Interreg 2 Seas Mers Zeeën
TICC
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PRESS RELEASE

Humanity at the heart
Transforming Integrated Care in the Community (TICC)

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Introduction

Launched in 2018, the objective of the TICC (Transforming Integrated Care in the Community) project has been to implement and evaluate a new organisational model of homebased care services in the 2 Seas area (United Kingdom, Belgium, and France). For over 4 years now, partners have been creating systemic changes in health and social care by implementing this model.

Indeed, this Interreg 2 Seas funded project focuses on the implementation of an integrated nurse-led community-based care model, inspired by the Buurtzorg model. In this model, professionals in self-managing teams work at community-level and handle every aspect of care and business supported by a reduced back office, simple IT, and coaches rather than managers.

TICC aims to enable health and social care organizations to implement nurse-led community care, increase staff productivity, recruitment, and retention, as well as improving patient satisfaction while decreasing costs, emergency admissions and staff absences. In the TICC project, a methodology to overcome blocking points in transferring socially innovative service models from one area to another has been developed and tested via the implementation of the Buurtzorg integrated care at home model.

The TICC project aimed to postpone the moment when residential or end of life care is needed, by delivering the care at home instead.

A total of 14 partner organizations contributed to the project and the TICC model was implemented in six pilot sites in the UK, France, and Belgium.

Background

Health & social care in the 2 Seas area

The 2 Seas area in Europe faces clinical, social, and financial challenges in health and social care as the population ages and public funding decreases. Recruitment and retention of the health and social care workforce in the 2 Seas area is challenging and the situation will further deteriorate as the existing workforce ages. Moreover, the community-based care models that have developed in the 2 Seas region over the last 20 years have led to the fragmentation and disintegration of care and a task driven, activity-based approach and remuneration leading towards negative outcomes. Kreitzer et al. (2015) pinpoint similar issues such as the quality and cost of care, poor health-related outcomes, lack of access to care, lack of transparency of information, and a growing dissatisfaction among both patients and caregivers in countries all over the world.

Therefore, the process of social innovation to transform health and social care models is well-presented in global, as well as national policies, with a focus on self-management of people and strengthening of community-based care delivery. Moreover, these processes are promoted by policy makers to realize new models of community-based care in community care in European countries. Using the input from professionals (i.e., nurses and social workers) in the social innovation processes to transform integrated care in the community care is a prominent feature (Cheater, 2010). For example, the 2008 UK-review 'High Quality for All' identified nurses and other frontline professionals as a key group to lead radical changes in six key areas: health and wellbeing, children and families, people with long-term conditions, rehabilitation, providing hospital care close to home and end-of-life care.

Still, exemplary innovations that radically and fundamentally change the what, how, and why of community-based health and social care delivery are scarce (Kreitzer et al., 2015).

A successful model of homebased care and services

An example of social innovation in home care is the Buurtzorg model with the mission: **humanity over bureaucracy**. For over 15 years now, Buurtzorg has proven to be successful in improving patients' living conditions and health professionals' and carers' work conditions.

The Buurtzorg integrated care at home model relies on self-managing teams of 12 carers and nurses, based at a neighbourhood level and handling each aspect of care, ensuring their financial sustainability. This model has led to a significant decrease in back-office need, a shift from the traditional manager to coach whose role is to provide advice to ensure the team's autonomy and, for patients, provision of health and care services at home at a lower price but with higher quality intervention resulting in fewer unplanned hospital admissions.

