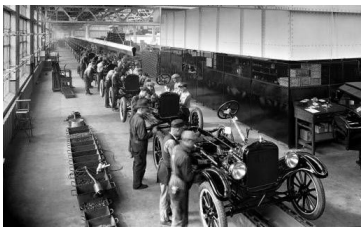
Adopting Buurtzorg: How to revolutionise care in the UK

Losing Control
6th February 2019

1

2

Care ≠ Cars



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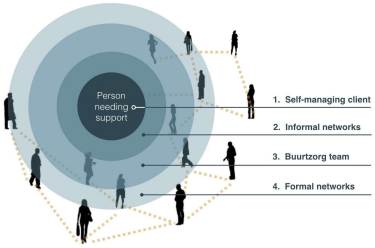
Buurtzorg = person-centred, relationship-based care



4

The client at the centre

- First coffee, then care
- Variety of clients
- Holistic approach — relationship not tasks:
  "Doing What Is Needed"
- Satisfied clients
- Good quality of care
- 1 or 2 "care coordinators"
- 3 or 4 different nurses
- Being part of the whole process

5

Support self-reliance

- Try to keep a person independent
- What are the client's goals?
- What does a person need?
- What can and will the client do by herself?
- The role of informal carers
- Co-creating practical solutions

6

Professionals in Self-Organised Teams

- Specialists working as generalists
- Local teams of 8-12 care professionals
- 70% registered nurses / 40% bachelor degree
- Framework and professional autonomy
- 24/7 accessibility by phone
- Choosing and managing own office
- Deciding own education and training
- Sharing and rotating organisational tasks
- Respecting differences in team
- Solution-driven interaction
- Consensus: 'Can you live with it?'

Best employer 2011, 2012, 2014, 2015, 2018, 2019

7

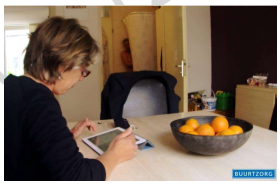
Supporting the teams: the nurse is the client

- 50 people in 1 back office; 20 coaches; 0 managers!
- Important role of the coach
- Back office taking care of bureaucracy, leaving nurses to nurse!
- Tasks of the back office:
  - Charging and dealing with insurers
  - Paying the staff
  - Managing regulatory compliance
  - Simplifying professional and regulatory governance

8

Clever IT as essential building block

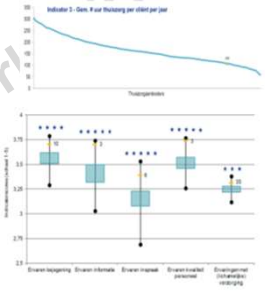
- Frontline tool:
  - Assessment
  - Care planning
  - Record keeping
  - Outcome tracking
  - Team planning
- Team performance
- Client portal
- Internal 'Facebook'
- Learning Academy
- Payroll & invoicing; data analysis (back office)



9

Proven impact, independently verified

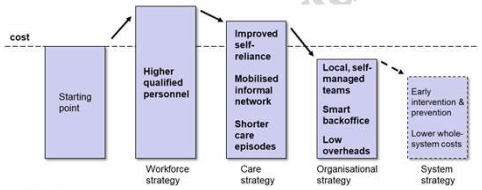
- Patients stay in care significantly shorter (108 hours v 168) and 50% of the patients receive care for less than three months. (KPMG, 2015)
- Overhead costs of 8%, compared to Dutch average of 25% (KPMG)
- Hospital admissions are reduced by 33%, and the average stay is shorter. (E&Y, 2009)
- Highest score on Customer Quality Index (KPMG)
- E&Y estimate that the Dutch social care bill would be €2bn less if all home care was provided in the same way.
- Top marks across all inspection categories from Dutch regulator (IGJ, 2018)



