



**RCN Policy and International Department  
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# The Buurtzorg Nederland (home care provider) model

## Observations for the United Kingdom (UK)

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## Purpose of this briefing

This briefing looks at:

- the success of the Buurtzorg community care programme in the Netherlands
- the growth of interest in the UK for replicating this success
- the challenges that will need to be addressed to realise this.

This briefing has been updated to reflect new findings collected by the RCN following various events in 2015 and early 2016.

The first of these was a seminar hosted in July 2015 between the RCN and Public World (Buurtzorg's official partner in the UK)<sup>1</sup>. This event was attended by Buurtzorg's founder and head, Jos de Blok, who explored in more detail the development of the model, as well as answering specific questions about how Buurtzorg's approach might be adapted for the UK.

Following this, Buurtzorg was discussed at the annual NHS Employers Conference in London in late July 2015. This meeting provided an important opportunity for UK health providers to hear and reflect on the experience of Buurtzorg in delivering patient-centred care. Jos de Blok presented on the Buurtzorg model and Janet Davies (RCN Chief Executive and General-Secretary) chaired a follow-up discussion.

Then in November 2015, a team from RCN Scotland visited the Netherlands to see the Buurtzorg model in action. RCN Scotland formed part of a delegation comprising civil servants, NHS Board/Local Authority representatives and advisers from the Chief Nursing Officer's team for Scotland. The visit focused on the day-to-day experiences of Buurtzorg staff and their patients. Delegates were able to shadow a Buurtzorg nurse in their daily care responsibilities, and to better understand how the Buurtzorg ethos affects areas such as career progression, skill mix, leadership and accountability, caseload management, patient profiles and IT support (among others).

Finally, in February 2016 the RCN and Public World hosted a follow up seminar which involved a Buurtzorg nurse speaking to members of the RCN's District Nurse Forum, as well as members of the RCN federation of nurse leaders. This meeting was extremely valuable in highlighting not only the prominent role of self-direction and autonomy within Buurtzorg teams, but also how these principles are applied to Buurtzorg patients as well. Examples were given of how teams are expected to proactively promote patient self-management for example, by involving local community services, neighbours, families and other social actors.

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

At the time of writing, a number of Buurtzorg pilots have been scoped across England and in March 2016 the Scottish Government hosted an exploratory meeting with relevant stakeholders (including the RCN) to agree a framework for testing the model there as well.

## An introduction to Buurtzorg

### What is it?

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

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

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

**Buurtzorg's answer to this problem was to give its district nurses far greater control over patient care – a critical feature which has driven its rapid growth.** In 2011, Buurtzorg employed nearly 4,000 district nurses and nurse assistants across 380 teams. By 2013, this had risen to 6,500 nurses (an increase of 62.5 per cent) across 580 teams.<sup>2</sup>

**Today, Buurtzorg's workforce cares for over 70,000 patients and according to Mr de Blok, some 50 per cent of these have some form of dementia.**<sup>3</sup>

To be clear, Buurtzorg is not the only provider of home care in the Netherlands. They operate in a competitive insurance-based marketplace where patients can choose their provider based on a number of considerations, including: cost, extent and quality of cover provided and reputation. Buurtzorg's innovative approach has enabled it to outmanoeuvre many of its competitors in all three of these areas.

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

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

## How does Buurtzorg work?

**Nurses lead the assessment, planning and coordination of patient care with one another.**

The model consists of small self-managing teams, each with a maximum of 12 nurses. Sometimes a team will also oversee Nursing Assistants (the Dutch equivalent to Health Care Assistants).

Teams provide co-ordinated care for a specific catchment area, typically consisting of between 40 to 60 patients.<sup>4</sup> The composition of these teams in terms of specialty and level of practice varies according to the needs of each catchment area.

**A significant reason why Buurtzorg has managed to provide excellent patient-centred care at competitive rates has been due to its approach of putting patient self-management at the heart of its operation.** How this works is that each new patient relationship begins with high levels of support provided by the team. This is then gradually withdrawn as self-management aids and supports from social care, voluntary and third sector organisations are identified, assessed and put in place. This approach is believed to cut long-term care costs by between 30 to 40 per cent and supports a national policy aim of delivering care closer to home or in a homely setting.