Probably the most unique feature of professional-led community care is the existence of self-managed teams that provide home care to people with needs in their neighbourhoods. Professionals in these autonomous teams work with formal caregivers, community support and family resources to bring people with needs to optimal functioning as quickly as possible. Professional-led community care is based on principles of trust, autonomy, creativity, simplicity, and collaboration. In the Buurtzorg model, the autonomous teams are geographically bound and limited to twelve professionals, which are all

generalists and autonomously conduct their work. Buurtzorg as an organization frees the frontline professionals from administrative and bureaucratic burden and in turn provides them with autonomy in their job and responsibility for their clients (Kreitzer et al., 2015). The emphasis in the teams strongly lies on creativity, mutual respect, humanity, and particularly trust in expertise, talents, and persons (Monsen & De Blok, 2013). They have the autonomy to do care needs assessment (using a standardized taxonomy), plan, document and monitor care. The frontline professionals agree on how to execute their tasks, determine schedules, assign roles, and focus on continuous improvement. In addition, the micro-scale the frontline professionals work on gives them access to local community-based resources. Overall, the focus of the Buurtzorg model is on returning clients' independence as quickly as possible.

However, Buurtzorg, in the same way as many other initiatives, **has been highlighted as innovative but hardly get transferred from one country to another**. The causes of these blockages needed to be identified & a method developed for overcoming the barriers to transferability. TICC aims to enable countries in the 2 Seas area – and beyond – to implement successful health and social care innovations quickly in a cost effective and sustainable way.

The TICC project

Adopting integrated neighbourhood care

TICC has created systemic change in health and social care, providing services better suited to our ageing population addressing holistic needs. It presents a methodology to overcome blocking points in transferring socially innovative service models from one area to another. Indeed, TICC project partners have brought expertise to identify barriers blocking innovation transfer and have designed a methodology to ensure successful innovative practices in health and social care can be easily implemented across borders. By working in partnership across four countries, the TICC implementation has highlighted barriers individual partners may not have encountered in isolation. Through this collaborative project, the 2 Seas programme has given the opportunity to set a regional European test before a wider roll-out of the method.

TICC has taken a Dutch model of good practice, evaluated it and implemented it in the United Kingdom, France, and Belgium. The project would not be possible without cross-border cooperation as the good practice existed in one country only and had not been implemented in any of the others, even though there was a clear desire and need to do so.

The example of Buurtzorg was chosen because of its undoubted and extraordinary success in its country of origin, the Netherlands, where it has revolutionised community-based health and care services. Its achievements -- improving care, the jobs of professionals providing care, and resource use -- provided the inspiration for the organisations that came together as partners in this project with a view to replicating its achievements in their own countries and localities. They were able to do so not only because of the generous commitment of Buurtzorg itself to enabling and supporting their experimentation but also because the European Union's European Regional Development Fund Interreg 2 Seas funding stream supplemented the very considerable financial investment made by the partners themselves.

Perspectives from pilot organisations

Over the past five years, the TICC model was implemented in six pilot sites in the UK, France, and Belgium. A detailed account of the barriers and challenges they have encountered, the solutions they have developed in their own contexts, the degree of implementation and the impact the model had is provided in the project's final publications.

Discover the perspective from two partners from the UK and France. **Medway Community Healthcare** (UK) provides a wide range of community services for people living in Medway and the surrounding area, from health visitors and community nurses to speech and language therapists and out of hours urgent care. **La Vie Active** (France) operates over 63 care institutions in the north of France supporting disabled adults, elderly dependent people, and others, some with dementia (11 NH), a guardianship service and a nursing home of 40 beds in Dourges since 2011.

Medway Community Healthcare

> *"The Transforming Integrated Care in the Community project provided a platform for us to critically look at how we deliver community nursing and other services within our organisation in relation to the Buurtzorg model. There was much value in working with our European partners enabling us to share experiences, understanding of different delivery models and reflect on our service delivery and opportunities for change."*

The patient, their families and clinicians were brought to the forefront as everything operational services do and are asked to both locally, nationally, and internationally should be considered in relation to the actual benefits they bring, to patients, staff and the wider health and care economy. In times of increasing demand for health and care and a diminishing work force to deliver, through high levels of vacancies across the European partners the research also enabled us to focus on how we could enable our clinicians, through releasing time to care, reducing moral distress and improving retention rates and recruitment rates based on a model that supports the ethos that is nursing.

