting over a coffee or pint…

Buurtzorg clients receive care and support for an average of 5.5 months, which probably makes Buurtzorg **something of a medium-term care provider in the UK**. Short-term reablement ('home from hospital') services tend to be provided for two to six weeks, community-based holistic services (such as social prescribing) for six weeks to three months, and services intended to meet long-term needs are likely to be ongoing. **I can't think of many care and support services within the three to six months range**. A gap in provision does not necessarily equate to unmet need, but there may be **a gap here worth exploring**.

Social prescribing blends medical and non-medical care by locating link workers within a medical setting, such as Primary Care Networks. Link workers must have skills including good communication, empathy and problem solving, and they might be trained in motivational interviewing, but **link workers are not expected to be qualified nurses**.

I've worked with social prescribing services and seen the good things they do – I believe there's merit in scaling them. However, I suspect there may be **a role for Buurtzorg as a sort of *enhanced* social prescribing**, where nurses blend medical and non-medical care in a different way over a longer timeframe than six weeks to three months. For example, they might work with someone *to treat* rather than manage their incontinence, reducing the social impact of this health condition, and then help them rebuild their confidence and become more involved with community activities.

Self-organised vs. hierarchy

Self-organising teams have **the power to give their clients choice and control** over their treatment, care and support.

- *"There's a lot of value in thinking 'How would I do it at home?' People tend to forget how good they are at organising things in their own life when they get to work. This is because of all the managers! People get used to not having to problem-solve and take decisions, and managers try to do the right thing but they're removed from the clients. It isn't necessary to be this complicated. And very often doing nothing is the right thing to do – you don't need endless 'innovation' – but managers aren't employed to do nothing".*
- **Staff are expected to take decisions, but are supported to do so**. They need to be confident collaborating as part of a team, and they need to be good at recognising when to call coaches for support.
- Questions may initially be asked about having overqualified nurses, such as: Why would they want to shower someone? However, they're not just showering; they're looking at skin integrity, supporting self-care as far as possible (e.g. by helping someone to wash themselves, even though it takes longer), and understanding clients' challenges with things like incontinence.
- There was a feeling among some interviewees that there may be a risk of unconscious bias leading to members of self-organising teams recruiting in their own image; reducing the diversity of an organisation and its ability to represent and meet the needs of its client base.
- Team aren't allowed to get too large. Buurtzorg teams must spilt into two once they reach 12 people.

Self-organised vs. hierarchy

But ***"almost-self-organised doesn't work".***

- You need to trust staff if you want them to hold power and in turn be able to give that power over to clients. *"You can't sort of trust them – you either do or you don't".*

Negotiation may need to take place with regulators, auditors, unions and other relevant bodies.

- The Care Quality Commission (the regulator of health and care in England), monitors, inspects and regulates providers against five questions: 'Are they well-led?' is tied-up with hierarchy and management.
- Cornerstone has been working with the Care Inspectorate in Scotland to explore ways to regulate a service built on self-organising teams rather than a hierarchical structure. Cornerstone approached them before starting to transition their organisation, and have found the regulator to be focused on improving care and open-minded about how this is done.

"The team is not a democracy – it's a consensus decision model". This can feel very strange to people at first. *"You can't complain you didn't vote for something and then wait for it to fail. You all take a decision, you work together to make it a success, but you keep talking and change it if it's not working".*

- In a consensus decision model, a nurse does not outrank a nurse assistant. *"They are two different and complementary jobs. The nurse has no leading role. They receive higher pay, but that doesn't equate to higher power".*

Self-organised vs. hierarchy

Coaches don't make decisions, but they will support the teams to make them.