**In the Netherlands, integrated care has been cited as easier to deliver because district nurses tend to be well known in the small neighbourhood/community in which they work.** This helps them to build good working relationships and strong dialogue with GPs, welfare and social care providers, police and paramedics. **The RCN's visit to Buurtzorg in November 2015 seemed to corroborate this view.**

**In terms of revenue, approximately 90 per cent of Buurtzorg's income comes from payments by Dutch health insurance companies.** As part of the Health Insurance Act (2006), private health insurers were given a more prominent role in increasing health system efficiency through prudent purchasing of health services on behalf of their customers.

**Insurers are regulated under public law and are required to accept all applicants.** More information on the role of insurers in the Dutch health system can be found here:

<http://www.commonwealthfund.org/publications/fund-reports/2015/jan/international-profiles-2014>

## What services does Buurtzorg provide?

Buurtzorg offers six key services. These are:<sup>5</sup>

1. holistic assessment of the client's needs which includes medical, long-term conditions and personal/social care needs. Care plans are drafted from this assessment

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<sup>4</sup> Buurtzorg Nederland (2011), 'A new perspective on elder care in the Netherlands' available at: [http://omahasystem.org/AARPTTheJournal\\_Summer2011\\_deBlok.pdf](http://omahasystem.org/AARPTTheJournal_Summer2011_deBlok.pdf) (accessed on 12 July 2014)

<sup>5</sup> Ibid

2. map networks of informal care and assess ways to involve these carers in the client's treatment plan
3. identify any other formal carers and help to co-ordinate care between providers
4. care delivery
5. support the client in his/her social environment
6. promote self-care and independence.

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

- **health promotion**
- **management of conditions**
- **disease prevention.**

**Buurtzorg cares for patients who are terminally ill, suffer from long-term conditions, dementia or require home care following major surgery.** Most of the nurses who join Buurtzorg are trained at a 'generalist' level (similar but not directly equivalent to a UK Registered Nurse in Adult Care). This allows them to deliver treatments from wound care and diabetes monitoring to IV infusion therapy and end-of-life care.

**Unlike in the UK, there is no formal district nursing qualification in the Netherlands** and none of Buurtzorg's nurses are trained to be independent nurse prescribers. Notably, the RCN's visit to Buurtzorg in November 2015 did not observe many patients requiring 'complex' nursing care needs that would require the intervention of a Registered Nurse. The interventions which were observed were those more associated with Health Care Support Worker (HCSW) competencies, for example: washing, assisting with dressing, applying compression stockings, applying leg emollients, etc.

## **The role of regulation and quality assurance**

The Netherlands has a national independent body which audits provider performance and outcomes. However, incentives are linked to financial and insurance priorities and there are currently no nationally agreed quality outcome measures. All inspections are pre-announced and Buurtzorg's results are believed to be very good (especially around client satisfaction).

Many of the positive outcome measures which Buurtzorg champions – especially around 'ways of working' such as the level of education of their nurses, continuity of care and relationship with

GPs, etc. – are not currently part of the national quality assurance system. Jos de Blok is advocating to change this and has already had some success. Insurance companies for example, have incorporated procurement criteria based on Buurtzorg principles.

## Buurtzorg's successes

Buurtzorg has achieved some notable breakthroughs, particularly in the following three areas (each of which is explored in more detail in this paper).<sup>6, 7</sup>

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

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

## On higher levels of patient satisfaction

- **Buurtzorg has delivered improved quality of patient care through 24/7 access to a district nursing team via phone or a home visit service.** Results have shown a correlated decrease in unplanned care and hospital admissions, as well as better patient satisfaction when compared to other home care providers in the Netherlands.
- **In 2009, the Netherlands Institute for Health Services Research (NIVEL) found that Buurtzorg had the highest satisfaction rates among patients in the country<sup>9</sup>.** These results have spurred global interest in replicating the model. In June 2014 for example, the University of Minnesota began designs for a Buurtzorg pilot model with funding being provided both by the university and by state/federal health authorities as part of the Affordable Health

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<sup>6</sup> Ibid

<sup>7</sup> Ibid

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

<sup>9</sup> AARP (2013), 'Buurtzorg Nederland: Nurses Leading the Way!', available at:

<http://journal.aarpinternational.org/a/b/2013/06/buurtzorg-nederland-nurses-leading-the-way> (accessed on 02 July 2014)

Care roll-out.<sup>10</sup> Buurtzorg's patient satisfaction rates were a key incentive for this project being undertaken.