La Vie Active

> *"For the Home Care Team at La Vie Active, the shift toward new professional practices has been welcomed enthusiastically by our team, who are keen to implement this approach in line with Local Health Authority guidelines."*

Offering self-management training and trialling it in our local context

According to the Buurtzorg model, self-management can be summarised as the ability of a team to decide how it manages its workload and to find ways of improving it more independently. The ten carers, secretary and Head Nurse of the Home Care Team immersed themselves in this new professional culture through a series of visits, training and job-shadowing sessions in the Netherlands. This enabled the Home Care Team to learn about these new working practices under the expert guidance of the Buurtzorg nurses.

And when it comes to the day-to-day work of the Home Care Team, these new professional practices can be seen in the organisation of team meetings, which are now held every Monday. Team members now manage their own work with support from the Head Nurse, whose role tends to be that of a coach

leading the meetings following a solution-oriented approach, i.e. decisions are taken jointly with regard to patient care, coordinating various care & health professionals, possible service relays, etc. Care plans defined with patients are discussed to ensure their relevancy and quality. The team is also now involved in recruiting new members. They receive the CVs, select candidates and conduct the hiring interviews. Embracing the team's recently established values is a key criterion for joining. Since the introduction of this new peer recruitment approach, we have found that the team is more united and stable.

Self-management also implies a more **horizontal approach to work**. For example, previously the Head Nurse of the Home Care Team drew up the home visits schedule and sent it to the team members, who simply followed it. Thanks to the TICC (Transforming Integrated Care in the Community) project, team members have been trained to draw up the schedules themselves. This has created a sense of shared responsibility for this collective work. And because team members manage themselves, they have a better work/life balance, which in turn boosts their well-being and optimises service continuity.

Digital solutions free up precious time

Previously managed entirely by the Head Nurse and the secretary of the Home Care Team from an office desktop, admission and care procedures are now handled by the team using special software — accessible from tablets or smartphones — which allows the individual monitoring of patients. This includes collecting and following up on requests, analysing the feasibility of an assignment, carrying out the initial visit, completing the administrative tasks associated with the admission (e.g. notifying CPAM - the public health insurance fund, the patient's GP, etc.) and updating the patient care plan. Patient visits are now managed remotely and in real time. This improves the prioritising of visits, allows more time to be spent with patients, as well as reducing the overall distance travelled. Moreover, each patient has an online follow-up file in which the carer has access to a directory of other care and health professionals (e.g., GP, private nurse, etc.) whom he/she can contact if necessary.

See what the La Vie Active Home Care Team have to say.
https://youtu.be/KfykEgBfgzw7

Placing Humanity at the Heart: patient stories

The TICC project has been implemented with a constant intention of placing **Humanity at the Heart of health and social care services**. In bringing patients and their families at the forefront, the project has witnessed a number of encouraging stories. Here are some of the testimonies:

> *"How nice to hear you all laugh that spontaneously makes a person happy."*
> – Resident in Belgium

“We notice that the atmosphere has been very good the last months. The team responds to all the needs of the residents. They do a lot of small things which means a big difference for the residents.”
– Member of family in Belgium

"The team really adapts to my needs. It's such a relief to have people in our home who really take the time to care for us!”
– Patient in France

“Absolutely lovely! The nurses were always happy and cheerful. They were professionals but at the same time always friendly and caring. It was generally the same people coming over, however, even on occasions, due to staff shortages, days off or holidays, they would call in somebody from another team that was just as professional. They did pass on knowledge to each other, which was very impressive.”
– Patient in the UK

"*The patient is the sole priority when they come. As far as I’m concerned, they always come with a smile, no matter how stressed they are!*"
– Patient in the UK

The COVID-19 global health crisis has impacted each and every one of us. During the outbreak, TICC partners had to adapt the way they were working and implementing the project, ***the number one priority being, as always, to care for its patients and professionals.***

After the first outbreak, TICC partners wanted to explore healthcare staff's experiences with providing care during the COVID-19 pandemic to identify strengths and areas for improvement. These aspects were given extra attention during the implementation by the TICC partners, so that the model can be implemented sustainably and successfully. These experiences were reported in a publication "COVID-19: From fear to opportunities in community care" in 2020. ***Further findings are shared in the project's final publications.***

Evaluation and blueprint for implementation

After intense years of implementation, data collection, analyses and reporting, Transforming Integrated Care in the Community (TICC) project has come to an end. In other words, the most important phase has started. Disseminate, share findings and knowledge gained in recent years, in order to support other organizations and individuals.