- Working in a consensus model makes it especially important that staff have training in conflict resolution. *"You will have conflict. You should have conflict. You might have less conflict in a democracy, but you'll achieve less and have lower morale too".*
- *"It's very different to having a manager who, by virtue of being there, is the go-to for decisions".*
- The coach will always ask if the question, decision or issue has been discussed with the team. *"They're not meant to be your first port of call".*
- *"One mistake organisations make is to have too many coaches. If you have too many then they're not busy enough and they start to manage!"*
- It is challenging to find the right people to be coaches. *"We're not looking for a coaching style of management – that's still management – coaching is very different and can be hard to recognise if you haven't seen it before".*
- *"If you don't allow a team to fail you will never teach them to be accountable".* Mistakes are acknowledged and learnt from. *"You see organisations pretend they don't make mistakes. Clients, families and staff suffer, and then the mistakes keep going. Why?"*

An unbureaucratic organisation

The **Buurtzorg model of organisation is counter-normative to UK models**, including within the public sector.

- Buurtzorg has a multidisciplinary team of about 50 back office staff. *"If you have an inflated back office then it becomes difficult to know how you are adding value to anything".*
- Everyone in the back office is there to support the frontline.
  - *"HR must make a particular shift in loyalty from managers to the frontline [when transitioning from hierarchical to self-organising approaches]. If they can't do this, then they are not right for the organisation".*
- There are no managers in the back office.
- *"There's a lot of collaboration"* within and across the back office because staff are not working in individual functions with separate budgets. *"We are not caught up in this sort of bureaucracy".*
  - *"Why would not-for-profits have 'business partners'? …a silly name. You have business in the commercial world. They're not accountable for any 'business'. We don't have these sorts of roles".*
- *"We have 'general supporters' focused on the frontline, with no function names. Labels drive worker identity and they restrict it. We allow expertise to be derived from different people and easily pooled".*

An unbureaucratic organisation

Everything is as lean as possible.

- *"Be clear on goals"*. Amstelring Wijkzorg has three goals, set by the Board:
  1) Have fun in your job.
  2) Deliver good care.
  3) Be financially healthy.
- The teams then devise plans to achieve these goals, which they own and are accountable to. The plans are monitored, but their content isn't judged.
- All IT is outsourced, with hardware leased rather than bought.
  - Clients own their files and decide who can access them. Staff sometimes have to say no to family members who want to access their loved one's records.
- Payroll, tax, legal and other administrative functions are bought in. *"We look for interesting partners who are way ahead of us"*. There is no need to replicate the innovation already happening elsewhere.
- Rather than have a policy schedule, issues are identified by teams through workshops, discussion groups and so on, and are then picked up by project leaders.
  - When Cornerstone in Scotland moved to a self-organising model, they went from 47 HR policies to six policies and one page of additional guidelines.

An unbureaucratic organisation

- Genuinely **focused on outcomes rather than outputs**. Benchmarking is helpful.
- **Buurtzorg teams must use the Omaha system**, which is the organisation's quality system involving the monitoring of patient satisfaction and outcomes. It was developed with teams and extensively tested in practice with them. The process of adoption took four years.
- **HR policies need particular attention.** Traditional HR policy is based on hierarchical relationships between managers and employees. *"You have to do things differently".*
  - This can be challenging. Under Swedish labour laws everyone has to have an individually negotiated salary, based on an annual appraisal, and organisations must articulate what individuals need to do to improve in order to get more money. So while the annual appraisal has been done away with by Buurtzorg in the Netherlands, it persists at Grannvård in Sweden.
- **The back office is there to support the frontline.** *"They are our customers and we are there for them – we don't do that by drafting a policy at a desk and launching it at them".*
- **The back office is a *"firewall"* or *"heatshield"*.** *"We defend them [the frontline] against all the things the world is inventing…and we also remove the obstacles". "We protect against outside diversions so they can create the culture they need to thrive".*
- **Everyone is focused on doing the right thing.** *"It's the whole point of the organisation. Do you want control? Or do you want to deliver really good healthcare?"*