- At the Public World / RCN seminar in July 2015, Mr de Blok explained that Buurtzorg uses the Omaha system to help measure good patient outcomes. The Omaha method is a research-based taxonomy (classification) designed to enhance practice, documentation, and information management across settings. It is especially popular in home care, hospice and assisted living case-management settings.

## On reducing the costs of care

- By limiting managerial structure and bureaucracy, **Buurtzorg's nurses enjoy greater autonomy when organising their own client visits and day-to-day nursing interventions.**
- **This has enabled Buurtzorg to achieve a 40 per cent reduction in client costs when compared to other homecare organisations.**<sup>11</sup>
- **In addition to this, Buurtzorg has achieved a 50 per cent reduction in hours of care due to health promotion initiatives and patient independence.**<sup>12</sup>
- **Buurtzorg's overhead costs are estimated at eight percent, compared to a competitor average of 25 per cent.**<sup>13</sup>
- **Despite being a not-for-profit organisation, Buurtzorg registered a four per cent profit margin in 2014.**<sup>14</sup>
- In terms of staff efficiency, **sickness rates for 2014 was four per cent, compared to a competitor average of six per cent.**<sup>15</sup>

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<sup>10</sup> Buurtzorg USA (2013), 'About', available at: <http://www.buurtzorgusa.org/> (accessed on 02 July 2014)

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

<sup>12</sup> Ibid

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

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

<sup>15</sup> Ibid

## On promoting self-direction for nurses

**A national quality of care survey has consistently ranked Buurtzorg as number one among all home care organisations.** In 2011 and 2012, Buurtzorg was also named Dutch employer of the year.<sup>16</sup>

- Approximately **70 per cent per cent of Buurtzorg's nurses are Registered Nurses (RNs) and 40 per cent hold a bachelor's degree level**, compared to a 10 per cent average for other Dutch home care organisations.<sup>17</sup>
- **Buurtzorg's approach to continuing professional development/education (CPD) also reflects its focus on professional autonomy.** Each nurse is able to decide their own educational needs but this has to be focussed on the wider needs of the team and the skills and knowledge required to meet patient needs. Each team has its own education budget and is supported with adequate time to undertake whatever learning activity they choose. Cumulatively, the total education budget is three per cent of Buurtzorg's income.<sup>18</sup>
- Registration of patients' information, time registration and communication are **supported by a web application called the 'Buurtzorgweb'** which nurses are able to access directly in order to deliver better care and share information and best practice with each other. In addition there is a **smart software IT system – 'Ecare'** which is designed to support daily practice (assessment and care planning), record keeping documentation and information management.
- **Buurtzorg's investment in smart technology also extends to providing iPads for all of its nurses, plus training to help them update patient records instantaneously using this technology.**<sup>19</sup>
- **Buurtzorg prides itself on its non-hierarchical structure.** There are no leaders within the teams and individuals work as equals with no member superior to another. They all take equal responsibility for making decisions within the team (based on consensus), solving their own problems.

This is helped by the use of a tailored coaching system. How this works is that when a new team begins, a coach is appointed to help them to recruit new colleagues, learn to use the Buurtzorgweb, divide the different roles in the team and build their network with other caregivers, both on a formal and informal basis.

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<sup>16</sup> AARP (2013), 'Buurtzorg Nederland: Nurses Leading the Way!', available at:

<http://journal.aarpinternational.org/a/b/2013/06/buurtzorg-nederland-nurses-leading-the-way> (accessed on 02 July 2014)

