SUSTAIN
Sustainable tailored integrated care for older people in Europe

Integrated care for older people living at home

Current situation and ambition of sites participating in the SUSTAIN project

Integrated care for older people living at home

Current situation and ambition of sites participating in the SUSTAIN project

The SUSTAIN project is funded under Horizon 2020 – the Framework Programme for Research and Innovation (2014-2020) from the European Union under grant agreement No. 634144. The content of this report reflects only the SUSTAIN consortium's views. The European Union is not liable for any use that may be made of the information contained herein.

Austrian Interdisciplinary Platform on Ageing / OEPIA

Editors: Paulina Wosko and Georg Ruppe

Authors: Borja Arrue, Eliva Atieno Ambugo, Caroline Baan, Gabriela Barbaglia, Jenny Billings, Simone de Bruin, Esther de Weger, Mireia Espallargues Carrera, Terje Hagen, Kai Leichsenring, Manon Lette, Mirella Minkman, Henk Nies, Giel Nijpels, Gerli Paat-Ahi, Georg Ruppe, Sophia Schlette, Annerieke Stoop, Nhu Tram, Silje Kathrine Vaage, Gerald Wistow, Paulina Wosko, Nick Zonneveld

Contact: ruppe@oepia.at

Vienna, June 2016

TABLE OF CONTENTS

1. INTRODUCTION

Paulina Wosko, Georg Ruppe, Simone de Bruin

Population ageing and the economic crisis have put pressure on European health systems. In an increasing number of EU Member States, a diverse range of integrated care initiatives are being put in place as new models for safe and efficient, prevention-oriented care to an increasing number of older people. Evidence of the effectiveness of integrated care is, however, inconclusive. Also there is little knowledge of how to successfully implement integrated care, how to learn from successful initiatives and how to transfer these best practices to other regions and health systems. So, while integrated care is being rolled out and infrastructures are in place, improvements to existing initiatives are necessary to make them more patient-centred, prevention-oriented, efficient, and safe. Moreover, approaches are needed that actively and meaningfully engage all stakeholders and that optimally facilitate the transfer and uptake of best practice across contexts and countries.

This report describes early findings from the SUSTAIN project, whose objective is to: 1. improve established integrated care initiatives for older people living at home with multiple health and social care needs, ensuring that they are person-centred, prevention-oriented, efficient, and safe; 2. ensure that improvements to the integrated care initiatives are applicable and adaptable to other health systems and regions in Europe. SUSTAIN is a collaborative project with nine countries in Europe: Austria, Belgium, Estonia, Germany, Ireland, Norway, Spain, The Netherlands and the United Kingdom.

In this project, integrated care is defined as those initiatives that proactively seek to structure and coordinate care prior in home environments and improve health outcomes while constraining healthcare costs. Many different terms are applied to integrated care including case management, disease management, guided care, transitional care, and shared care. In this project, the umbrella term 'integrated care initiatives' is used. Core elements of these initiatives are: a) a well-coordinated and proactive approach to health and social care needs; b) person-centredness whereby older people and their informal carers are involved in decision-making and planning their care process, and healthcare providers take their individual needs into account; c) involvement of professionals from multiple disciplines within health and social care; d) coordination of care to ensure continuity and e) (simultaneous) delivery of multiple interventions, both care-related and facilitating (e.g. shared IT systems). Integrated care will be improved by developing robust strategies that initially draw on the principles of the Chronic Care Model (CCM) and other related models (Barr et al., 2003; Epping-Jordan et al., 2004; Wagner et al., 2005).

Older people are defined as citizens aged 65 and older with multiple health and social care needs. The focus is on this age group as complexity of care generally increases with age.

From 2015 to 2019, the SUSTAIN project will work with local stakeholders from fourteen initiatives (sites) in seven countries aiming to achieve integrated care, and will support them in further improving their care based on a number of identifiers. The sites, which are located in Austria, Estonia, Germany, Norway, Spain, The Netherlands and United Kingdom, will be supported by several research institutes and European-wide organisations including AGE Platform Europe (located in Belgium), the European Health Management Association (located in Ireland) and the International Foundation for Integrated Care (located in The Netherlands) (www.sustain-eu.org).

This European Report presents the fourteen sites, their characteristics, their areas for potential improvement including, for each site, a specific improvement project, which will be implemented and evaluated.

The initiatives have been identified using the following inclusion criteria, which have been constructed from previous research (Billings and Leichsenring, 2005; De Bruin et al., 2012; Leichsenring, Billings, and Nies, 2013; Wagner et al., 2005):

- Focus of the integrated care initiatives should be on people at least aged 65 years who live in their own homes and who have multiple health and social care needs;
- Integrated care initiatives should address older people's multiple needs, in other words, they should not be single disease oriented;
- Integrated care initiatives should aim at keeping people at their own home (or environment) for as long as possible;
- Professionals from multiple disciplines (health and social care, e.g. nurses, social workers, pharmacists, dieticians, GPs) in multidisciplinary teams should be involved;
- Integrated care initiatives should be established, i.e. operational for at least two years;
- Integrated care initiatives must be willing to improve towards more patient-centred, prevention-oriented, safe and efficient care;
- Integrated care initiatives should cover one geographical area or local site;
- Involvement of the integrated care initiative must be mandated by one organisation that represents the initiative (to facilitate partnering).

2. METHODS OF RESEARCH

Jenny Billings, Esther de Weger, Paulina Wosko, Georg Ruppe

The SUSTAIN project will last 48 months and is divided into three interrelated phases covering eight interrelated work packages (see Figure 1).

In the first phase (i.e. **preparation phase**), which has just ended, we established working relationships with two integrated care initiatives in seven countries (Austria, Estonia, Germany, Norway, Spain, the Netherlands, United Kingdom), where improvements will be implemented. To understand where improvements are necessary, baseline assessments have taken place in each of the countries to understand characteristics of the different integrated care initiatives, the services' care settings, key objectives, care pathways, contextual issues, funding and governance structures. We also asked the sites how they gave shape to SUSTAIN's core domains, (i.e. patient-centredness, safety, efficiency, and prevention-orientation) and what they thought what would be potential improvement areas.

In the second phase (i.e. **implementation research to improve existing integrated care initiatives**) based on the outcomes of the baseline assessments, tailored sets of improvements will be designed and implemented by the sites together with stakeholders (i.e. policymakers, commissioners, health insurers, health and social care professionals, older people, informal carers). The implementation of improvements and the overall evaluation of the implementation processes and their outcomes will be guided by a multi-methodological approach, the Evidence Integration Triangle (EIT). Overarching analyses will be undertaken to compare and integrate data from the different sites to robustly identify what works for whom, in what context and with what outcome. Throughout the project, the applicability and adaptability of the improvements in different context are central, to ensure that different regions and countries use each other's knowledge and learn from each other's experiences.

In the third phase, (i.e. **translation to products and impacts**) previous work will be translated to products and impacts for different user groups. Tailored dissemination strategies will be designed to increase uptake of SUSTAIN's findings.

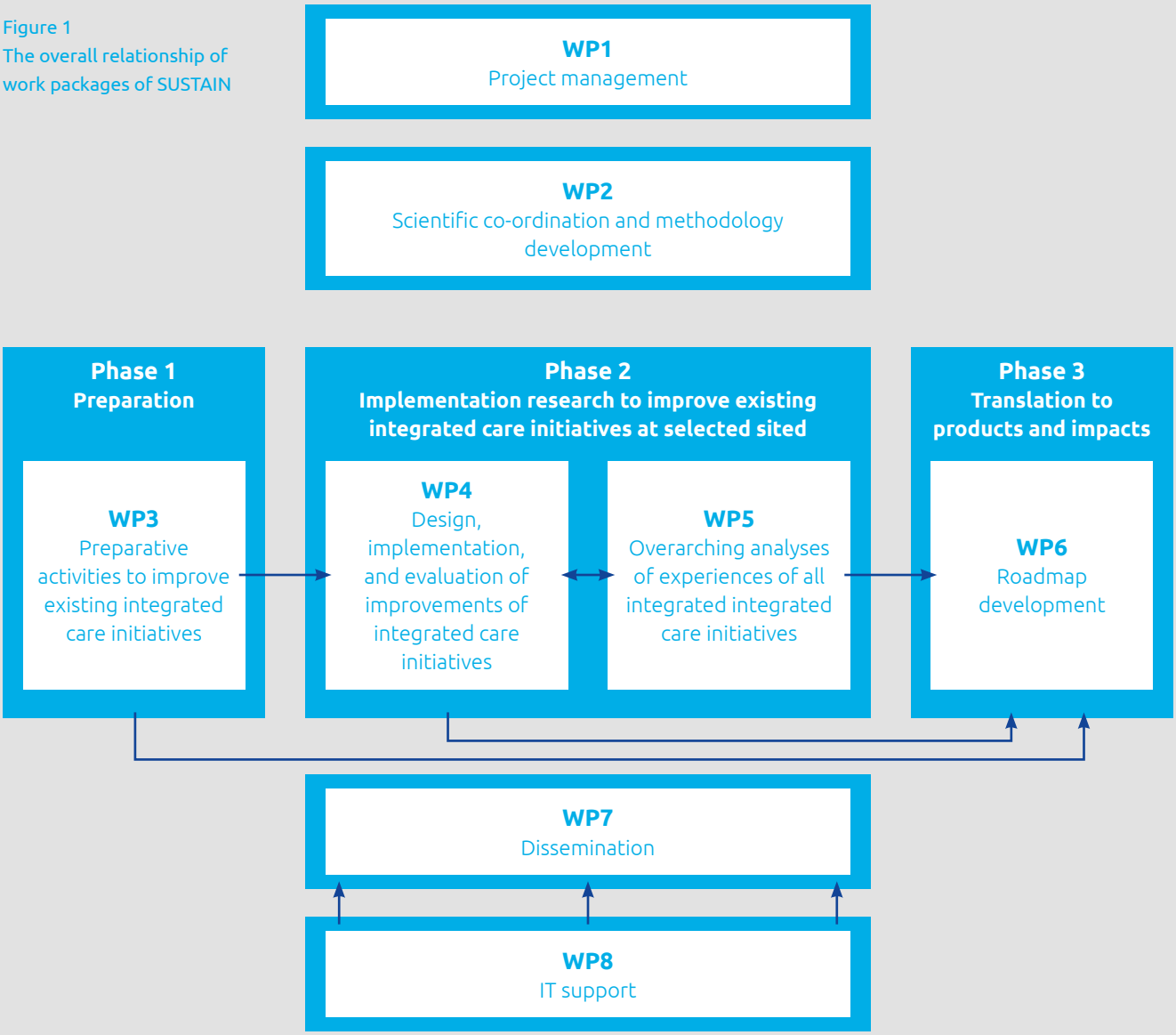
This section focuses on the methods used during this first phase. Data collection was carried out by the seven partner countries — Austria, Estonia, Germany, Norway, Spain, the Netherlands, United Kingdom — between September 2015 and May 2016.

2.1 Data collection methods

The baseline assessment used a mixed-methods evaluation approach and was conducted over two stages. During the first stage of the assessment, interviews were carried out with one user, one carer, one manager and one professional at each site. The professionals and managers were recruited by the research partners, while the users and carers were recruited by those professionals and managers. In order to ensure the data was comparable across the seven countries, uniform topic guides were developed for the interviews (See Appendix I). The topic guides were constructed collaboratively by the research partners and were based on research evidence on key enablers and barriers to integrated care, for example, contracting arrangements, IT infrastructure, coordination of care (e.g. Suter et al., 2009; Curry et al., 2013; Billings J and De Weger E 2015; Shaw et al., 2011; Jackson et al., 2008).

