Notes and reflections on a study tour to the internationally acclaimed Buurtzorg Model

The THIPP method - Buurtzorg type model in Tower Hamlets

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Study visit for the Integrated care pioneers and New Care Models vanguards organised by the NHS European Office

Almelo, Tuesday 26 January – Wednesday 27 January
Tower Hamlets Integrated Provider Partnership
We are a national MCP Vanguard site

We are working at pace to deliver new ways of working across mental and physical health and social care

The THIPP NHS Partners have formed a Consortium and are the preferred provider for Community Health Services in the borough having been through a competitive dialogue process over the past 18 months
Why did we want to go to Buurtzorg?

• To learn more about the delivery of a successful model of community nursing care
• To understand how it might help with some of the big issues we are facing, like workforce and improving patient experience
• To see how this might translate into our own plans for community health care in Tower Hamlets
• To share ideas with partners both locally and nationally
• To spend time with each other, developing relationships reinforcing our partnership style of working
• To get out of Tower Hamlets for 48h
• Erewash
• Solihull
• South Hampshire
• Dudley
• Wakefield
• West Cheshire
• Worcestershire
• Cornwall
Buurtzorg

• Neighbourhood care
• New organization and new care delivery model
• Started in 2007 with 1 team/4 nurses
• Delivers community care
• Grown by Jan. 2016 to 9,500 nurses in 850 independent teams
• Teams are small and never grow bigger than 12 members
• 45 staff at the back office, 16 coaches, 2 directors
• 70,000 patients a year
2004 Dutch position

• Fragmentation of care

• Anticipated perfect storm of aging population coupled capacity problems due to demographic developments (shortage of 400,000 nurses within 10 years)

• Clients confronted with many caregivers for personal care, nursing care and home care

• Nurses very unhappy

• Went out to Portugal in the semfinals of Euros (who had also beaten England in the quarterfinals)
Positives

• Patients love the model
  • Continuity of care
  • Quality
  • Time spent with professional
  • Ranked #1 of 307 providers

• Workforce love it
  • Feel empowered to make own decisions about how to work and organise team
  • Best Dutch employer of the year 2011/12/14/15

• Insurance companies love it
  • Despite model being more expensive at face value, overall costs including hospital admission (or lack of it) lower
Important caveats

• Buurtzorg is all about community nursing and personal care
• Nurses undertake a lot of the personal care tasks
• Doesn’t fully embrace partnership working within the team
• Buurtzorg + embraces physio/OT therapists but have to fit in the team and have to sign up to the ethos and put the team clients above all else
• IT is incredibly functional but is really only a stand alone system for the district nursing team. Doesn’t talk to GP systems or accessible by other organisations
• Workload issue comparing UK vs The Netherlands
• Transferability to Tower Hamlets
• Universality of UK model cf ability to ‘close list’
• Cost of estate – 400 euros a month rent
• No harnessing of the power of MDT or colocation with social services
# Key differences of Buurtzorg and UK experience

<table>
<thead>
<tr>
<th>UK community care model (based on Tower Hamlets)</th>
<th>Buurtzorg Care Method</th>
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<tbody>
<tr>
<td>Split of personal care from nursing care</td>
<td>Integrated personal and nursing care</td>
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<tr>
<td>Assignment of tasks based on skill and expertise</td>
<td>No distinction is made between the nurses</td>
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<tr>
<td>Focus on creating larger integrated care teams</td>
<td>Deliberate effort to maintain the size of each team between 9-12</td>
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<tr>
<td>Control, quality assurance and clinical governance</td>
<td>Self-governing teams supported by coaches</td>
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<td>Fixed working hours</td>
<td>Flexible working hours aligned to patient demand for care</td>
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<td>• Over reliance on agency</td>
<td>• No agency staff</td>
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<td>• Education budget is centrally governed</td>
<td>• Each team has own training and education budget</td>
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<td>• Control and performance management</td>
<td>• Trust and enabling freedom to self-govern</td>
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<td>• Ownership and responsibility of care not clearly articulated</td>
<td>• Responsibility rests with the team</td>
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<td>• Patient complaint : contact ratio 2.8 per 1000</td>
<td>• Patient complaint : contact ratio &lt;0.01 per1000</td>
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<tr>
<td>• Higher levels of acuity</td>
<td>• Lower levels of acuity</td>
</tr>
<tr>
<td>• 75% spent on direct patient care (25% overhead costs)</td>
<td>• 92% spent of direct patient care (8% overhead costs)</td>
</tr>
<tr>
<td>• No surplus revenues</td>
<td>• Surplus revenues spent on nurse education and training</td>
</tr>
<tr>
<td>• Increase in pay through combination of promotion, length of service and standard annual increase</td>
<td>• Increase in pay through level of education, standard annual increase and bonuses based on years of working for Buurtzorg</td>
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<td>• Working in dilapidated office environment</td>
<td>• Working in modern environment</td>
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<tr>
<td>• Nurse to management/support function ratio (9:1)</td>
<td>• Nurse to management/support function ratio (182:1)</td>
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Crowding out of control based governance