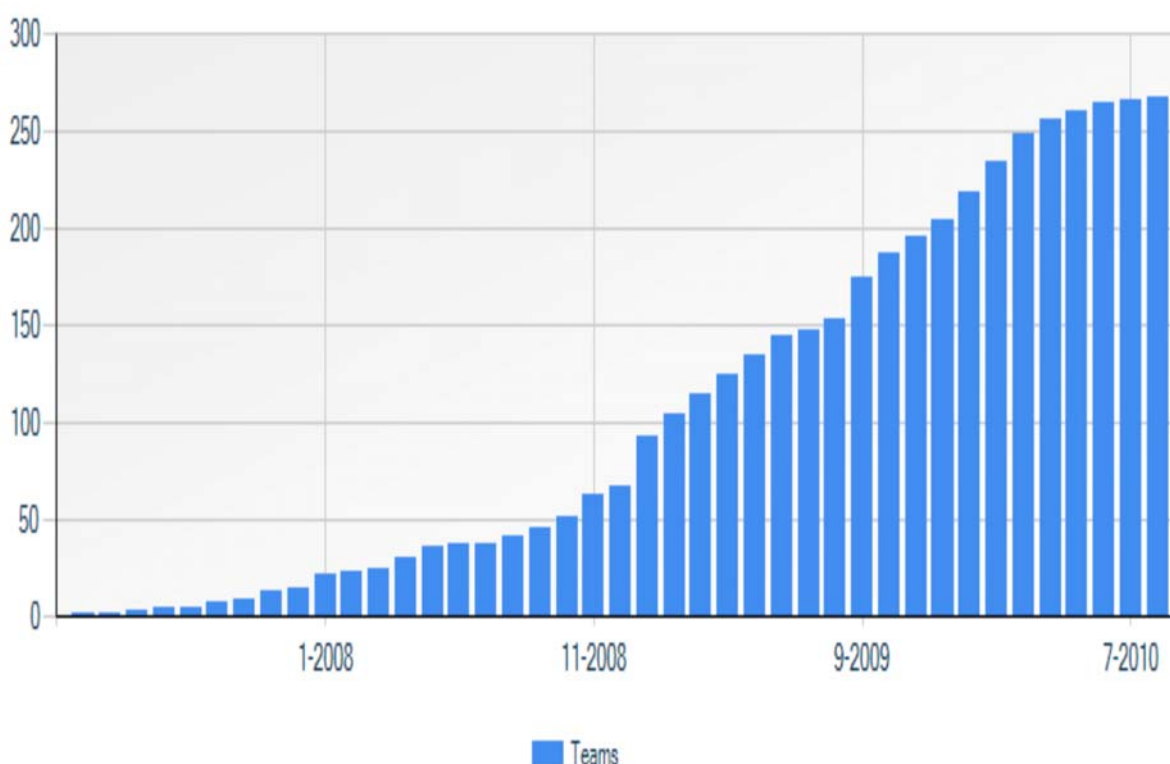
<sup>17</sup> Buurtzorg (2014), 'Buurtzorg Nederland', available at: <http://www.kingsfund.org.uk/sites/files/kf/media/jos-de-blok-buurtzorg-home-healthcare-nov13.pdf> (accessed on 12 July 2014)

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

<sup>19</sup> Ibid



- Thanks to the Buurtzorgweb patient database and self-supporting teams, no managers are needed and the back office function is comparatively small, although growing – 47 employees was the figure quoted by Mr de Blok in 2015, compared to 20 in 2011. The focus on simple, accessible IT systems has helped to reduce the bureaucratic workload so that patient-facing time is maximised.<sup>20, 21</sup>
- Buurtzorg has grown rapidly - the below graph shows expansion in total team numbers up until 2010.<sup>22</sup> **The organisation's ability to facilitate this rapid expansion evidences an integral structural foundation, as well as a strong recruitment appeal.**



<sup>20</sup> Buurtzorg Nederland (2011), 'A new perspective on elder care in the Netherlands' available at: [http://omahasystem.org/AARPTTheJournal\\_Summer2011\\_deBlok.pdf](http://omahasystem.org/AARPTTheJournal_Summer2011_deBlok.pdf) (accessed on 12 July 2014)

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

<sup>22</sup> King's Fund (2014), 'Buurtzorg Nederland model', available at: <http://www.kingsfund.org.uk/sites/files/kf/media/jos-de-blok-buurtzorg-home-healthcare-nov13.pdf> (accessed on 12 July 2014)

## Observations on the Buurtzorg model and its applicability in the UK

**Without a doubt, the Buurtzorg model has captured considerable interest and success especially in its demonstration of nursing capability and self-management in delivering better patient care.** This has been evidenced by growing interest across the UK and elsewhere as to how Buurtzorg's innovative approach to community nursing might be adapted.