Transitioning to this approach

- ***"Be brave".*** There was consensus that it's *"very scary for an organisation". "It is difficult to break through the focus on why not rather than why". "The main thing is to be brave. It will be worth it".*
- ***"Let go".*** Getting rid of the managers is difficult. *"There were a lot of claims the nurses 'weren't ready, when really it was the managers who weren't ready to leave and the senior managers who weren't ready to give up their power".*
- ***"It is always a big bang".*** You cannot recruit coaches and not let go of the managers. "*If the managers are there they keep on managing, especially in the back office". "It has to be all at once".*
- **Teams may need time.** Sometimes teams adopt informal managers. This might feel comfortable at first, but *"the team will grow in confidence [usually over the course of the first year] and realise they achieve more through autonomy and consensus'. "Ultimately they ask the leader to leave".*
- **Celebrate success, but *"You must be allowed to fail".*** *"You can't say in week two that everything is amazing so you can pursue some fundraising". "If you don't allow a team to fail you will never teach them to be accountable".* Amstelring Wijkzorg sends flowers to teams that make a mistake and learn from it.
- **Don't forget your clients!** *"You have to talk to your clients that you work in a different way"* [sic]*. "We're aware of clients who have become angry, saying 'I don't want you here any more – all these questions!' You have to explain their active participation sometimes – it's not just about doing things for them while they don't do anything".*

Scaling this approach

It has proven easier to scale Buurtzorg in the Netherlands than in Sweden.

- Providers in the Netherlands can work with and broker national agreements with the small number of insurers that dominate the market.
- Providers in Sweden have to work with each of the 290 municipalities, which use a range of IT, reimbursement, governance and contract monitoring systems.
- Some Swedish municipalities allow any provider that fulfils basic criteria to start providing services. Others open competitive contracting to become one of a small number of approved providers, where *"It is almost impossible to win unless you are the cheapest".*
- There is a feeling that Sweden's plethora of commissioners may make it easier to pilot new approaches than in the Netherlands, but scaling successful pilots is very difficult.
- Interviewees with knowledge of both the Dutch and Swedish systems felt health and care to be more joined-up in the Netherlands than in Sweden, which has also made it easier to scale a holistic service.
- There are workforce-related financial challenges to scaling the service in Sweden. A registered community nurse can earn €1,000 gross per month more than a nursing assistant. Some municipalities are only willing to pay a nominally increased rate for a nurse rather than a nursing assistant, despite requiring a registered nurse to be available 12-18 hours a day, seven days a week.

Different cultural contexts

Self-organising teams are *"enabled by a culture of blunt communication"* between team members in the Netherlands – *"no one takes offence".*

- Straightforwardness is so intrinsic to Dutch society that there's a word for it: 'bespreekbaarheid'. It means 'speakability' – everything can and should be talked about.
- This is a helpful and healthy context for self-organising teams to operate in. Team discussions are frank but constructive. Compliments and encouragement are freely shared, but there's no pussyfooting around concerns either. It is exceptionally rare that someone take offence, and the idea of a festering work-based grudge was a difficult one for Dutch interviewees to even grasp.

This concept of 'speakability' is not intrinsic to Swedish society.

- This has made it harder to implement self-organising teams there.
- *"It's intuitively a good idea – everyone can probably think of issues at work they wish people would talk about. But we're used to being diplomatic. We don't always make the point clear. It takes time to see the benefits of frank discussion and change that mindset and behaviour".*

Variation in social behaviour may affect the feasibility of transferring self-organising teams from one health and care community to another.

Different cultural contexts

Self-organising teams are also enabled by a culture of consensus decision-making, which has been embedded into both public and private life in the Netherlands.

- 'Poldermodel' (or 'polder model' in English) is the Dutch practice of consensus decision-making, characterised in the 1980s and 1990s by cooperation between government, employers and trade unions.
- Named after the Dutch habit of working together to reclaim pieces of land (polders) from the sea, the model sees government, employers and trade unions try to find compromise – sometimes through weeks of negotiation – usually arriving at a binding consensus.
- There are challenges with the poldermodel, including the ability of the three parties to respond to the changing nature of work, such as the rise in the gig economy. Nonetheless, this approach to decision-making has seeped into broader society, including family life (Economist 2004) and provides a backdrop for flat leadership structures and the absence of hierarchy.
- Egalitarian principles are also demonstrated in the Dutch welfare system, including unemployment benefits and labour protections. While the UK health and care workforce is beset by challenges with insecurity such as zero-hours contracts, the Dutch system tries to balance the demand for flexible working with the security needed by workers, an approach known as 'flexicurity' within the EU.