10

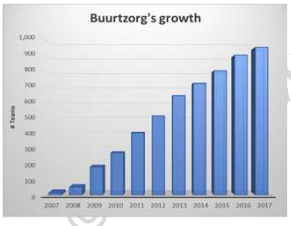
The business case

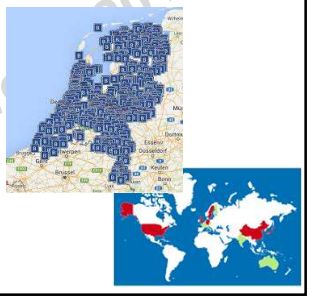
- 40% lower client costs compared to other home care organisations
- Overhead costs estimated at 8% compared to a competitor average of 25%



11

Organic growth: from 1 team of 4, to 950 teams and 14,000+ caregivers



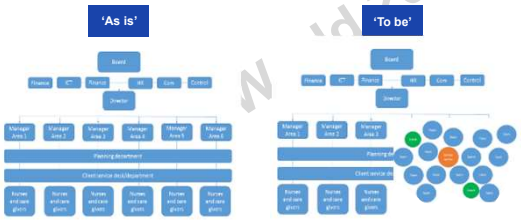


12

Experiences from the UK

13

Can the model work in an existing organisation?



14

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15

Buurtzorg in Britain & Ireland

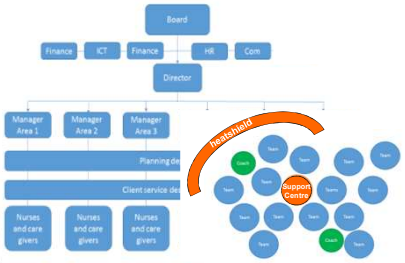
16

Using pilots to get to grips with the model

- 'Greenfield within brownfield'; suspending organisational laws of physics
- Small self-managed teams in defined location
- Focus on the client and informal network
- Coach: team focus
- Heatshield: organisation focus
- Repurposing backoffice through Support Centre
- Keeping things small, keeping things simple

17

How to create a protected 'bubble'

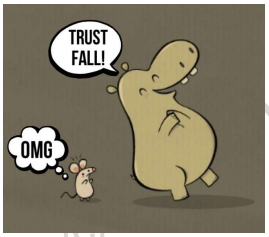


18

Iterative approach: Test & Learn

19

This is not just about self-managing teams



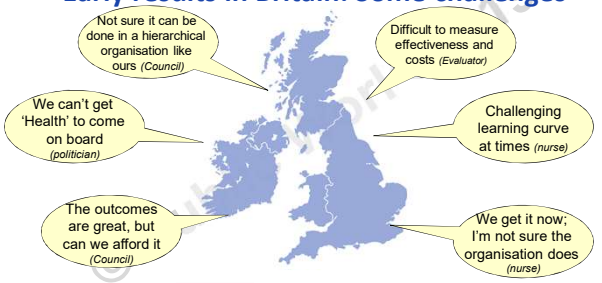
- Create the conditions for self managing teams to self manage
- Trust the professional
- Create real 'at your service' culture
- Repurpose the entire organisation
- Smart IT
- Expect the need for improvement along the way
- Foster leadership with vision and commitment to transformational change
- Be relentless in drive for simplification

20

Early results in Britain: Real impact

21

Early results in Britain: Some challenges



22

In summary

- Great care ✓
- Great jobs ✓
- Great support ?
- Great savings ?

23

Please help me; my questions for you

1. (How) can we move clients away from Pilot+Evaluation approach, to Test&Learn (and Upscale)?
2. (How) can we design a truly integrated health & social care service using this model? What needs to be in place? Who needs to be on board?
3. Where are the most fertile prospects for doing this successfully?
4. If applied outside health & care, what ingredients of the model translate well to other contexts/sectors?
5. How do we reconcile a model that is essentially bottom-up (from the frontline) with the fact that the power in h&sc lies at the top of the hierarchy.
6. Should we go 'straight to the top' (NHS England) and if so how and what should be our ask?

24

"Making things complicated isn't particularly hard…

But making things simple, that can be pretty complicated"

25

BUURTZORG Britain & Ireland

Find out more:

www.buurtzorg.org.uk
@BuurtzorgBI
admin@publicworld.org
+44 20 3092 4789

@PaulBuurtzorgBI
paul@publicworld.org
07866 741601

26