**At the time of writing, several pilots have been launched across England with a further six to eight tests also being scoped in Scotland.**

Some areas which the UK should be focusing on

- **Fostering an entrepreneurial culture among nurses, supporting them to present tangible solutions to many of the significant challenges facing community care in the UK.** This approach has enabled Buurtzorg to win the endorsement of key observers both within and outside of the Netherlands.
- **Bolstering district nursing services by increasing nurses' autonomy, enabling them to deliver patient-centred care, and by increasing funding for district nurse training.** A 2013 report by the Royal College of Physicians concluded that, in their current state, health services for the elderly and vulnerable are variable, inconsistent and do not meet key needs. The report proposes that community-based health working, similar to that found in the Buurtzorg approach, should play a central role in future service deployment.<sup>23</sup>

## Challenges

The RCN's November visit to Buurtzorg only enabled observation of the model in a fairly limited capacity. Consequently, there are a number of issues which need to be considered for the various UK pilots wishing to test the model fully, including the below.

- How does the model work for patients living in areas of deprivation or who have more challenging lifestyles?
- How does the model work for patients living in remote and rural areas and what is the average travel time commitment for the nurse between patients living remotely?
- How does the model work in practice in the out-of-hours period (late evening and during the night)?

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

**These and other questions remain key priorities for the RCN in order to ensure that our practical understanding of this model is as good as it can be.**

Invariably any effort to “lift” the Buurtzorg model and assume that it would immediately work in the UK is problematic. This is not to dismiss the importance of learning lessons from Buurtzorg’s success, but **it must be remembered that systems such as Buurtzorg have developed over time to fit the unique care and funding landscape of the host country.** In the case of Buurtzorg, some of the challenges which the UK would need to consider are listed below.

- **Buurtzorg’s dependence on insurer payments reinforces the need for a considered view as to how the UK can build the right incentives system in order to replicate its success in delivering good patient care and financial sustainability.**
- **The RCN’s visit to Buurtzorg noted that both staff and patients benefited from significant infrastructural support.** This included patient’s homes being equipped with tailored aids such as wet rooms to support safe washing, and interconnected technology for staff to monitor/update schedules, care reports, etc. It is not clear whether a UK catchment area of patients (admittedly skewed in terms of socio-economic disparity) would have a comparable level of support.
- **Similarly, the Buurtzorgweb function and Ecare system have been key innovations in enabling Buurtzorg’s nurses to access and update patient information quickly and equitably, but this capability is often absent in the UK.** Consequently, the UK pilots need to recognise the essential enabling potential for this technology and make appropriate investments to develop their own versions to maximise the chances of success.
- **The differing requirements regarding CPD for nurses in the Netherlands and the UK remains a major challenge.** In the Netherlands, although Registered Nurses are regulated there are no mandatory learning requirements following registration. By comparison, the UK’s Nursing & Midwifery Council (NMC) has made it explicitly clear through its revalidation model that nurses working in the UK must meet minimum CPD requirements throughout their career in order to practise legally.
- **Buurtzorg’s stringently non-hierarchical approach might sometimes be counter-productive from an operational perspective.** For example, once a team has completed its coaching stage, it will not receive any additional support unless it requests this directly. Consequently, it is arguable that having a managerial position – even if this were elected from within each team – could help to identify key support needs, as well as helping to resolve disputes among staff which, at the present time, rely either on internal resolution, or on an intervention by Jos de Blok.

- **The Buurtzorg model works well within the urban context of the Netherlands where transport infrastructure tends to be good. Extending this model to rural/more sparsely populated areas requires consideration.** According to the World Bank, the percentage of the national population located in towns or cities for the UK was 82 per cent in 2013, only slightly less than the Netherlands at 89 per cent.<sup>24</sup> This indicates that large numbers of patients are easily accessible to well-organised catchment teams. Consequently care does need to be taken to ensure that rural populations in the UK are also integrated into any such model.
- **There are very limited career enhancement opportunities at Buurtzorg but this does not appear to be a major concern for its staff.** The model has undoubtedly been incredibly successful in recruiting more nurses into the community setting, and the RCN's visit found that for many of these staff, career progression was not a priority, with many having left previous employment which had "better" career prospects in search for a more fulfilling role. This was reinforced at the RCN/Public World February 2016 seminar with a Buurtzorg nurse.