The majority of the questions were based on widely used and validated questionnaires measuring key enablers, for instance person-centredness and care coordination (e.g. Uittenbroek et al., 2015). The topic guides also included questions about SUSTAIN's four main themes of person-centredness, prevention, safety and efficiency.

Figure 1
The overall relationship of work packages of SUSTAIN



Specifically, during the interviews, professionals and managers were asked to discuss governance and funding arrangements, leadership and collaborative working practices, while users and carers were asked to discuss their perception of the sites and the care they received. Managers were also asked to provide quantitative information on the "characteristics" of their initiatives (e.g. rationale, aims and objectives, structure, outcomes) and to highlight key stakeholders for the initiatives (See Appendix I).

The results of the first stage of the assessment were the basis of discussions with key stakeholders during workshops organised by the research partners. The aim of the workshops was to discuss the initiatives' strengths, weaknesses, and areas for improvements in order to develop an improvement plan.

2.2 Data analysis method

The qualitative interviews with the users, carers, professionals and managers were thematically analysed using a uniform template of analysis (See Appendix II).

The template was based on a partner discussion of the initial findings of the first stage of the baseline assessment. During this discussion broad themes were created, and supplemented with themes and prompts from the interview topic guides. The template was developed so that data could be sorted and condensed into each initiative's strengths, weaknesses and improvement areas (in order to help channel the data and provide focused feedback at the stakeholder group workshops). The template incorporated brief quotes and summaries of discussions of all interviewees in order to compare and contrast their views.

The "Characteristics of the Initiative" tool completed by the managers was quantitatively analysed using a uniform SPSS template (See Appendix II) to enable quantitative comparisons of all research sites. Such quantitative comparisons allowed us to review more systematically the variety of integrated care initiatives being carried out in the different care settings. All interview data were entered into a database in broad themes.

3. CURRENT SITUATION AND AMBITION OF SITES PARTICIPATING IN THE SUSTAIN PROJECT

This chapter presents the demographic backgrounds of the seven participating countries and their status and development of integrated care. Moreover, there will be a description the of selected sites, including the level of service integration and the particular strengths and weaknesses from the point of view of each country. Finally, different areas for potential improvement and the specific improvement projects will be presented.

3.1 Austria

Kai Leichsenring, Georg Ruppe and Paulina Wosko

3.1.1 Demographic background

Austria is demographically one of the oldest countries in Europe. Of the total population of 8.5 million inhabitants about 18.5% are above 65 years of age, with an even higher share of older people in the region of Styria (19.7%) and a lower share in Vienna (16.9%). As in most other EU Member States the ratio of older people is likely to rise to 28% by 2050 (Statistik Austria, 2016).

Currently about 360,000 older people (65+) are entitled to the Austrian Long-term Care (LTC) Allowance, a cash benefit for all citizens with assessed care needs of at least 65 hours per month. This indicates that at least about 23% of older people are in need of long-term care, with higher age groups showing rising shares of beneficiaries, especially in the higher levels of the LTC Allowance that is granted according to seven defined levels of care needs (Federal Ministry of Labour, Social Affairs and Consumer Protection, 2015). About 70,000 older Austrians are living in residential care facilities, whereas the large majority (80%) of people with LTC needs are living at home.

3.1.2 Status and development of integrated care in Austria

In Austria issues of coordination and integration of care both within the health system and between health and social care (long-term care) have been a major challenge over the past two decades. This is due to the idiosyncratic division of responsibilities, rationales for policy domains, information flow and fragmented sources of funding. However, with the rising number of people with chronic conditions and new patterns of care needs (e.g. due to dementia and other cognitive impairments), problems at the interfaces, for example between hospitals and community care, have become evident. Therefore a number of initiatives have been started to adapt organisational structures and processes, for example information exchange and discharge from hospital, as well as education and training programmes. Still, related reforms remain piecemeal, are often discontinued and not systematically evaluated.

The Austrian health system is based on universal coverage of the population by means of mandatory social health insurance, which is supervised by the Federal Ministry of Health that is also responsible for general framework legislation. Due to its federal constitution, however, a wide range of responsibilities are performed by the nine regional governments. For instance, regional governments are responsible for the provision of hospital care based on 'Regional Health Funds' and Diagnosis Related Groups (DRG) - funding. Patients can choose their GPs and specialist doctors who are remunerated according to a mixed system of fee-for-service and a capitated element for basic services (Hofmarcher, 2013).

The number of services and facilities that are mainly provided by private non-profit organisations (Caritas, Red Cross and other large welfare organisations affiliated to political parties), but also a rising share of private for-profit providers, has steadily increased since the 1990s, though at different pace in the various regions and unevenly distributed between rural and urban areas. Competition between providers is relatively scarce as long as demand exceeds supply. However, the number of stakeholders has increased due to the extension of privately organised 24-hour care provided by live-in migrant carers from neighbouring lower-income countries (Slovak and Czech Republics, Hungary). To date, about 25,000 beneficiaries of the LTC Allowance are using such arrangements, based on basic regulations and public subsidies to contrast moonlighting (Schmidt et al., 2015; Winkelmann et al., 2015).

The establishment of Regional Health Funds (2006) stipulated so-called 'reform pools' with the aim of promoting projects to improve coordination and cooperation between primary care and hospital care. Furthermore, integrated planning of health services across sectors was introduced by 2008 to further strengthen the implementation of needs- and patient-based pilot projects. As a result, a number of disease management projects (DMP) were developed in various regions and for selected diseases. The results of these projects were however scarce.

In the area of long-term care, supervised by the Ministry of Labour, Social Affairs and Consumer Protection, some improvements concerning quality assurance and simplifications related to the administration of the LTC Allowance have been implemented. In relation to coordination and integration, no progress has been made, for instance it is still not possible (and even prohibited in some regions) to provide community care services in residential settings, with the exception of some regions where 'service housing' has been established. Vice versa, it is also not possible for staff in care homes to provide community care. A peculiar measure to increase integration was implemented in two regions (Upper Austria and Styria) where the public administration defined operational districts, each of which was then allocated to a single provider organisation. No evaluation has yet been presented to show whether this intervention, on the detriment of consumer choice, has really resulted in the expected increase of cost-effectiveness in home care.

Hospice and palliative care are one of the most active and reform-oriented areas in health and long-term care in Austria. Driven by a dedicated 'Hospice Association', important steps to raise awareness for end-of-life care and to establish concepts of palliative care across health and long-term care provision have been made, for example by projects such as 'Palliative Care in Care Homes' and the further extension of 'Mobile Palliative Care Teams'. Indeed, the concepts of palliative care (multi-disciplinary teams, patient-oriented, holistic approach) have a potential to serve as a general model for person-centered care, but their integration in mainstream provision of LTC remains to be seen.

3.1.3 Rationale for selecting the two specific sites

The two Austrian sites were chosen because they represent examples of innovative practice and characteristic features of the Austrian context for integrated care.

The Coordinated Palliative Care (CPC) in Graz (Styria) is specialising in a defined area of care at the interface between health and social care, namely end-of-life care. Originating from specific needs of cancer patients in clinical care, the concept of palliative care has been further developed towards interventions between in-patient and out-patient care, in particular by the establishment of 'mobile palliative care teams' that are able to work in clinical and residential settings as well as in the community (i.e. patients' homes, addressing both the needs of patients at the end of life and their families).

With observed changes in needs structures, the model has moved dynamically towards serving older people with chronic conditions and multi-morbidity.

The Gerontopsychiatric Centre (GPZ) in Vienna is a unique centre for community-based geronto-psychiatric consultancy (clinical-psychiatry and neurology), offering anamnesis and serving as a service centre for patients, their families (carers), and for other stakeholders in health and social care (hospital wards, GPs, health and social care services and facilities). The small multi-professional team running the GPZ in Vienna is thus networking with a wide range of stakeholders to address the needs of older people suffering from cognitive decline, related morbidities and social problems.

3.1.4 Site I: Coordinated Palliative Care (CPC)

The main aim (mission) of the initiative is to spread the concept of palliative care in Styria (and beyond), and to establish appropriate services across all health and social care settings considering that palliative care wards are not sufficient to provide person-centered care at the end of patients' lives.

The initiative started to function by 2001 with the implementation of the first 'mobile palliative care team'. By 2005 it succeeded to secure one-stop funding by the 'Styrian Health Fund' and is thus able to offer services for patients with foreseeable terminal illness free of charge under the roof of the Styrian Hospital Holding (KAGES), but across health and social care settings.

The mobile palliative care teams (MPCT) in Styria were the first outside Vienna to provide this kind of services on a regular basis (since 2002). They are currently covering the entire region albeit with restricted resources.

Formally CPC is an organisational unit of the KAGES (Regional Hospital Holding) to which it is accountable with a budget allocated by the Regional Health Fund. However, the individual MPCTs are organisationally affiliated to three welfare organisations (The Red Cross, Volkshilfe, Hilfswerk) that are providing regular home care in defined districts of Graz (and Styria Graz). The MPCT Graz is affiliated to the Red Cross and provides services in all districts of Graz and surroundings.

A wide range of network partners includes, among others, GPs, specialist doctors, the Hospice Association (which coordinates volunteers supporting the MPCTs, if appropriate), pharmacies and care homes. However, while written agreements were established with all home care providers, networking is based on voluntary commitments. The teams have various superiors and supervisors. In addition to the Director General, there is a Medical Director and a Nursing Director (Head Nurse) at each home care organisation and the Coordinator of the volunteers (Hospice Association).

Table 1
Characteristics of the Coordinated Palliative Care (Graz, Styria)

Objectives	Provision, coordination and dissemination of palliative care
Services provided	Mobile palliative care teams supporting and accompanying patients and their families at the end of life (medically, psychologically, socially) across various areas and sectors; Supporting all relevant stakeholders from GPs, home care providers, care home providers etc. in the context of health and social care with 24/7 availability (hotline)
Target group	Cancer patients and older people with terminal illness and/or multimorbidity at the end of life
No. of potential clients/patients (Graz & surroundings)	4.000
Inhabitants (Graz & surroundings)	400.000
Average no. of clients per year (Styria, 2014)	2.500 (80% cancer patients, i.e. 40% of all cancer patients)
No. of staff (FTE)	9 teams across Styria (54.6 FTE, 96 professionals) + 2.5 FTE for coordination, Graz: 1 team (~10 FTE)
Budget per year	€3.8M
Average costs per client/patient	€1.890

There are written agreements concerning cooperation and regular meetings within the provider organisations and meetings of the General Coordinator with all head nurses across Styria. Also the Medical Directors meet regularly. In Graz the team is organised by the Red Cross. Medical doctors' continuity is guaranteed by arrangements with hospital doctors who partly replace the 'regular' MDs of the MPC teams in case of (planned or unplanned) absences. MPC team members can also replace colleagues across territories and providers.

Other important external stakeholders with respect to funding issues are the Regional Health Fund and (indirectly) the regional Social Health Insurance Agency, but also individual departments of the regional government (e.g. the unit responsible for care homes). With respect to overarching control also the Federal Auditing Authority is playing a certain role. As cooperation with GPs is only partly successful, the Chamber of Medical Doctors would be an important interlocutor but no relationships have developed thus far.

3.1.4.1 Level of service integration, strengths and weaknesses

The individual MPCTs certainly represent a fully integrated model of care with some degree of coordination between the regional teams. However, there are gaps of coordination and integration with other stakeholders such as the mainstream home-care teams (although the MPCTs are formally integrated under the roof of individual home care provider organisations) and, in particular, the individual hospital wards. This latter shortcoming is particularly evident in Graz with its university clinic.