**Central hypotheses**

Negative attitudes toward trust-based self governing systems

- A strong present bias and difficulties to act in accordance with one’s long-term interests
- An unreadiness to support a trust-based delivery system when it contravenes our organisational identity and perceived risks to patients
- Learned helplessness, which the system supports
Intertemporal Choice and Transformation

Decisions between alternatives whose consequences will be realised at different timepoints (in the future)
Difference

Delayed consequences

Immediate consequences

Happier staff
More patient facing activity
Reduced incidents

Loss of control
Loss of identity
Feeling of coercion
Financial Burden
Transforming services together

• If you think you are going to be successful running your business in the next ten years the way you did in the last five years, you are out of your mind. To succeed you have to disturb the present.

Roberto Goizuetta, Chief Executive Coca Cola
Buurtzorg cost base

• Turnover 2014: 280.000.000 euros
• Direct spend: 89%
• Overhead: 8%
• Surplus: 3%
• Sickness rate: 5% (average 7%)
Comparative costs

KPMG 2015 review found:

- Buurtzorg amongst the best in the country on patient reported experience, whilst providing substantially fewer hours of care
- 62% of providers had casemix adjusted costs that were more expensive than Buurtzorg even though its personnel costs were higher than average (54.47 euros vs 48.74 euros per hour

### Exhibit 2. Cost Comparison: Buurtzorg vs. Other Dutch Home-Care Providers

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<tr>
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<th>Buurtzorg</th>
<th>Other Dutch home-care providers</th>
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<tbody>
<tr>
<td>Average hours of home care (per client per year)</td>
<td>108 hours</td>
<td>168 hours</td>
</tr>
<tr>
<td>Average home-care costs (excluding follow-up costs)</td>
<td>€6,428 ($6,990)</td>
<td>€7,995 ($8,695)</td>
</tr>
<tr>
<td>Average follow-up costs in the Exceptional Medical Expense Act (mainly nursing home cost)</td>
<td>€2,029 ($2,207)</td>
<td>€2,510 ($2,730)</td>
</tr>
<tr>
<td>Average follow-up medical (physician and hospital) costs</td>
<td>€7,787 ($8,468)</td>
<td>€5,187 ($5,641)</td>
</tr>
<tr>
<td>Total case-mix adjusted cost per client, including home care and follow-up costs</td>
<td>€15,357* ($16,701)</td>
<td>€15,856* ($17,243)</td>
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</tbody>
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* Only the total costs include case-mix adjustment.

Where next?

• What should the scope and scale of our pilot be?
• What should be our activity assumptions?
• Should it be nursing and personal care only, or multi-disciplinary?
• Should we focus on adults and/or children?
• How do we fund the pilot, with appropriate support and evaluation?
• What are the statutory and regulatory considerations?
• How can we give the pilot some “headroom” to get on creatively and resourcefully?
• How do we think about the delivery of personal care, in the context of the council’s responsibility under the Care Act, and the likely introduction of charging?

• How do we design the workforce and how do we recruit to the pilot?

• How do we manage the pilot in a way that energises the workforce more generally?

• What are the education products, e.g. induction, supervision, learning inputs, coaching? How will they be provided?

• How do we play in our partnership commitment to quality improvement tools and techniques?
• The brilliant Buurtzorg IT system seems critical to the model, can we use something similar, what would be the impact on inter-operability?

• How do we understand the baseline so we can design an effective evaluation?

• To what extent should the steering group do all of the above v. recruiting a team and letting them have the freedom to discover solutions?

• We need to team up with others working on piloting this model