Different cultural contexts

While not underpinned by the same level of 'speakability' as in the Netherlands, consensus decision-making is also part of Swedish culture.

- This is known as 'förankringsprocessen', meaning 'the consensus process'. It essentially means "getting everyone involved with everything" (Moon 2018).
- "Everyone voices an opinion and everyone listens. Then they compromise. The word compromise is music to a Swede's ears. Everybody gets something. Not too much and not too little, but *lagom*. Nobody wins and nobody loses" (Moon 2018).
- This is role-modelled within the Swedish Parliament (to a point at least, and certainly more so than in Westminster's combative approach), where members sit within constituency rather than party groups.
- 'Decision anxiety' ('beslutsångest') can occur – *"there's more process than in the Netherlands and the whole thing is less pacy".*
- Some interviewees felt decision-making would be quicker if Swedes were less concerned about being diplomatic and were more frank with each other. *"The Dutch just don't seem to take offence! We do".*
- *"…but I think it's more efficient than my experience of the UK, because people explore decisions and then make them happen. You seem to repeat a lot of processes and tasks in the UK".*

Variation in decision-making behaviour may affect the feasibility of transferring Buurtzorg from one health and care community to another.

Different cultural contexts

There is a strong focus on independence in Sweden, which complements Buurtzorg's model of care.*

- The promotion of independence is ingrained from childhood, with the most common age to leave home being between 18 and 19, compared to an EU average of 26 (Eurostat 2019). *"We don't depend on our children. It is not successful for them to take care of you instead of living their lives. They need to be independent and so do we"*.
- Swedish society is relatively open about death, with 'Swedish death cleaning' now something of a decluttering trend in the UK (Scott 2017). Its focus on getting rid of things that could cause loved ones annoyance or distress to deal with after your death is linked to the concept of independence.
- There was a feeling among some (but not all) interviewees that this **makes it easier for people to think about and accept their functional decline** than in the UK, which in turn *"makes it easier for health professionals to have constructive conversations with people about how they can work together to make life as good as possible".*
- However, this focus on independence means more people live alone (the highest percentage in the EU; Eurostat 2018) and **makes it harder to establish support networks**. *"Heaven forbid you to talk to my kids, neighbours or anyone else to build up my network. We don't bother each other" [sic].*

Variation in social attitudes may affect the feasibility of transferring Buurtzorg's model of care from one health and care community to another.

*Promoting self-management, building trusting relationships and networks of support, and providing care in a person-centred way.

The third sector interface

Clients can be **linked to voluntary organisations, community groups and others in the third sector** who can support them to achieve their goals and maintain or regain independence.

- This is done in a very similar way to UK social prescribing, with clients and staff working together (and with loved ones) to identify organisations and groups that can help clients achieve their goals and maintain or regain independence. Staff may go with clients to the first few sessions of an activity or peer support group to help them settle in, work out transport with them, get to know new venues, and so on – just as link workers do in social prescribing services.
- *"I think we see this happen most when people are lonely or isolated".*

It is **up to new teams to *"create a social map"*** of what's available within their community.

- However, English local authorities have a duty to establish and maintain a service for providing people [all people, regardless of need, and including care and support staff] with information and advice relating to care and support (Care Act, 2014: 4; DHSC, 2018: Paragraph 3.15).
- There is therefore a push for English services to work with local authorities to utilise and enhance the maps (often electronic directories) they've already developed as part of their discharge of this duty, rather than inadvertently duplicating or usurping them (Reeves & Cole 2019).
- *"Part of what they [teams] do is to activate the community to support the model".* This includes third sector organisations, but also *"the coordinators, like GPs and therapists and pharmacists".*

The third sector interface

The **third sectors have differing portfolios of health and care roles and services**.