The cooperation within the Palliative Care Team is generally good, as stated by both the manager and the professional. Personnel resources are deemed to be appropriate by the professional, in particular concerning the quality of staff, as they are very closely cooperating. Another strength of the MPCT is that the individual, rather than his/her symptoms, is the focus of and is at the center of the initiative. This is a central value of the palliative care approach.

The coordinated palliative care is also aware of existing weaknesses. In particular in Graz there is a large range of `team-cultures´- with internal conflicts in some teams. This, as stressed by the professional, has to do with how different professional groups are socialised and define their professional roles. Concerning training and education this is also a weak point. In general, consultancy skills to find out what people really need is an area that needs improvement as underlined by the manager. Also the unilateral 'integration' effort on the part of the MPCT is another weak point.

3.1.4.2 Areas for potential improvement & one specific improvement project

In conducting interviews at different levels and especially in the course of the stakeholder workshop various fields for potential improvement – particularly for better integration of services – were detected:

- Definition and distribution of service responsibility for the target group
- Structured collaboration between the mobile palliative care team and providers of community care services (and primary care)
- Information flow between the acute-care sector and MPCTs regarding admission and discharge.
- Links between palliative care and residential care facilities.

During the workshop one specific improvement project was selected, objectives were defined and put on the agenda for further development and implementation by a small steering group. The steering group will be composed by representatives from the six most relevant cooperation partners (KPS, MPCT, Rotes Kreuz, Hilfswerk, Volkshilfe, KAGES). The group will consist of six people as well as one or two representatives from the SUSTAIN Austria team as observers. The current working title of this project is: "Structured care of palliative-geriatric patients living at home".

The aim of this project is to define a set of criteria and improved communication methods for a structured and coordinated care process between the palliative care teams and other social and health care providers. As an important part of this project, participants identified the necessity to enhance the definition of the target group as well as the responsibilities of partners involved in a seamless care process (including informal caregiver). The implementation of the improvement project will start in three different districts of Graz and its surroundings (Straßgang, Gries, Kainbach) and will involve three different providers of mobile care services (RK, HW, VH).

3.1.5 Site II: Gerontopsychiatric Centre (GPZ) Vienna

The basic mission of the GPZ is the support and adequate treatment of older people and their families living at home and suffering from psychiatric problems in most cases cognitive disorders. It is a unique centre for community-based gerontopsychiatric consultancy (clinical-psychiatry and neurology), anamnesis and service centre. It also includes a 'Memory Clinic' and offers counseling (by phone and face-to-face) to GPs, health and social care services and family carers.

The GPZ is affiliated to the 'Psycho-Social Services' in Vienna that are run and financed by the municipality of Vienna. After identifying substantial lack of gerontopsychiatric competencies and related services for home dwelling older people in the city of Vienna, the Gerontopsychiatric Centre has launched in 2001. In most cases up to this point, when home helpers and their organizations and/or family carers faced problems, they turned to the 'Psycho-Social Services' (PSD) that had not been specializing on such cases.

Table 2
Characteristics of the Gerontopsychiatric Centre (Vienna)

Objectives	Diagnostic and therapeutic case management in the context of gerontopsychiatric problems
Services provided	Primary focus: clarification of diagnosis and environment, plus consultancy Secondary focus: support for family carers and professional caregivers Tertiary focus: training and further education for providers
Target group	People suffering from dementia (main target group) but also from other psychiatric disorders (such as depression, psychosis, addiction) and their families; most of them living at home
No. of potential clients/patients (Vienna)	20,000 people suffering from dementia and living at home and 5,000 in residential settings
Inhabitants (Vienna)	1,84 million
Average no. of clients per year (Vienna, 2015)	About 10-20% of the target group living at home have been reached by 2015 (about 1,500 patients per year, of which 500 per year new)
No. of staff (FTE)	8.5 FTE, 4 nurses, 3 geriatricians, 2 psychologists, 1 social worker
Budget per year	€900,000
Average costs per client/patient	€600

The multi-professional team (8.5 FTE) of the GPZ consists of psychiatrists, psychologists, nurses and a social worker. All services are free of charge for the clients. The integrated team is networking with a wide range of stakeholders in the area of health and social care.

The GPZ cooperates with a wide range of organizations like `Fonds Soziales Wien', which purchases social services for the city of Vienna, all providers of home care, Alzheimer Austria, providers of day-care, GP's and specialized doctors.

Funding for GPZ is provided by the city of Vienna. There is no funding at all by the health insurance. Assessments are geared at necessary interventions, diagnosis, referrals etc. These follow-up cost are, however, covered by the health insurance.

3.1.5.1 Level of service integration, strengths and weaknesses

The GPZ works on the basis of a multi-professional team and provides comprehensive and professional services at a remarkable level of integration already. Users as well as cooperation partners of the GPZ that took part in the baseline assessment process generally expressed high satisfaction concerning the kind and quality of services provided. However, many successful ways of working and of integrating these services in the regional health and care system are based on quite informal relationships and vague personal agreements. Management as well as professionals are well aware of the importance of personal contacts and informal co-operations, but they also see the limits and the potential fields for improvement.

A key strength is the internal communication and collaboration: The manager and professional state that communication and collaboration within the small and multi-professional team of the GPZ is satisfying and efficient. There is also constant exchange of medical and non-medical knowledge.

Person-centered and safe interaction were mentioned several times as key objectives of the service. Users as well as carers have experienced the services provided as respectful and individual. Both the user and carer felt accepted with all their specific needs and had the feeling that they could always contact the GPZ in case of specific problems.

Weaknesses that were identified in the interviews are in particular a lack of formal and sustainable agreements of cooperation. There are no general rules – or even contracts - as a basis of collaboration with external professionals or some relevant organizations. The collaboration with the regional health insurance as well as with the hospital sector is particularly weak and represents a potential field for improvement.

As in many areas of public services and in particular among social and health care services that are especially in demand, sustainable financial and personnel resources (particularly understaffing) are always an issue and can be regarded as a weakness.

Furthermore there is a weakness in the IT structures. Due to safety issues there is no electronic data interchange. This can be rather obstructive in the collaboration with different providers. There is also no electronic medical history, which limits evaluation possibilities.

3.1.5.2 Areas for potential improvement & one specific improvement project

In conducting interviews at different levels and especially in the course of the stakeholder workshop, various fields for potential improvement – particularly for better integration of the provided services, could be detected. As a first step all invited stakeholders were asked to think about different areas of potential improvement that could be influenced by the site itself and/or by involved cooperation partners. The findings were clustered according to key areas of concern, such as financing/personnel resources, person-centered approach, information/ public relations, cooperation with other health and social care services /GPs/health insurance etc.

In the group discussion the following issues were identified as relevant and promising for a potential improvement of integrated service provision by the GPZ:

- Interface GPZ and institutional care (residential-/hospital care)
- Information pools such as training for professionals
- Support of and collaboration with the GPZ by an expansion of inpatient diagnostics.

The improvement should particularly concern the case- and discharge management of hospitalized patients, who are recognized during their hospital stay as obviously or suspiciously suffering from any kind of cognitive disorder, but could not (for whatever reason) be diagnosed or treated sufficiently in the hospital. Medical and nursing staff of all relevant hospital wards should be aware of the services offered by the GPZ for this group of patients and should, at the point of discharge, inform all respective patients (and/or their relatives) and recommend them to make use of the possible support and (follow-up) services by the GPZ.

The participants decided to start the implementation of this pilot project at first as a cooperation between one large hospital, the "SocialMedicalCentre East"/SMZ Ost, within the Viennese Association of Hospitals (KAV) and the GPZ.

The current working title of this project is: "The optimization of dementia diagnostics, integrated medical follow-up and awareness".

In this way several ideas of the workshop participants could be compiled in one potential improvement project by the end of the workshop.

3.1.6 Discussion and conclusion

The selected Austrian sites represent specific examples of integration and coordination in a context of rather weakly developed mechanisms for cooperation and networking between sectors and organizations. Person-centered care is clearly a strength of the palliative care model. It is therefore no surprise that within the MPCTs multi-disciplinary cooperation around the needs of the patient has become a daily routine. This is equally true for the small GPZ team.

In both cases there seems to appear bottlenecks and shortcomings when it comes to trans- and cross-organizational collaboration. This leads to a strong feeling of 'us' and 'them' based on problems of mutual understanding and acknowledgement. The lack of time and space for communication, information exchange and procedural agreements, which is also due to restricted personnel resources, were identified as key barriers and thus as starting-points for improvement projects.

At both sites it was relatively easy to get access to interview partners, although for users it was not straightforward due to the particular target groups at both sites. For the purpose of the baseline assessment, interviews with users and carers were of restricted relevance.

With regard to the workshops: In Vienna there was a very collaborative atmosphere as all participants were acknowledging and appreciating the achievements of the GPZ. The group also included the most relevant stakeholders ranging from funders/purchasers and regulators to providers and carers. Following a short phase of confusion and too high expectations, the workshop process led to a clearly defined improvement project, which seems to be feasible and is supported by all stakeholders. In Graz it was more difficult to gather the entire range of stakeholders. While the process for defining an improvement project went relatively straightforward, a major irritation occurred towards the end of the workshop due to a general misunderstanding. Although the role of OEPIA as a research partner, whose task is to accompany and evaluate the implementation of the improvement project, had been presented at the start, many participants had also expected/imagined financial and/or personnel support from OEPIA for the improvement project. Due to the restricted (time) resources of the MPCT Graz it will be necessary that the CPC provide substantial support.

Results indicate that both Austrian sites have realized integrated care in specific areas of care, namely in (mobile) palliative care and in (the assessment of) psycho-geriatric care.

A number of issues have been identified that show great potential for improvement. Communication at the hospital/community care interface was defined as a priority of the GPZ, and the steering group will elaborate on this during its first meeting to discuss a potential improvement project. For the CPC in Graz, it will be a challenge to implement the defined improvement project at the interface of MPCT and home care services. Due to personnel shortages, it will be necessary to find additional resources for the steering group.

3.2 Estonia

Gerli Paat-Ahi

3.2.1 Demographic background

Since the 1990s, the population of Estonia has been decreasing and as of 1 January 2016, 1,311,759 people live in Estonia. According to different population projections, this number will keep falling (Giannakouris, 2008). Despite the fact that in recent years the birth rate and the average life expectancy have increased, the population keeps declining. This can be explained by a decrease in birth rates between 1990 and 2000 (OECD, 2015a).

The Estonian population is also ageing. Average life expectancy at birth in 2004 was 72.4 years and rose to 77.2 years by 2013. In 2013, average life expectancy at birth was 72.7 years for males and 81.3 for females. The current statistic for females is close to the European average, which was 83.1 years in 2012. At the time, the life expectancy at birth for males living in the European Union was 77.5 years. In 2013, only six countries in the European Union had a shorter average life expectancy at birth than Estonia (Praxis & TNS Emor, 2015).

In 2014, 18.4% of the Estonian population was age 65 years and older. This figure is estimated to increase to 27.6% by 2040 (Servinski, 2012). An ageing population can be illustrated by the dependency ratio, which shows the relationship between the elderly (at least 65 years old) and working-age population (15-64-year-olds). According to the most recent Estonian population census, there are 27 old people per 100 workers, in other words for every old person there are 4 working-age persons (citation needed). Comparing dependency ratios in 32 European countries (EU and EFTA members), Estonia is at most 10th place. Italy and Germany have the highest dependency ratios, where for every 100 working-age people there are 32 and 31 old people, respectively. According to the population projection, the Estonian dependency ratio will increase to 36% by 2025 and to 47% by 2040. By 2040, due to an ageing population, for each elderly person (age 65+), there will be only two rather than four working-age people. Based on the UN population forecast, in order to keep the dependency ratio in Europe smaller than 15%, pension age needs to be raised to 70 years by 2025 and to 75 years by 2050 (Servinski, 2012; Praxis and TNS Emor, 2015).