A blueprint for successful transfer

One of the main outputs of this project from the start was to be a "**blueprint for successful transfer of social innovative service models in health & social care from one country to another benefitting all public/private services**".

So, what is a 'blueprint'? According to the Cambridge English Dictionary, it can be simply "an early plan or design that explains how something might be achieved". For some purposes such a plan or design might be highly detailed, as implied by the literal source of the metaphorical term, given by the same dictionary as "a copy of a technical drawing that shows white lines on a blue background". And for some technical purposes – bearing in mind that the term originated in the construction industry – a blueprint, says the dictionary, is a "complete plan that explains how to do or develop something".

However, the 'successful transfer of social innovative service models' cannot be accomplished in the same way as builders apply a blueprint handed to them by an architect. Certainly, the skill and experience of the builders themselves is as important to the outcome as the design to which they work, and to that extent there is a parallel with health and care. However, an equally important difference is that, unlike the construction of a building in which success requires them to follow the detail of the design to the letter, success in health and care depends on the professional practitioners themselves co-designing their service with the people they support, drawing on their own qualifications, experiences, and common sense as they go. This applies to any human-centred service, and especially to health and social care, a highly complex environment in which outcomes are the dynamic product of myriad relationships of many kinds.

So, the quest for a Buurtzorg blueprint might best start with the reality that the organisation that inspired this project has never, from its conception around a kitchen table in 2006 to its continuing

evolution some 17 years later, made a highly detailed plan. Moreover, perhaps the core lesson of the TICC project is that there is no one way to draw inspiration and guidance from Buurtzorg's success.

This final publication is therefore an evaluation of what its active participants have done over the last five years, the barriers and challenges they have encountered, and the solutions they have developed in their own contexts.

Evaluation: a detailed study of the TICC implementation

The final evaluation report consists of the highlights of all research methods carried out within TICC. Firstly, questionnaires were distributed among healthcare professionals, patients, and informal caregivers. This was done in a pre- and post-test design, which also included control groups. Several concepts were measured in the quantitative study, such as: autonomy, empowerment, quality of life, job satisfaction and care satisfaction. Preliminary findings illustrated that TICC team patients had a better quality of life than control team patients. A significant improvement was detected in the physical element of quality of life, and even the mental aspect of quality of life showed a trend in favour of TICC teams.

Additionally, a total of seventeen focus group discussions were conducted by delivery partners and described healthcare professionals' experiences concerning implementing the TICC model. Results of the focus group report indicated that the TICC model presented advantages for staff, patients, and informal carers. Most findings regarding the implementation and impact of the TICC model were shared across the three countries.

Finally, the degree of implementation over the course of the project was also examined. Based on a gap analysis, it was examined at three points in time to what extent the participating healthcare organizations fulfilled the crucial properties of the TICC model.

All in-depth information is available in the open access report.

All reports are or will be available shortly on the TICC legacy website!
www.ticc-transformation.eu

Partners

A total of 14 partner organizations from the UK, the Netherlands, France, and Belgium contributed to the TICC project.