- In the UK, third sector organisations and groups provide services through which they discharge statutory duties (sometimes subsidised by charitable funds), as well as a support offer that falls outside of and adds value to statutory responsibilities.
- The Netherlands has a similar blend, with organisations that deliver public services, organisations dependent on membership and donations, and organisations like social enterprises that are "arising in response to a retreating welfare state and the perceived failure of markets to deal with pressing problems" (Pape & Brandsen 2016).
    - There was a feeling from people aware of both the Dutch and English third sectors that charities in the Netherlands are not subsidising the provision of statutory services with charitable funds to the extent that some English charities are. *"That would be a step too far – how do you reign that in once you go there?"*
- In Sweden, there was a feeling that the third sector tends to focus on a support offer that falls outside of and adds value to statutory responsibilities. *"In Sweden you have some charities that are working with people 'on the outside of the system' like street homeless and asylum seekers. Then you have volunteer-led organisations that take lonely people out for walks and coffees. I suppose the first has higher unit costs and is maybe a more formal organisation than the second. But there is not a well-developed charity market. We have a comprehensive welfare system".* [The interviewee noted that this may differ across regions, but was accurate within the regions they have worked / currently work in].

The third sector interface

Some areas' third sectors are better-funded and cultivated than others – just as in the UK.

- Some Dutch insurers and Swedish municipalities pay for third sector activities and some don't.
- It is relatively common in Sweden for people to receive funded support to address loneliness and social isolation – possibly linked with their promotion of independence and attitudes toward intergenerational caring. These services tend to be considered preventative in England, with no individual entitlement to receive them. Provision and access are therefore patchy (the British Red Cross has investigated this).
- There was a feeling among interviewees that in both the Netherlands and Sweden – as in the UK – the areas with the least thriving third sectors tend to be the areas of highest deprivation. This can mean people living within these areas find it more difficult than most to identify organisations and groups that can help them achieve their goals. Overcoming these inequalities is challenging.

Money does not tend to transfer in parallel with clients from providers, like Buurtzorg, into the third sector.

- *"For us it's not really a topic – how the organisations are getting their funding – they have to take care of their own foundation. The only thing we are doing is trying to find the best place for our clients".*
- Third sector interviewees reported concern about the lack of funding transfer into the sector. All identified this to be a systemic issue rather than one specific to Buurtzorg.
- Concern for sector sustainability was stronger in the Netherlands than in Sweden. Third sector interviewees spoke of being asked to *"do more for less"*, including provide public services.

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Conclusion: What might this mean for third sector organisations and groups?

The English third sector's priority is to ensure the financial sustainability of social prescribing. This recognised, there is an emerging sense it may be better-placed than public bodies to lead work to implement a Buurtzorg approach to social prescribing

Desirable? Yes. Feasible? Hopefully.

Buurtzorg, and organisations like Amstelring Wijkzorg that have followed its approach, are delivering results for people, staff and the system in the Netherlands and Sweden that are desirable within the UK.

It might be feasible to adopt the Buurtzorg models of care and organisation in the UK (with a focus on England), but it's not as simple as lifting the approach and transferring it. *"It will need to be tweaked".*

- Demographic challenges are similar across the Netherlands, Sweden and UK: ageing populations; more people living with multiple long-term conditions; increased loneliness and social isolation; and challenges around the sustainability of paid and unpaid care. The 'ageing-in-place' push for care within the home, and the shift from secondary to primary and community care are consistent responses to these challenges.
- The Buurtzorg model of care aligns well with England's policy agenda, including its stated ambitions of person-centred care, blended medical and non-medical care, building trusting relationships and networks of support, and promotion of self-management. Self-organising teams have the power to give their clients choice and control over their treatment, care and support – *"but almost self-organised doesn't work"*.
- The Buurtzorg model of organisation is necessary for the model of care, and is counter-normative to UK approaches. It appears be in direct conflict with some frameworks, notably regulatory, but work in Scotland suggests this is surmountable.
- Social behaviour (*"blunt communication*" and 'speakability' in the Netherlands), social attitudes (the promotion of independence in Sweden) and decision-making behaviour (consensus rather than democracy in both countries) seem to particularly benefit the Buurtzorg approach – variation in these may affect the feasibility of transferring it from one health and care community to another.