3.2.2 Status and development of integrated care in Estonia

Population ageing in Europe is bringing about important social challenges that will continue into the future; changes that are having an impact on the society (e.g. increase in the demand for care services), economy and labour market (e.g. decrease in the number of working people) and policies (e.g. potential increase in the demand for policies tailored for older people and are thus a strain on public finances). The welfare of the elderly depends on the extent to which they are activite and engaged in the society.

Active ageing is talked about much in Europe and can be described as older people actively taking part in society including in economic, cultural and everyday life, whilst maintaining their own autonomy and independence. According to the WHO, active ageing will enable people to realise their physical, social and mental potential throughout their lives (Praxis and TNS Emor, 2015).

Responsibilities for the provision of long-term care in Estonia is divided between the healthcare and welfare systems. The healthcare system provides home and institutional nursing care and geriatric assessment services. The welfare system provides LTC in welfare institutions, day-care services, homecare and housing services, as well as other social services (OECD, 2011).

Long-term care services are divided into health and nursing care, and personal care. Healthcare is the responsibility of the government-funded Health Insurance Fund (EHIF). Nursing care services include those that are home-based and the ones provided in day care and institutions. Personal care services are mainly organised by local governments.

Health care is managed and financed by the public sector. According to the Health Services Organisation Act (Riigi Teataja, 2001) there are two types of health care services: stationary and ambulatory. Nursing care services are listed as (institutional) nursing care service (i.e. stationary care and ambulatory care), under which only home nursing service is listed now (since 2014). Nursing care service providers need to have a permit from the Health Care Board. The Ministry of Social Affairs regulates nursing services.

At the current development level, the most appropriate model of integrated care for Estonia is the model of the co-ordinating network. The co-ordinating network model implies that the people and institutions in the network have activities clearly focused on cooperation, but their ties may not be necessarily very strong and the partners may change. In the case of such integration, the relationships are formed based on actions and contracts (Paat and Merilain, 2009).

3.2.3 Rationale for selecting the two specific sites

In 2015, there were around 90 home nursing centres and a number of self-employed home nurses in Estonia. The SUSTAIN project has included two institutions: Alutaguse Care Centre and the home nursing service provider MEDENDI. MEDENDI offers home nursing care services; Alutaguse Care Centre offers integrated care services and round-the-clock home-care care service. The objective of both institutions is to help the elderly patient to live in his/her home for as long as possible.

Alutaguse Care Centre and MEDENDI were chosen to take part in the project mainly because of their willingness to participate and their motivation to improve their services. The difference in location is an advantage, serving both urban (MEDENDI) and rural (Alutaguse Care Centre) clientele. This regional diversity will offer insights on how to improve integrated care services in Estonia as a whole.

3.2.4 Site I: Alutaguse Care Centre

The main aim (mission) is an innovative and caring nursing home that meets the expectations and needs of people requiring care and ensures their coping. The Alutaguse Care Centre is a nursing home known and recognized in Estonia. The Alutaguse Care Centre is an innovational and caring nursing home that meets the expectations and needs of people requiring care and ensures their coping.

3.2.4.1 Level of service integration, strengths and weaknesses

Alutaguse care centre is a well-run organisation, which follows specifically laid out guidelines and regulations. In addition, the organisation has an in-depth quality handbook, where well-developed specific roles and responsibilities are laid out for the staff members on every level. Alutaguse care centre staff consists of experienced and knowledgeable health care workers, whose motivation is much higher compared to other similar institutions.

The main weakness, identified in the interviews, was the fact that the cooperation between similar organisations in the area is weak. This could be explained by the competing nature between the organisations. However, cooperation with similar organisations in other parts of Estonia is good. Another weakness identified was a lack of cooperation with family doctors and the specialists. The institution cares for people from all over Estonia and it is sometimes difficult to contact the family doctor or medical specialist based in another part of the country. The need to communicate arises from the fact that the information about patients' medical history is not available for Alutaguse Care Centre staff. The only information they see is that contained in the referral letter.

In the workshop, staff burn out/understaffing was one of the problems identified, which implies that the staff have less time to spend and communicate with patients and with each other. Since work is arranged in shifts, there is no effective way to assure effective communication. Information is passed on through e-mails but the workers do not think this is sufficient. Another weakness identified is the fact that although the resources for necessary activities are there, there is the lack of resources for leisure activities (e.g. trips, organised entertainment for the elderly).

3.2.4.2 Areas for potential improvement

The potential solutions for problems identified in the interviews and workshop were improving ICT infrastructure (especially accessible patient databases), more sustainable funding, establishing result based indicators, and further integration between health-care and long-term care systems. These suggested improvements are crucial. However, in some aspects, the organisation's hands are tied and government action is necessary.

The workshop identified two main problems, which could be solved on the organisational level.

Table 3
Characteristics of the Alutaguse Care Centre

Objectives	The objective of the Foundation Alutaguse Hoolekeskus is to facilitate living in dignity and safety for older and disabled citizens by supporting, promoting and maintaining their quality of life. The nursing and health care services of the Care Centre are mainly intended for older people from the Mäetaguse rural municipality and southern region of the Ida-Viru County. The Alutaguse Care Centre is based on a holistic approach recognizing clients' physical, mental, social and spiritual needs and considering these to be of equal importance. The services have been planned with consideration of the real needs of senior citizens.
Services provided	Services for older people include integrated nursing care proceeding from the needs determined by an assessment of the patient's state of health; the services are offered in conformity to the objectives established and based on the (nursing) care plan. All activities are documented; the need for services is re-evaluated periodically to adapt individual (nursing) care plans.
Target group	Senior and disabled citizens
No. of potential clients/patients	30.000 (age group 65+)
Inhabitants	148.000
Average no. of clients per year	200-400
No. of staff (FTE)	55
Budget per year	€400,000
Average costs per client/patient	€800

One improvement that was suggested to find more time to communicate with patients; another one is to improve the information flow within the organisation.

Project 1 ("Client profiling")

The problem is that staff are not enough acquainted with the client. This can be changed by assessing the patient's problems and needs from the family by means of a questionnaire. The activity would create a profile for the client (including medical and physical information as well as information on hygiene, special needs etc.). To implement the project, cooperation is needed between hospitals, social workers and the family of the patient.

Steps to be taken - 1) develop a questionnaire 2) make the questionnaire accessible on the web page 3) require patient's family to fill in the questionnaire before signing the contract 4) establish indicators to assess the effects of the proposed system 5) establishing the questionnaire system and monitor it regularly

Main risks associated with the project is that the family might perceive the requirement to complete the questionnaire as 'spying' on the client and may lead to family members not revealing the truth about the patient. Risks can be reduced by efficiently providing information to the client and the family.

Project 2 ("Talk to me")

The problem is that information moves slowly between staff and does not reach everyone. There is no systematically way to exchange information (including IT systems). The solution would be to create a system that makes the information accessible. The aim of this change project would be to improve access to information. Consequently, service quality would improve. Feedback and mutual understanding would evaluate the effectiveness of the project. To implement the project, all of the staff should be included, as well as patients and their families if necessary.

Steps to be taken: 1) develop necessary ICT-system 2) meet regularly 3) create an events calendar (distributed to patients and families as well) 4) on the arrival of a new patient, have a meeting with everyone associated with the patient 5) regularly monitor the outcome.

Main risks associated with the project would be the lack of space, time and funds, and disinterest among the workers. Risks can be reduced by active communication and information sharing, motivating the staff and good planning.

In the framework of the SUSTAIN Project, participants in the workshop decided it is sensible to pursue the second option - Project 2 ("Talk to me").

3.2.5 Site II: MEDENDI

MEDENDI is derived from Latin, meaning 'to heal', metaphorically to amend, correct, relieve. These words describe MEDENDI, with a mission to offer high-quality individual nursing care at home to improve and maintain people's quality of life.

3.2.5.1 Level of service integration, strengths and weaknesses

MEDENDI is a well-run organisation, where staff has well-developed specific roles and responsibilities. Staff are highly motivated, which is visible from low staff turnover. In addition to a decent organisational culture, another highly regarded benefit was the home nurses' ability to work independently. Staff consist of experienced and knowledgeable health care workers. Unlike Alutaguse Care Centre, MEDENDI has good cooperation with FDs and specialists.

Main weakness identified in the interviews as well as in the workshops was the inability to hire other specialists due to economic reasons arising from the fact that EHIF only finances home nursing service. This makes the service for the patient very specific and the patient has to turn to other organisations to find different type of help (e.g. carer, physiotherapist etc.).

Another weakness identified, was the lack of medical information about the patients, which is usually solved by contacting the doctor who provided the referral. Since MEDENDI target group resides at homes, in some cases there is a for need cooperation with social workers of the local governments. The cooperation however, is tenuous or non-existent. There is no information flow between MEDENDI and local governments and together no actions are taken to improve the conditions of the patients. Another weakness mentioned, was the fact that workers receive no feedback on their work since according to the law they have no access to the information about the patients after the care provision stopped.

Table 4
Characteristics of MEDENDI

Objectives	Home nursing services are designed to assist older people and patients, who are discharged to home after surgery, as well as disabled people, or other patients, who for some other reason need follow-up care and treatment. In collaboration with the patient's family and a specialist doctor the best solution is found and the role of nurse is to help patients to stay at home.
Services provided	Medendi provides services that include consulting, drug distribution, blood pressure measurement, pulse reading, measurement of blood glucose with a glucometer, preventing pressure ulcers, treatment and care etc. Also rehabilitation in household activities is provided. Therapy of household activities includes: assessment of the client's operational capability in his/her home environment; mapping of obstacles in the home environment and recommendations for readjustments; identifying the optimal personal assistance; setting the goal of activities; giving advice regarding personal assistance.
Target group	Clients who are staying home after the surgery, disabled clients, or other clients, who for some other reason need follow-up care and treatment
No. of potential clients/patients	71.000 (age group 65+)
Inhabitants	575.600
Average no. of clients per year	1000-2000
No. of staff (FTE)	11
Budget per year	€190,000
Average costs per client/patient	With Health insurance clients free of charge. €28 per visit

3.2.5.2 Areas for potential improvement

The potential solutions for problems identified in the interviews and workshop were improving ICT infrastructure (foremost accessible patient databases), more sustainable funding, establishing result based indicators and further integration between health-care and long-term care systems. These suggested improvements are all crucial, however, in some aspects, the organisation's hands are tied and government action is necessary.

The workshop identified two ways to address the issues experienced - improving effective information interchange and creating needs based support system.

Project 1 ("Human centred information")

The problem faced is the lack of cooperation between healthcare and social systems. Legislations should be made more flexible and a common IT platform, accessible to everyone involved, should be created. The project's goal is to provide person with access to the type of care needed without any overlap or duplicating. The project can be described as successful if patient's needs are satisfied and health stable. As well as guaranteeing workers' optimal workload in case, issues of overlaps are resolved. In addition to health care workers, local governments, social workers and society need to get involved.

Steps to be taken – 1) improving cooperation 2) readjusting the system 3) establishing an information interchange system 4) division of tasks between different participating parties 5) agreements and making sure agreements are kept.

Main risks for the project are stringent legislation, disinterest and demotivation of participating parties and lack of financial resources. Risks could be reduced by offering versatile cooperation, strong leadership and public agreements (including the public sector).