Nonetheless, a negative consequence of this is that were the UK to adopt this same approach then district nurses would not be working at a level of practice, nor would they be nurturing the skills needed to be considered senior clinical decision makers. This presents an important question about how the Buurtzorg approach would fit with existing nursing career pathways, frameworks and UK leadership requirements, as well as some of the recent reform recommendations (such as Francis, Shape of Caring, etc.) which clearly highlight the need for strong nurse leaders working in a multi-disciplinary approach when improving capacity in the workforce and developing sustainable services.

- **It is also important to note that self-directing teams need to be mindful of equality and diversity issues in the absence of a centralised approach, and that their composition should reflect the communities which they serve.** During the Public World/RCN seminar, Mr de Blok highlighted specific examples of where team diversity within Buurtzorg was more in evidence, but also accepted that more could be done in this area.
- **Concerns have been raised that Buurtzorg's 24/7 care commitment can lead to shift patterns which are not always conducive to a good work/life balance.** This has been cited for example, in cases where a patient requires a visit or is in distress, late at night and the responding team has already worked a full day.
- It has also been noted that **significant disparities in service provision can occur, especially depending on the time of day.** Night-time services for example tend to perform less well which indicates a significant patient risk, as many of Buurtzorg's patients are elderly or terminally ill and are therefore likely to need good night-time care.

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

- **There is more research to be done about how Buurtzorg supports patients with complex needs.** It may be that patients don't get to a state of 'complexity' because they are successfully supported to self-manage with minimum intervention by a Buurtzorg nurse over time (having had substantive input at the beginning when first assessed and supportive community and social infrastructure put in place to meet their needs). Alternatively however it may be that complex health needs are seen within the acute hospital environment where the more 'specialist' skilled practitioners tend to be concentrated.

It is wholly possible that the reasons for this are a mix of the above and many other lesser understood factors. Positively however, what came across very strongly from the RCN's visit to Buurtzorg was that the model's approach of an initial intensive period of nurse input and support for new patients – many of whom suffer from dementia, long term conditions, required care following surgery or had palliative care needs – was followed by a steady reduction in intervention towards patient self-management. This has achieved a significant reduction in time and cost over the long term (sometimes up to 30 – 40 per cent), as well as achieving higher rates of patient satisfaction.

## View of the RCN

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

**However, the RCN also recognises that no model which seeks to address the incredible complexity of 'joined-up' community care, especially in times of tightened financial budgets and changing patient needs, is ever going to be perfect.** The RCN maintains that part of the solution to this problem is by empowering frontline staff (as Buurtzorg has already demonstrated) and supporting current and future nurse leaders. Interestingly, what Buurtzorg has demonstrated is that models of leadership can be much more flexible than perhaps is currently understood in the UK and that the traditional model of nurse leadership (often based on ward settings for example) may not be effective when it comes to providing the best possible care in a community/home care setting.

**We therefore maintain that community care in the UK requires more nurse leaders who are empowered to pioneer better models of care – emulating the same entrepreneurial spirit of Buurtzorg and Jos de Blok – but shaping it to the unique national, regional and local circumstances of the UK.**

In addition, while the challenges of care provision (especially for older people) across countries may be similar in terms of broad-brush description, they are rarely completely identical.

**Consequently, lifting the Buurtzorg model as it is without considering the significant differences between the UK and the Netherlands in terms of funding structures, demographics and patient needs, etc. will invariably present challenges.**

The King's Fund in its analysis of Buurtzorg has reached a similar conclusion. While extolling the model's virtues, it recognises that Buurtzorg's approach 'may not be right for all health systems but it highlights the potential benefits of taking a fresh look at professional roles.'<sup>25</sup> It is the view of the RCN that this 'fresh look' can only achieve meaningful results if the central plank of the Buurtzorg model – its emphasis on nurses as self-managing agents of change – is maintained throughout.

**Royal College of Nursing**  
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<sup>25</sup> Ibid.