The Health and Europe Centre - UK
A social enterprise providing European services to the NHS and other health organisations in the southeast of England. It has the objective of providing learning opportunities through collaborations with colleagues from other countries and is highly experienced in partnership working.
healthandeuropecentre.nhs.uk

Buurtzorg Concepts – The Netherlands
Buurtzorg Concepts works to promote and support international learning from the experience of Buurtzorg Nederland, a non-profit Dutch home-care organisation that has gained international attention for delivering high quality holistic care at lower cost through self-managing teams of nurses. Set up in reaction to the fragmentation and industrialisation of health and care at home in the Netherlands, Buurtzorg provides holistic person-centered care through small (max 12) teams based in small neighbourhoods.
www.buurtzorg.com

Kent County Council - UK
Kent County Council is a local authority serving over 1.5 million people in the county of Kent, south-east England, including responsibility for social care in the context of the English system. The council aims to develop models to deliver integration across its population and services that improve outcomes and experience of care, making the best use of resources.
www.kent.gov.uk

Kent Community Health Foundation Trust - UK
Kent Community Health Foundation Trust is an experienced provider of community nursing providing 24-hour care seven days a week supporting patients with long term conditions, illness, or frailty within the National Health Service in England. KCHFT also provides intermediate care services and works with patients, family/carers, colleagues in health and social care and the voluntary sector to enable patients to retain their independence and safety at home, recover from illness or injury and avoid unnecessary attendances or admissions to acute hospitals.
www.kentcht.nhs.uk

Medway Community Healthcare - UK
Medway Community Healthcare provides a wide range of community services for people living in Medway and the surrounding area, from health visitors and community nurses to speech and language therapists and out of hours urgent care. The majority of the services provided are NHS though some services are commissioned by the local authority. As a social enterprise they are also able to provide additional services, like physiotherapist-led Pilates classes, podiatry sessions and training courses for schools. Any profit made from these services, is invested back into improving all the services they provide.
www.medwaycommunityhealthcare.nhs.uk

Soignons Humain - France
Soignons Humain promotes new organisation models in the field of home care and health services, with improved satisfaction of patients, employees, and the public purse, in France.
www.soignonshumain.com

Public World - UK
Public World is a business-to-business social enterprise that helps build healthy and strong local and workplace communities by supporting self-managed teamwork with the aim of making work fairer, happier and more productive, and institutions more accountable. Trading also as Buurtzorg Britain & Ireland.
www.publicworld.org

Zorgbedrijf Antwerpen - Belgium
Zorgbedrijf Antwerpen provides services to the elderly and children in the city of Antwerp, Belgium, offering both residential care and home care.
www.zorgbedrijf.antwerpen.be

Emmaüs - Belgium
Emmaüs Elderly Care is just one of the five welfare and healthcare sectors of the Emmausgroup in Belgium. Ten Kerselaere is the oldest and most well-known residential elderly care facility in Heist op den Berg. The concept combines safe and comfortable housing facilities with assisted living facilities and state of the art care.
emmaus.be

Eurasanté - France
Eurasanté is the economic development agency dedicated to health, nutrition, and healthy ageing in the Hauts-de-France region (and the coordinator of the regional silver economy committee).
lille.eurasante.com

VIVAT Service à la personne - France
VIVAT was established in 2006 and has grown steadily in size and activity scope through the opening of new agencies to provide care services over a wider area of France and comprises VIVAT Marcq Wasquehal, VIVAT Lille Seclin, VIVAT Douai Cambrai, VIVAT Bailleul Bergues and the franchise VIVAT Lomme Lambersart.
www.vivat.fr

Groupement des Hôpitaux de l'Institut Catholique de Lille - France
GHICL carries out clinical trials supported by a multidisciplinary team that includes clinical research assistants for trials monitoring, data-managers in charge of databases elaboration, and specialists in biostatistics and methodology who provide assistance in clinical trials development and in the data analysis.
www.ghicl.fr

HZ University – The Netherlands
HZ has 4,500 students offering many different study programmes and a strong international orientation in the Netherlands. The university is divided into seven academies, with some courses taught in English.

It conducts innovation pilots regarding cross-sectorial cooperation between health, vitality, and tourism, bringing together entrepreneurs, government, and users, with particular attention to nurse-led community care.
hz.nl

La Vie Active - France

La Vie Active operates over 63 care institutions in the north of France supporting disabled adults, elderly dependent people, and others, some with dementia (11 NH), a guardianship service and a nursing home of 40 beds in Dourges since 2011.
vieactive.fr