Project 2 ("Human centred and needs-based support system")

There is a lack of integration between different information sources. It can be improved by integrating all information sources, making them easily managed and accessible. The project aims to make the flow of information better and optimized between different participating parties. The project is successful if patient as well as the worker is always equipped with necessary information. The project should engage home nursing care centre, family doctors' centre, family, local government, social workers, facility centres, and if possible society and volunteers as well. The project should have proper IT support.

Steps to be taken – 1) map out critical information, which is vital to share, 2) work out the best IT solutions to gather and share information, 3) create a specific target groups to share information with, 4) question the target group to evaluate the effectiveness of the information sharing, 5) monitor results. This would be a pilot project, which can be tested on a smaller sample of people and later applied in all of Estonia.

Main risks associated would be the risk of not reaching a consensus on to whom and what kind of information to share, information flow could grow too extensive, so information would not be comprehended adequately. Risks could be reduced by asking constant feedback and monitoring.

3.2.6 Discussion and Conclusion

For both sites a potential development plan was chosen, which will be further improved. Alutaguse Care Centre's plan aims to improve the communication within the organisation and MEDENDI's plan is aimed at the improvement of the communication between all stakeholders.

The plan for the Care Centre does not seem to face big obstacles (since the workers are very motivated and ready to take action), in MEDENDI's case, however, the plan involves people from outside the organisation, which can cause problems. Implementation of IT systems and its financing is another challenge.

Interviews and workshops conducted in Estonia were successful. Sites were very responsive and willing to cooperate. Since long-term care is not discussed much in Estonia, the participants were enthusiastic about the opportunity to discuss and contribute to the topic and are hopeful about developments in the field. The greatest problem identified was information interchange and access to relevant information. There is also a problem in Alutaguse Care Centre with information flow and communication between workers since they work in shifts. It was also pointed out that there is limited access to patient's medical and other care related information. Developments on improving access to medical information are underway on governmental level and the situation should have a solution soon (with the introduction of e-health). Because of the problems faced by both sites, it was agreed that information and communication needs to be improved within organisation as well as in the field.

3.3 Germany

Sophia Schlette

3.3.1 Demographic background

Demographic change will radically alter Germany in the coming decades. The population of Germany has been shrinking since 2003 and is now 81.7 million residents. Positive net migration has not made up the difference between the death rate and the birth rate. Both are ongoing trends. According to the Federal Statistical Office, Germany's population will decline to 65-70 million by 2060 - a decline of 15% to 21% accompanied by a decline in the working-age population. At present the population group under 20 roughly equals the group of people 65+ in size, each group accounting for 20% of the total population. The average age of the population is expected to rise until about 2060, when one in three people (34%) will be at least 65 years old.

In past decades, Germany saw very high net migration thus delaying population decline. Except for a slump in 2008 and 2009 since 2010 immigrant numbers have outnumbered those moving away by about 128,000 / year. With migration, Germany has become more ethnically diverse. Today one-fifth of the total population has an immigration background, a trend that will continue and present additional challenges in health, long-term, and social care. On the plus side, immigration has helped to cover pressing staffing needs, and a lot of health professionals from Eastern and Southern Europe have in fact contributed to this.

According to the German Statistics Office 2.6 million people were in need of long-term care in 2013. Women are more affected than men. Women are also more likely to live at home alone in old age. LTC needs increase with age. In the age group 70-75 one in 20 persons is in need for LTC, for those over 90 years 2 out of 3 are receiving services under LTC insurance provisions (64,4% average – women much more often (67,9%) than men (51,8%). The type of care is also highly gender-sensitive. For instance, the percentage of older and very old women in nursing facilities is significantly higher in women. It increases from 21,1% in the age group 65-69 to 47,8% for those 90 +. For men the increase is from 23,6% to 34,5%.

As regards the health care market, Germany spends approximately 11% of its GDP on healthcare – consistently ranging among the top four spenders in the OECD.

3.3.2 Status and development of integrated care in Germany

Integrated Care (IC) has gone through various phases over the past 10-15 years. The concept was introduced in 2004, when the Government passed comprehensive strategic legislation paving the way to contracting and collaborating across the traditional vertical silos and health care settings. Financial incentives were offered and quickly picked up both by hospitals and providers in primary and secondary care. The threshold for "integrated care" was set deliberately low so as to make new forms of care attractive and easy to comply with requiring as little as two partners contracting with each other. Not everyone was happy with that, as some strategists had pleaded for more comprehensive criteria to qualify for integrated care funding. Broader population-oriented care projects only made for a small fraction of the new IC models. When funding ran out at the end 2009, integrated care was no longer endorsed politically, the very term was replaced by a less ambitious notion more embedded in the status quo: sektorenübergreifende Versorgung ("care across sectors").

Politics is one driving force behind the shift towards more collaborative forms of care in Germany. Others are generational change and feminization throughout the health professions. Young doctors want to practice medicine, have a family, and prefer working fixed schedules over running a business and are drawn to larger group practices.

As a result in recent years many physician networks and group practices have formed. Health care centers (Medizinische Versorgungszentren = MVZs) work with doctors as employees, offering a wide range of services (e.g. general practice, internal medicine, gyn/obs, mental health, occupational health, pediatrics, and diagnostics) as well as rehab services and sometimes pharmacies in a one-stop shop.

Like in other countries, in Germany, too, long-term care services and social services are means tested. The LTC insurance, which is mandatory, differs from health insurance in that it is not a full coverage package. Instead, for LTC services it is expected that people qualifying for LTC support contribute with their savings, or income from pensions, or family assets.

Similarly, senior services are tax-funded and provided by the municipality or charities based on need. They can complement home health care and consist of help maintaining independence at home (e.g. help getting dressed, home adaptations and preparing meals).

The structural separation of health, long-term care and social services has added to the fragmentation of care and funding in Germany. Comprehensive recent legislation (Pflegestärkungsgesetz I-III, of 2015-16) aims to close this gap.

3.3.3 Barriers to coordination and integration

In Germany, obstacles to integrated care exist at multiple levels. As elsewhere in Europe cultural values and professional roles are in the way of care coordination and team-based care.

In addition – and that is more of a homegrown issue in Germany – there were political obstacles related to the "reunification" of two very different health care systems after the fall of the Wall. Without any performance assessment, the East German system was abolished – for reservations against "state medicine" - and the West German system of private providers in a statutory health insurance system imposed.

Only very few policlinics managed to survive in the states of Brandenburg and Berlin, forming cooperatives or becoming hospital outpatient clinics. Ironically, those integrated care facilities that continued to operate after 1989 have since served as role models for integrated delivery systems.

Professional roles and physician self-perception as free profession have also been in the way of integrated care. Germany's health system is grounded on the principle of self-governance (i.e. decision-making sits with regional physician organizations with regard to access, quality, capacity planning, reimbursement, etc.). A broad consensus had it for years that those closest to the patient and with the clinical expertise – physicians – are better suited than policymakers to take health care decisions. Moreover, patient advocacy groups have voiced concerns that free choice of doctors – another key pillar of this health care system - might be reduced at larger integrated care clinics.

In sum, Germany faces multiple structural, ideological and subjective obstacles to integrated care. The debate is very emotional, as it touches upon vested interests of the dominant provider group and the highly held patient choice. More than from within, system change towards more integrated forms of care will be accelerated by technology, new professions and players in primary care, and workplace preferences by the next generation of health care professionals.

3.3.4 Rationale for selecting the two specific sites in Germany

KV RegioMedZentrum Templin and Careworks Berlin were approached to serve as case sites in the SUSTAIN project. They both fulfil the study criteria of having established the foundation of an integrated care initiative, being open to innovation and continuing improvement, of having similar target groups people aged 65+ living at home or in assisted living facilities with multiple health and social care needs, a distinct regional focus, and a work philosophy that embraces professionals from multiple disciplines working in teams. For balance, we selected a rural site and one urban site. The rural site displays all the challenges of aging, migration, and system fragmentation in the microcosm of the town of Templin. RMZ, our case site, shows a way forward by putting geriatric trained medical assistants into the driver's seat. In a decidedly different environment, the urban site in Berlin-Marzahn, CWB, follows an integrated care approach that works particularly well in a high-density housing neighbourhood, showcasing the advantages of a one-stop-shop. Moreover, to ensure richness of data, we selected two sites that were at different levels of integration. Both sites are representative as examples for the way forward toward new forms of comprehensive care for older patients with complex health and are needs in Germany.

3.3.5 Site I: KV RegioMed Zentrum Templin (RMZ)

In response to massive demographic change in rural Brandenburg, in 2014 an innovative care concept for older patients has been put in place in the Uckermark district, situated in the Northeast of Brandenburg. Run as a GP practice in the ownership of the regional physician association, it is housed at a local hospital in the town of Templin (16,000 inhabitants (2011), 23% 65+). The innovative program offers intensive outpatient geriatric coaching for older patients with complex needs.

With its Complex Therapy program, RMZ follows a preventive and rehabilitative approach aimed at strengthening the patient's own coping capabilities. For three weeks, patients visit the Elder Practice on a daily basis. While receiving care and supporting therapy, program participants learn about their medication plan, fall prevention, and a healthy diet and lifestyle. For each patient a personal, tailored care plan is developed, and guidance to professional and voluntary services in the community is also provided.

A key role is held by the case manager, the so-called Agnes zwei. This practice assistant, specially trained in geriatric care, communicates with patients, physicians and other health care agencies and assists patients with administrative and logistic matters. Agnes zwei was developed by "Innovative Healthcare in Brandenburg", a joint initiative of the regional statutory physician association (KVBB), and two regional statutory health insurers.

The RMZ Templin is part of a larger regional strategy to support Brandenburg in times of stark demographic shift. The regional physician association has assumed an active role early on in order to secure access to health care and contribute to redefining and downsizing health care structures that have become or will soon become obsolete. Templin and its countryside, the Uckermark district, are representative of a typical, highly fragmented health care market. Since the area is remote patients are local and depend on local services. The lack of other health care facilities nearby leads to a situation where there is virtually no way in and no way out – there is no patient import or export from or to other regions. The flipside of the locked-in situation in Templin and its rural backyard is the social isolation of its older population, and the lack of mobility, public transportation, and therefore poor accessibility to health and social care services.

This particular setting allows for a prototype improvement project where all local stakeholders will be involved. Key stakeholders include staff employed by KVBB – mostly medical assistants trained in geriatric and home health care (Agnes zwei nurse) to substitute doctors, local GPs as referrers, therapists for post-program follow up, specialists, the geriatric ward at the Sana Hospital, social services for non-health home support and home adaptations, the mayor, the local media.

3.3.5.1 Level of service integration, strengths and weaknesses from different viewpoints

As mentioned, the project's approach is one of integration and structured collaboration involving GPs, specialists in private practice, the hospital, therapists, and social services.