Third sector priorities

English third sector organisations and groups, including the networks, coalitions and alliances that represent them, are **vehemently supportive of person-centred care**.

- National Voices, the Richmond Group of Charities and the Care & Support Alliance all advocate the system must practice the theory it preaches and become truly person-centred.
- Buurtzorg's self-organising teams have the power to give their clients choice and control over their treatment, care and support.

However, the **concerns from Dutch and Swedish third sector interviewees** that 1) some areas are better-funded and cultivated than others, 2) there is a lack of funding being transferred into the third sector in parallel with clients, and 3) the areas with the least thriving third sectors are the ones with the higher-need populations, all **resonate with third sector colleagues in England**.

These concerns particularly resonate with regard to the scaling of social prescribing:

- The act of linking people / creating a social prescription does not immediately meet people's needs.
- It is the personal networks and practical and emotional support within the third sector that help people live their lives as well as possible.
- Therefore, there is a strong feeling that **social prescribing schemes must either provide or be developed alongside plans for sustainable funding of third sector infrastructure.**

Third sector leadership

That said, as Cornerstone is demonstrating in Scotland, **third sector organisations can show leadership by initiating constructive collaboration with agencies such as regulators** to adapt their frameworks so that they can work with a Buurtzorg-style model of organisation.

Third sector organisations have a track record of 'showing and telling' the wider health and care system how to do things differently in order to help people live their lives as well as possible. The Richmond Group of Charities' Doing the Right Thing, Movement for All, and Taskforce on Multiple Conditions offer examples of this approach.

Evaluations of this 'showing and telling' (see e.g. Joy et al 2018) suggest **third sector organisations can offer strong leadership within an ever-changing health and care landscape**:

- Stable leadership, plus organisational memory – in contrast to the public sector's high turnover, particularly of senior staff.
- Agility to try new ways of working, without becoming overburdened by ever-changing governance structures and the associated focus on procedure change rather than actual practice change (see e.g. Better Care Fund partnerships, Sustainability and Transformation Partnerships, Integrated Care Systems and now Primary Care Networks).
- Flexibility, including the ability to focus on outcomes rather than outputs.

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Recommendations

Taking this forward,

plus an offer to third sector colleagues

Where now? Taking this forward

1. **People working in the third sector** (at national, regional and local level) should keep exploring, sharing learning and talking about the Buurtzorg approach, including how to realise its models of care and organisation in the UK.

   We all want person-centred care to happen; lots of us are fed-up with the lack of progress; yes, there are some examples of proper person-centred care happening in the UK, but we're nowhere near it happening at scale; there may well be other ways of achieving and scaling person-centred care, but Buurtzorg is one that we should seriously consider.

2. **People working in the public sector** (at national, regional and local level) should recognise people, groups and organisations in the third sector as essential partners in Buurtzorg-type approaches, and collaborate with them on both the theory and practice of implementing them in the UK. This includes addressing the priority that funding transfers in parallel with people between the sectors.

   The sustainable success of Buurtzorg-type approaches depends upon partnership with the third sector.

   Though the NHS and local authorities are incredibly stretched, a variety of people within the public sector have had the opportunity to travel overseas and visit organisations like Buurtzorg and Amstelring Wijkzorg. It is very difficult to understand how these organisations work without seeing them in action, but people in the third sector tend not to have access to funding for overseas travel. Organisations like WCMT can help to bridge some of the divide, but this report is nonetheless the result of many hours of my unpaid work. It would be good to see more UK delegations to Buurtzorg services considering the third sector perspective and sharing their learning upon return.