Table 5
Characteristics of KV RegioMed Zentrum Templin (RMZ)

Objectives	To provide a "bridge structure" between home, primary and hospital care. To improve health status and support user's self-determined goal setting with intensive assistance from GPs and geriatric trained medical assistants.
Services provided	3 weeks complex therapy program: health care and exams, rehabilitation and prevention, nutrition education.
Target group	Milder geriatric patients, early stages of dementia, or stroke patients who can be managed at home and are expected to benefit from resource mobilization.
No. of potential clients/patients	7.000
Inhabitants	28.000 in Uckermark district, population 65+ is 25% (2014), projected 43% by 2030
Average no. of clients per year	200
No. of staff (FTE)	This figure cannot be given for one site alone, as it is a collaboration of several stakeholders with different staffing situations. Also, note that except for two KVBB staff, other collaborators see non RMZ patients as well. KVBB: 4 employees in Templin and Potsdam, 1 medical director, 1 lead medical assistant (Agnes zwei), 5 GPs. Sana Hospital: 1 geriatrician, 6 therapists, 2 cardiologists, 2 gastroenterologists. Several home care nurses employed by local charity
Budget per year	€300T RMZ is a clinic run by the regional physician association, KVBB. Governed by Social Code Book SGB V § 105 (Statutory Health Insurance). The complex therapy program is funded under socalled "structure contracts" that are drawn bilaterally between KVBB and three of five sickness funds.
Average costs per client/patient	€2.289 (€109 per day)

Strengths

The small team in Templin is made up of highly motivated, specially trained staff. It is supported by equally dedicated project managers at KVBB in Potsdam.

We are particularly pleased to count with strong backing from the Templin town mayor and its business development department.

National visibility and high expectations. In 2014 Federal MoH Hermann Gröhe was present when the RMZ was officially launched. Media coverage was considerable at the time.

Weaknesses

The project is understaffed and mostly relies on a handful of very dedicated geriatric trained medical assistants. It needs all the backing from KVBB and will in the future benefit from a better alignment of funding streams under a new integrated care contract with the main sickness funds.

The three-week complex therapy program is not well known.

The hospital is suspicious of losing patients, and self-employed therapists fear they may lose patients to the program as well. In both cases, we will work with sceptical stakeholders to create a more collaborative spirit and a win-win situation based on mutually reinforcing roles.

Lack of mobility and social isolation. Public transportation in Germany has long been focused on the school schedule, facilitating students transport. In greying communities, this does not make sense. New ways of transportation have to be designed that take into account opening hours of senior clubs and community centers.

3.3.5.2 Defining one area for potential improvement

The SUSTAIN improvement project will focus on information, public relations, and communication about the complex therapy program in the region, using various tools and platforms from both within the health sector and outside, such as local policy makers and industry fairs. The project aims to increase visibility and acceptance among providers: physicians for their role as referrers into the program, the hospital as a partner to keep geriatric patients at the home, and therapists that will work with patients to keep them steady with ongoing, if less frequent, sessions and classes.

3.3.6 Site 2: Pflegewerk Berlin (CWB)

Careworks Berlin (CWB) is aimed at improving the care of older people with complex health and long-term care needs in the Berlin neighborhood of Marzahn-Hellersdorf. Based on integrated care provisions as mapped out in the German Social Codes V (health) and XI (long-term care), CWB's innovative approach consists of combining discharge management, case management and palliative care under one roof. Patients' health and social care needs are determined using the Resident Assessment Instrument (RAI); however, patient records are not yet integrated digitally. 300 patients are receiving Mediplus TuR (therapy and rehabilitation) services, another 400 are assisted with long-term care.

Consisting of high-density housing popular among residents, the Marzahn-Hellersdorf district is ageing rapidly. Of a 256.173 population 92.000 are older people, of these 12.000 are estimated to have long-term care needs. Across Berlin, CWB operates a comprehensive network of facilities where therapists, physicians, social workers, pharmacies and volunteers explore new ways of collaborating along the care continuum from multi-morbidity to end of life.

The by and large favorable policy context has already been described elsewhere. What is interesting about CWB is its physical context. Located in a high-rise neighborhood of former East Berlin, these buildings, not much loved after the fall of the wall, are become popular again for older people, many of whom eventually grew up in these concrete block quarters. While not attractive by any standard, the apartment buildings are extremely convenient. They all offer elevators, and the flats are right-sized and fulfill all standards of barrier-free, accessible living. Add to that a health care facility, physical therapy practices, home-health nursing services, a community center and a house for volunteers, and you have a natural integrated care center in the midst of the community.

3.3.6.1 Level of service integration, strengths and weaknesses from different viewpoints

CWB is a fully integrated delivery system, much like a "Kaiser Permanente" for older people living in assisted living facilities and/or nursing homes.

All staff is employed by the organization, which has found a way to bundle payments from the various insurance schemes and public funding sources. Service integration relies on two groups that are not usually in focus in eldercare: therapists and volunteers.

Strengths

Leadership at CWB is creative and solution-oriented. All employees are dedicated, empathetic, and person-centred. They work flexibly by going beyond the silo thinking imposed by the various ramifications of German social legislation, enabling user needs to be considered more holistically with a clear focus on improving the quality of life and wellbeing of patients. Furthermore, CWB offers services from the moment of admission, when a person moves into one of their assisted living facilities. There is no cap on length of stay in the service. CWB is performing well as it has reduced admission rates further than others.

Another strength is the role of therapists as patient pilots, as is the crucial role of volunteers. The role of therapists, who spend long hours with their clients, has not yet been fully explored in the context of person-centric, tailored, integrated care. CWB is convinced that it has a unique approach that could guide other new forms of care for frail old patients.

CWB is also bringing in volunteers as helpers for activities of daily life and social activities for the elderly, addressing two challenges: Social isolation of older people living alone as a health hazard and predictor for physical decay and neglect, and a perspective offered to dependable volunteers who can be trained and supervised to join the labour market upon completion of their volunteer service.

Weaknesses

The very strengths of the CWB may well be its weaknesses. The managing director is providing flagship guidance and leadership to the organization, and the family-owned company is supportive of that. However, there are difficulties retaining some staff, particularly physicians are not staying for extended periods of time. Fluctuation also affects the structured volunteer services.

The lack of funding available means improvements to the IT infrastructure may not be possible.

3.3.6.2 Areas for potential improvement

Improving the alignment of care among nurses, therapists, and volunteers via coaching and joint training measures.

To this end, the improvement project will consist of a new space for information sharing re care plans, assessments, patient careers, unplanned admissions, post-acute plan adjustments, and social support.

Table 6
Characteristics of Pflegewerk Berlin (CWB)

Objectives	To combine discharge management, integrated care, and case management under one roof. To support the user's self-determined goal setting with intensive assistance of therapists that are embedded in multi-professional teams.
Services provided	Assisted living, home nursing, rehabilitation and prevention.
Target group	Older, chronically ill people with long-term care needs as well as those affected by isolation that comes with living alone.
No. of potential clients/patients	92.000 older people, of which 12.000 with long-term care needs. Of these 3.300 receive home health care or care in nursing residencies. This being a large neighborhood in Berlin, there are multiple other providers of LTC, home health care, nursing care etc.
Inhabitants	256.173 (2014) in Marzahn-Hellersdorf.
Average no. of clients per year	Ca. 300 clients use therapeutic services by TUR, a CWB daughter company. Ca. 400 clients with long-term care needs receive services by CWB.
No. of staff (FTE)	In all of Berlin: 289: At Blumberger Damm: 49
Budget per year	CWB services are partially insurance-funded with asset-tested copays, partially tax funded. Statutory funding is governed by three different Social Code Books (SGB = federal social legislation framework): • SGB V Statutory Health Insurance: Medical care, therapies, home health care, medical aids and devices. approx. Budget €175T (health care) approx. €90T (medical devices) • SGB IX Rehabilitation and aids for the disabled. Budget approx. €250T • SGB XI Long-Term Care Insurance: Long-term care, nursing assistance. Budget approx. €380T
Average costs per client/patient	Ca- €1.800 for all treatment, assistance, case and care management services combined for each of the 300 TUR therapy clients (excluding services for LTC clients – data not provided).

3.3.7 Discussion and conclusion

Germany's two case sites are both pioneers in the much too long neglected field of integration across health and long-term care. Both benefit from a host of legislative and policy activities at the national level, where policymakers have at last assumed a stronger commitment to solving the looming crisis in long-term care.

The two projects are located in very diverse settings and managed by different organizations. Each of them in their respective environments is serving as a role model for integrated care for frail older patients living at home, and both have attracted attention nationwide. While one project, RMZ, has been initiated from within the statutory health care system, CWB has been built from a private ownership perspective. Both offer high-frequency, high-touch complex therapy approaches. While RMZ focuses on a three-weeks complex therapy program upon referral from a general practitioner, CWB has a longer-term approach where care begins the moment people move into their assisted living facility, following and supporting patients throughout their last years of life.

To add, CWB is going new ways of teamwork by putting therapists into the patient navigator's role. It is also bringing in volunteers as helpers for activities of daily life and social activities for the elderly, addressing two challenges: Social isolation of older people, and a perspective offered to volunteers who can be prepared for the regular labour market upon completion of their volunteer service.

At RMZ, the key challenge is to overcome fragmentation and competition between providers, which are remunerated the traditional fee-for-service way – a root problem hindering patient-centric, more holistic care.

Staff at both sites are specially trained in geriatric care and highly motivated. Recruitment and retention of qualified employees is a challenge, as nurses and practice assistants are often overworked and underpaid. A lack of space and time also stands in the way of communication between various professionals, who at times don't have clear perceptions of each other's roles. This has been a challenge identified at the CWB site and will be addressed in the course of the improvement project. By contrast in RMZ Templin, a major challenge is a lack of information about the program itself – with few people on the dedicated team, there is no time for program PR activities or briefings of providers or carers in the community. Again, this is where the SUSTAIN improvement project will intervene.

3.4 Norway

Eliva Atieno Ambugo, Silje Kathrine Vaage and Terje Hagen

3.4.1 Demographic background:

Norway is a northern European welfare state. It is divided into 19 counties and 428 municipalities, and has a population of 5.15 million people of whom 81% live in urban areas (Statistics Norway [SSB], 2015). The country's predominantly tax funded welfare system is extensive and includes coverage of health care, education, retirement pension, and unemployment/parental/sick-leave benefits. These generous welfare supports coupled with Norway's egalitarian values have helped position Norway as a competitive performer on several fronts (e.g., life expectancy, standard of living) (Central Intelligence Agency [CIA], 2015; SSB, 2013). Even so, the country struggles in some areas including high unemployment among youth (The Organization for Economic Co-operation and Development [OECD], 2015b) and immigrants (Olsen and Ekeland, 2015), and a high level of sickness absence/disability/early retirement (9% of persons aged 15-64; Keese and Manca, 2015). Norway's tax burden on individuals and corporations is necessarily high given the welfare system in place. A sizeable, healthy, and productive labor force is thus crucial to the country. The three leading causes of death in 2012 in Norway were ischaemic heart disease (12.7% of deaths), stroke (7.9%), and Alzheimer's/dementia (7.2%) (World Health Organization [WHO], 2015a).

Norway spends approximately 9% of its gross domestic product on health, a figure that is among the highest in the OECD. Compared to the other OECD countries (OECD, 2015c), Norway performed well on several, but not all, of the measured indicators of health and health system performance—suggesting a positive impact on population health of some of the country's high health expenditure. Like most industrialized nations, Norway is faced with a growing aging population whose health and social care needs are poised to exert significant strains on local and national budgets (Swartz, 2013; CIA, 2015). Considering that the elderly are a dominant driver of healthcare costs not only in Norway, it behooves health officials to design and implement smart policies that result in good outcomes for service users and cost savings for the state.

3.4.2 Status and development of integrated care in Norway

As reported by Romøren and colleagues (2011), healthcare professionals, managers, and leaders have recognized the need for and initiated projects aimed at promoting coordinated care in Norway for several years. The projects have been small/local, focusing on specific patient groups; and they have operated without the official backing of the Ministry of Health. Some nation-wide initiatives have also been launched. The first major survey of the state of 'coordinated healthcare services' in Norway was carried out in 2003 by the government appointed 'Wisløff committee' (Romøren et al., 2011; Wisløff et al., 2005).

The report identified patient groups especially in need of coordinated services and emphasized the need for integration at the operational level of health service delivery—with responsibility for implementation centered at the local/regional level. The report also recommended the establishment of agreements between primary/municipal healthcare (henceforth municipal care) and specialist/hospital care (henceforth hospital care) regarding procedures for hospital admissions and discharges. Key objectives of the agreement included "… reducing unnecessary [hospital] admissions, reducing waiting time before hospital discharge, and [making] transitions from hospital to home as efficient and safe as possible for the patient" (Romøren et al., 2011, p.3). The Ministry of Health and Care Services (MHCS) supported this recommendation, and formal agreements between primary and specialist health services were established nation-wide in 2008. The MHCS then proposed a new healthcare reform aimed at promoting "coordination in health and long-term care" (Romøren et al., 2011, p.4). Motivated in part by the need to contain healthcare costs by reducing the demand for hospital services, parliament passed the Coordination Reform in 2011. The reform called for more patients to be treated in primary as opposed to specialist care, thereby giving municipalities greater responsibility for healthcare delivery. The reform's success partly depends on how well municipalities and hospitals collaborate, and on the degree to which there is coordinated health service delivery within and between these sectors.

Skilled health and social care staff are key actors in coordinated care programs. Small municipalities in Norway that are under-resourced (e.g., competent staff) can have difficulty implementing effective coordinated care programs (Romøren et al., 2011). Other factors identified in the literature that have the potential of adversely affecting (the process and outcomes) performance of coordinated care initiatives include poor transfer of information between health service sectors (e.g., between hospital and municipal care), institutional features such as being a large or cost-efficient hospital (Tjerbo and Kjekshus, 2005), and not (or only) marginally involving key actors like informal/family caregivers (Røthing et al., 2015). Another structural barrier to coordinated care is the administrative separation of municipal and hospital care. These sectors have separate governance structures, budgets, and professional cultures that hinder collaborative work (Heløe, 2010; Romøren et al., 2011). Tackling some of these barriers to coordinated care—for example, reorganizing a complex institution's governance structure and budget—will be difficult but not impossible if the will is there.

3.4.3 Rationale for selecting the two specific sites in Norway

Surnadal municipality (6000 inhabitants, rural, nearest hospital 113 kilometers) in Møre and Romsdal county in Mid-Norway, and Søndre Nordstrand borough (38,000 inhabitants, sizeable immigrant population) in the city of Oslo are the sites that were chosen for the Norwegian component of the SUSTAIN project.

In addition to serving older adults living at home with multiple chronic conditions, the sites were chosen based on their degree of innovation and urbanization. Both sites are innovative in the sense that they are testing out new models of integrated care. The model in Surnadal, Holistic Patient Care at Home (HPH), is a general care pathway that follows patients onwards from the point of discharge from the hospital. The goal is to ensure that users are receiving the right services at the right time and place, and in a seamless manner. The model in Søndre Nordstrand, Everyday Rehabilitation at Home (ERH), has as its main goal to implement a mindset of independence and mastery in activities of daily living among service users.

3.4.4 Site I: Integrated primary health and social care in surnadal municipality

Surnadal municipality's HPH initiative was developed in 2009 both in response to local needs and national discussions that foreshadowed the Coordination Reform. The initiative was developed as a collaborative project with three hospitals (St. Olavs, Orkdal, and Molde), five neighboring municipalities (Trondheim, Orkdal, Hitra, Sunndal, and Fræna), and three organizations: the regional health authority of Mid-Norway (Helse Midt-Norge), the Norwegian University of Science and Technology (NTNU), and The Foundation for Scientific and Industrial Research (SINTEF: a research organization).

The HPH model is a general care pathway for all of Surnadal's residents in need of municipal health services. When necessary, services are tailored to individual user's needs. The key actors in the model are the hospital (for in/outpatient and emergency care) and the municipality (GP consultations, rehabilitation services, short/long-term institutional stays, and home services). At the point of discharge from hospital, the user's needs are assessed by a multidisciplinary team of health professionals from the hospital and the municipality. Depending on the user's condition, she may be discharged home to receive home nursing services as needed, or she may be admitted for a short-term stay in an institution for observation/rehabilitation. At home, the user is visited by a nurse after three days to assess her progress and evaluate her home environment. A GP visit is also arranged for the user two weeks post discharge. This visit is then followed by that of the primary contact/nurse after four weeks. Going forward, the user's needs determine how frequently she is monitored, the type and amount of home services she receives, and whether or not she is re/admitted to the hospital or an institution for short/long-term care.

The aim of HPH is to help users to smoothly transition between hospital, institutional, and home care; and to support them to live at home as long as possible, thereby reducing re/admissions to hospitals and other institutions. Encouraging and nurturing users' sense of mastery and independence in the activities of daily living is central to HPH. The care model emphasizes safety and a prevention-oriented way of working. Several checklists are employed as roadmaps to guide HPH's activities and allow for systematic monitoring of users' needs. Table 7 provides a brief overview of the characteristics of the initiative.

Table 7
Characteristics of the Integrated primary health and social care in Surnadal municipality

Objectives	Develop a holistic coordinated care pathway for all municipal residents in need of care, with an emphasis on safety and promoting health/ preventing diseases and further deterioration of health.
Services provided	Home nursing and rehabilitation.
Target group	All residents of the municipality in need of municipal health services, with special focus on the chronically ill.
No. of potential clients/patients	Approximately 1,008 service users age 67+ in 2012.
Inhabitants	Total population in Surnadal = 5981. Population age 65+ = 1008.
Average no. of clients per year	Home nursing and rehabilitation = 190 people. Practical assistance at home = 130 people. Both home nursing/rehabilitation and practical assistance = many users but the figure is not available.
No. of staff (FTE)	64 employees total, 45 FTE.
Budget per year	HPH is funded by the municipality. The 2016 budget for home nursing services and rehabilitation is 32 million kroner (US$ 3,809,523 per exchange rate of 8.4 kroners to a $1).
Average costs per client/patient	Not available.

The Norwegian healthcare system is organized within four tiers (Ringard et al., 2013). At the national level, the government/ministry of health has ultimate responsibility for the healthcare sector. Its duties include designing national health policies, proposing health reforms for legislation by parliament, overseeing the implementation of health regulations, and managing the healthcare budget. At the regional level, four regional health authorities oversee the country's hospitals, which are organized under hospital trusts. Not much responsibility for health services delivery lies at the county level except that counties have oversight of dental care (both private and public) and provide publically funded dental care for children and minors (Ringard et al., 2013). Primary care including general practitioner (GP) services, institutional and home nursing, rehabilitation, after-hours emergency services, and public health work (e.g., health promotion initiatives) are organized at the municipal level. Municipalities, which are funded by block grants from the central government and local taxes, discharge their duties fairly independent of the central government. However, the latter retains some control of municipal budgets in the interest of safeguarding "equal access of public services" to all (Ringard et al., 2013, p.22). It is within the context of the Norwegian healthcare system that Surnadal and Søndre Nordstrand have implemented their integrated care initiatives.

HPH's external partners include St. Olavs, Orkdal, and Molde hospitals, neighboring municipalities like Orkdal and Sunndal, and organizations such as the RHA of Mid-Norway, the Norwegian university—NTNU, and the coordination reform unit in the Orkdal region. HPH's internal partners are primarily other departments within Surnadal's municipal health services, such as physio- and occupational therapy and long-term institutional services; but also GPs (who are contracted by the municipality), the Norwegian Labor and Welfare Administration (NAV), and health professionals from the hospitals.

3.4.4.1 Strengths, weaknesses and area for potential improvement

In this section, we report the findings of the exploratory interviews from Surnadal, describing the strengths and weaknesses of HPH as perceived by the interviewees.

Strengths

Overall, the user and carer there were content with the manner in which HPH healthcare staff interacted with them. They felt that they were listened to and treated with respect, kindness and friendliness. The health professional also expressed satisfaction with her work environment, describing it as an open space where staff can speak freely about their concerns, and they are listened to by management. The manager felt that she has good freedom and control in doing her work. She also perceived that HPH has a good learning culture. The introduction of e-messages has improved communication between some actors involved in care delivery (e.g., HPH staff, GPs, hospitals).

HPH's way of working, with its clearly defined roles and responsibilities for staff and detailed checklists that facilitate users' smooth transition through the care pathway, has positively and substantially contributed to care delivery. The checklists incorporate an assessment of the user's safety and are tailored to the user's needs. HPH staff collaborate with the fire department to ensure that users' homes are safe. When necessary, users' homes were modified to better meet their needs. Anecdotal evidence from service users, staff, and external researchers shows that the program has a good reputation, a low-level of staff turnover, good professional competence, and serves all users in need of care.

HPH is financed by the municipality and should be sustainable into the future. Users whose care needs fall within the HPH system experience relatively smooth transitions through the initiative's care pathway. The user and carer also perceived that the staff work well together, have consistent information, and are knowledgeable about the user's care needs. Collaboration between the staff and GPs/hospitals had also improved.

Weaknesses

A heavy and demanding workload coupled with lack of sufficient staff is a problem that HPH management is aware of but is yet to address given budget constraints. Budget problems have focused attention on saving, which is demotivating for staff. Staff shortages have also meant lack of time and opportunities for job-related learning. There is a need to standardize information technology (IT) systems across all key actors at the local and national level. That each of municipal health services, pharmaceuticals, and hospitals and GPs use different IT systems hinders information sharing, which results in inefficiencies in coordinated care planning and delivery. It was the manager's experience that national policies regarding municipal health services can be vague, making it difficult to implement them effectively. HPH needs an internal system for conducting research and evaluating the program's performance. Additionally, the initiative is underperforming in the areas of person-centeredness and safety considering that some of the user's needs were not met (e.g., for longer-duration rehabilitation).

The user was completely dependent on the carer but the carer did not receive enough respite, putting him at risk for burnout. The user and carer were also not sufficiently involved in care planning and goal setting yet such involvement is a key element of person-centeredness—a key feature of coordinated care models. Demanding workloads may have also undermined person-centeredness and safety because staff sometimes lacked time to complete the checklists, including the safety checks and procedures embedded therein. Additionally, there was an over-reliance on the alarm system (to contact the nurse) and emergency services in the event of an urgent need, and not enough basic first aid/medication safety training for the user and carer. A central feature of coordinated care models is the expectation that the different departments involved in providing health and social services have a good structure in place for collaborating such that users can seamlessly, and with good support, navigate the health and social care system. Care delivery for some HPH users was more fragmented, for example people with mental health problems whose needs cut across different sectors (e.g., HPH, NAV, and social housing). This is because the different health and social care departments have separate budgets, and this acts as a disincentive for collaborating.

Overall, while acknowledging the above challenges, the exploratory interviews suggest that HPH's internal way of working is somewhat consistent with a 'coordinated care' model of service delivery. It is when HPH is considered together with other health and social care sectors that it falls short.

An area for potential improvement: HPH stakeholders agreed that formally involving users and carers in HPH activities (e.g., goal setting, care planning, other forms of user/carer input) is needed. Although individual users have good influence over the services they are receiving, there is room for increased participation.

3.4.5 Site II: Rehabilitative care in Søndre Nordstrand borough in Oslo

ERH began in 2013 and was developed as a pilot project and tested in Søndre Nordstrand. It will transition into a standard municipal health service this year/2016. ERH seeks to address the challenges associated with an ageing population, and reduce the attendant healthcare costs by enabling users to live safely at home for as long as possible. The initiative provides comprehensive rehabilitative care and training in activities of daily living to users at home for a limited time (4-8 weeks). It is designed as a patient-centered service that prioritizes user's goals and needs. Its multidisciplinary teams consisting of physio- and occupational therapists, nurses, and professional trainers help users identify their personal challenges and resources. ERH hopes to change society's prevailing expectations of care provision (i.e., that one is entitled to care when old) and promote sense of mastery and independence among users. That is, users should not be passive recipients of care but active participants in shaping their own health.