   We all want to see proper person-centred care. We need to work together to achieve this. We must all be open and generous with our learning and ideas.

Where now? Taking this forward

3. **Third sector provider organisations that are in a position to do so**, working with **organisations that can ensure people are partners in the design of services**, should consider 'showing and telling' what a Buurtzorg approach could look like in the UK.

4. **Buurtzorg in Britain & Ireland** should continue to invest time and energy into collaborating with the UK's third sector.

5. **Funders**, including Big Lottery, Nesta and the Health Foundation, should be invited to join these conversations, and will hopefully be glad to do so.

Buurtzorg is achieving the person-centred care and associated results that we aspire to in the UK, but it does so through a very different way of working – one that's removed from the way the NHS and local authorities currently work.

The third sector can be very good at leading by example. If we're serious about person-centred care, then it's worth third sector provider organisations, in partnership with people who may use these services and their carers, scoping what a Buurtzorg-type approach could look like. This may fit well with a social prescribing service – there are opportunities to start afresh with these, rather than have to unpick layers of existing management, hierarchy and legacy IT systems – but there will be other opportunities too.

It may well take the third sector's courageous and agile leadership to demonstrate what it really means to give power over to the frontline so that staff can give that power over to the people using services. But these are challenging financial times for the third sector as well as for the public sector, and funders that are committed to person-centred care need to be invited to shape these conversations from the outset.

Where now? Taking this forward

6. **There is much cause for optimism**, but **everyone in the health and care community** should be pragmatic about Buurtzorg-type approaches.

The Buurtzorg approach is not the answer to everything. It is still frustratingly problematic to get hospitals and GPs to share data in the Netherlands. It is still cheaper for a Swedish municipality to send someone to hospital on a Friday afternoon because it will come out of a regional budget, than it is to fund a nurse from their own budget to to visit and take steps to avoid hospitalisation. Buurtzorg reduces costs, but that does not necessarily mean it releases in-year cashable savings.

We must avoid the trap our health and care community sometimes falls into of talking up a new idea as a panacea for all problems. We set so many ideas up to fail this way. We know that words like 'radical' and 'innovative' create a barrier between people working in health and care and members of the public (BritainThinks 2018), but we continue to throw them around anyway. Sometimes it feels like we've forgotten what we're even talking about. Health and care are meant to be about people.

We also need to remember that self-organising teams and the giving over of power to people using services is likely to be new to all involved. Despite years of talking about giving people "choice and control", it's not the norm. It will probably take quite a long time for this way or working to take-off, so let's be realistic about it. It's also one of many reasons why it needs to be done in partnership with people who will use the services and their carers.

There may even be easier ways of getting power to people using health and care services and making proper person-centred care happen. If so, then we should of course be talking about these too. But Buurtzorg is achieving good things, at scale, and wants to benefit people by seeing its approach replicated, so it seems like a good place to start.

Next steps

An offer to third sector colleagues:

There's a lot of information within this report and none of us are exactly flushed with time, so **how about a webinar that picks out the key points and creates an opportunity for discussion**, questions and answers? The format of this would probably depend upon funding, but I'm hopeful of being able to access enough to at least do something. Public and private sector colleagues would of course be welcome, but the focus will be on a third sector perspective.

And, if that generates the interest, how about a **subsequent meeting of people** interested in exploring whether the third sector could 'show and tell' the wider health and care community what a Buurtzorg-type approach to proper person-centred care could look like in the UK? I'll do the logistics and get the discussion going.

Contacts

Please feel free to get in contact with me to find out more about this work, about other projects I've worked on, or about Churchill Fellowships (which I can't recommend highly enough!):

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Please remember that while I've focused my Fellowship on Buurtzorg's work, I do not work for them. If you would like to know more about their work, especially in the UK, then Brendan is a good person to ask:

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