The initiative is part of the municipal health services provided to the residents of Søndre Nordstrand borough. It is thus overseen by the municipal health administration of Oslo. Hospitals are ERH's main external partner. Its internal partners are other departments within Søndre Nordstrand's health services, the closest ones being home nursing services, the practical assistance department, GPs (who are contracted by the municipality), and the application office (which determines one's eligibility for ERH and other health services, and the type and amount of services offered).

3.4.5.1 Strengths, weaknesses and area for potential improvement

Strengths

A key goal of ERH and other services in the borough (e.g., home nursing, practical assistance) is to implement a mindset of mastery among service users and healthcare staff.

Table 8
Characteristics of Søndre Nordstrand Boroughs's Everyday Rehabilitation at Home (ERH) Initiative

Objectives	Rehabilitative care in the home to enable users to live at home as long as possible by nurturing their sense of mastery and independence.
Services provided	Intensive/comprehensive rehabilitative exercises and training in ADLs over a period of 4-8 weeks in user's home.
Target group	Adults above 18 years.
No. of potential clients/patients	Approximately 2000 residents above age 65.
Inhabitants	37.913 (2015)
Average no. of clients per year	190 users were referred to ERH in 2015. About 50% of the users completed the program. Approximately 15 users are enrolled in ERH at any time.
No. of staff (FTE)	9,2
Budget per year	The budget for ERH was 5.5 million kroner in 2015, including subsidies. (US$ 46,200,000 per exchange rate of 8.4 kroners to a $1).
Average costs per client/patient	Not available

Many users feel that they are entitled to receive assistance when they get old and sick, and this undermines efforts at rehabilitation and independent living because the users become less proactive about maintaining their health and functional fitness; and is costly for the borough. ERH's efforts to encourage mastery and independence is important both for user outcomes and cost savings. Fortunately, there is a lot of support and political goodwill for ERH, and the staff and manager expressed satisfaction with the amount of resources available for equipment (e.g., household- and mobility aids for users).

The management and staff consider ERH to be a patient-centered service where user's goals, needs, and interests are prioritized. The majority of users improve over the service period, and the management and staff perceive that users are content with the service. The user and carer were positive about the treatment they received from ERH staff. In their opinion, the staff were always kind and friendly. The carer expressed that the staff worked well together, were informed about the user's condition, and they conveyed consistent information to the carer and user. The user and carer also felt that they had benefitted from receiving ERH services and they were very satisfied with the training and the various equipment (e.g., wheelchair, electric scooter) the user had received. They also felt that the user's needs were well assessed, and even though the user no longer receives ERH services, they continue to use the tips and practice the exercises they learnt from the staff. It was also helpful for the user that the health services were publically funded, and that the few out-of-pocket costs that arose were affordable.

The ERH manager and staff reported having a good work environment in which they communicate and work well together. They were satisfied with working in multidisciplinary teams consisting of physiotherapists, occupational therapists, nurses and professional trainers. The healthcare professional was also satisfied with her manager, describing her as supportive of the team and open to suggestions. It is positive that the manager is committed to the ERH initiative and open to suggestions for improvements. That she hired a professional with expertise in mental health speaks of her interest in strengthening the quality of the services.

ERH benefits from being located in the same building as home nursing services, the practical assistance team and the application office. This co-location has encouraged communication and collaboration between the units. Communication was also facilitated by Gerica, the database that enables ERH to communicate with the application office, GPs, hospitals and other service providers. The manager and staff described Gerica as an efficient tool.

Weaknesses

The exploratory interviews uncovered several areas of improvement in ERH, including understaffing and disproportionate workloads that interfere with the staff's morale. The manager was aware of these challenges, but they are yet to be addressed by higher-level management who, according to the manager and healthcare professional, are more concerned with cost saving. The imbalanced and vulnerable staffing arrangements will adversely affect the staff's motivation and should be addressed. Additionally, the staff hardly interacted with the higher-level managers. The health care professional felt that the management had little insight into ERH's way of working. It would be motivating for the staff if management interacted with them more often in order to learn about their achievements and challenges. The manager recognized that she is responsible for motivating her team and addressing their staffing needs. As their spokesperson, she needs to bridge the gap between the staff and the top leaders.

Unfortunately, no additional funding has been allocated to the initiative thus far even though it is scheduled to be a standard service in the borough this year. The higher-level management emphasizes savings, and while this will help make the program sustainable, it will also lead to a reduction in services. As a result, users whose needs cannot be adequately met at home will require more costly institutional care.

The borough has invested time and resources in creating a mindset of mastery among its healthcare staff. ERH employs 'mastery agents' who provide the staff and management with training on mastery. The manager believes that the mastery agents have been useful, but remarks that it takes time to change attitudes, and the learning culture within the initiative still needs improvement. A stronger commitment is needed to encourage learning for improvement, change unconstructive attitudes, and incorporate evidence-based research into practice. The manager recognized these needs and is working to address them. Other areas of improvement relate to the user and carer's experiences. Although they were satisfied with the service, not all their needs were adequately met. The user felt that he occasionally had to repeat himself and that his care was not reviewed during the service period. It was also evident that the duration of ERH services (i.e., 6 weeks) was not enough. Although the carer was aware that she could apply for additional services for the user, she was reluctant to do so because it was stressful to not have control over when the staff came to the house. This was unfortunate considering that both the user and carer needed the support. Giving informal caregivers good support enables them to better care for their loved ones at home for a longer period, which is cost effective for municipalities.

The user mentioned that "he leaves the interaction [with the staff to his carer]". Such detachment does not promote sense of mastery and independence in the user, and it runs counter to ERH's objectives. The staff should make a greater effort to encourage the user to interact more actively with them and the care activities. ERH can also encourage support safety for the user and respite for the carer simultaneously by providing the user with a companion who, in addition to minding the user's safety when the carer is out running errands, can allow the carer to have time off for respite. Currently, there is an over-reliance on the alarm system, emergency services, and family as the main ways that the user and carer can communicate when urgent needs arise. In addition to these channels, the user and carer should receive some training on basic first aid, and on medication use and safety. Use of checklists that incorporate safety- and prevention-oriented measures for the user and carer would be prudent.

As a part of the pilot project, ERH is gathering data on patient outcomes (e.g., activity ability/functional status) and service needs via three instruments. Two of the instruments gather information about users' 'activity ability' before and after ERH is implemented. Findings from these instruments showed that most users improved in their functional status, and their need for services also decreased.

However, it does not appear that ERH actively employs evidence-based research, including using the results generated from the instruments to improve the program in a systematic way. ERH needs an internal reporting system to assess both process and outcome measures including those pertaining to costs. ERH would also benefit from improved communication and collaboration with other health- and social care- departments in the borough, and also with hospitals and GPs. This is particularly evident at the point when patients are discharged from hospital. That HPH staff do not always receive sufficient information from the hospital about new users is a persistent challenge. Hospitals give the application office and ERH too short a notice when patients in need of the borough's health services are discharged. Additionally, when a user is transferred from ERH to ordinary services (e.g., home care), the staff face difficulty transmitting important information about the user to ordinary services. These ways of working are inefficient and undermine proper planning for users' care.

ERH has much to improve upon before it can be considered a full-fledged coordinated care model, but it is well positioned to develop in this direction. It appears to be functioning relatively well intra-departmentally, and co-location has also facilitated collaboration with other service departments. However, better coordination of care among key sectors (e.g., ERH and hospitals) is necessary if the initiative is to truly embrace a coordinated care method of working.

Areas for potential improvement: ERH stakeholders identified the following areas for potential improvement:

- Procurement of household- and mobility aids for users.
- Greater involvement of users and informal caregivers in ERH activities.
- Use of welfare technology.
- Providing users with more information about municipal health services, and improving communication between the different services.

3.4.6 Discussion and conclusion

A key aim of this report was to learn about the Holistic Patient Care at Home (HPH) initiative of Surnadal municipality and the Everyday Rehabilitation at Home (ERH) initiative of Søndre Nordstrand borough in Oslo. We interviewed a manager, a healthcare professional, and a service user and his/her informal caregiver from each of these initiatives to learn about their experiences. Results from these exploratory interviews showed that the user and carer from HPH and ERH felt that the staff listened to them, treated them with kindness and respect, and were knowledgeable about the users' care needs. The initiatives however underperformed in some areas of person-centeredness and safety. For example, the users and carers were not sufficiently involved in goal setting and care planning, they did not receive basic training on first aid or medication safety, some of the users' needs were not met, and the carers did not receive enough respite.

The staff and managers expressed satisfaction with their work environments. They liked that they could communicate openly with each other and their managers about their concerns. The HPH professional also shared that their systematic way of working, including the detailed checklists, improved both the quality of care and communication with the GPs and hospitals. Even so, use of different information technology systems by HPH, GPs, and hospitals undermines collaboration. Additionally, both initiatives are understaffed, a problem that, when coupled with the higher-level leaderships' emphasis on savings, is demotivating for staff.

An important aim of both initiatives is to encourage sense of mastery and independence among the users. HPH and ERH need an internal system for conducting research to measure their achievements. The initiatives have good local support and are incorporated into municipal health services, which should make them sustainable into the future. However, the reach of HPH and ERH in terms of the quality, duration, and number of services offered will likely remain limited given budget constraints.

HPH and ERH have enhanced collaboration among the staff within the initiatives' and between some healthcare departments whose activities are linked to the initiatives. This said, findings from the exploratory interviews and the stakeholders' workshops indicated that, while HPH and ERH have promoted coordinated care, much work remains to be done before either initiative can be considered a fully functional coordinated care model.

The health and social care needs of Norway's growing elderly population calls for innovative and cost-effective programs that effectively meet users' needs. Results from the exploratory interviews revealed strengths of both the HPH and ERH coordinated care programs, including improved communication and collaboration among staff, positive work environments and user-staff interactions, and a commitment to encourage sense of mastery and independence among users. However, the initiatives have some weaknesses including inadequate funding and understaffing, limited user and carer involvement, and inadequate support for carers. Even so, HPH and ERH emerged as promising initiatives that are promoting coordinated care in Norway.

3.5 Spain (Catalonia)

Gabriela Barbaglia and Mireia Espallargues Carrera

3.5.1 Demographic background

Spain has been a parliamentary monarchy since 1978. Political devolution to regional governments has been incrementally implemented over the last 30 years. Thus, the political organization of the Spanish state is made up of the central state and 17 highly decentralized regions (termed Comunidades Autónomas that is, Autonomous Communities, ACs) with their respective governments and parliaments. With a population of 46 449 565 (1 January 2015), Spain covers 505 955 km2 and has the third largest surface area in Western Europe (Garcia-Armesto et al., 2010).

The fertility rate is one of the lowest in the EU (1.3 children per woman in 2013), showing a sustained downward trend from 2010. The inflow of migrant population, especially in the last decade, has had a demographic impact in rejuvenating a population that is otherwise rapidly ageing. Life expectancy at birth has been increasing from 2000 and in 2013 was one of the highest in Europe: 86.1 for women and 80.2 for men (Eurostat, 2016a). In 2015, the proportion of the population aged 65 or over was 18.5%, similar to the Europe (EU-28) figure of 18.9%. But when looking at the proportion of population aged 85 and over, Spain is one of the top countries in Europe (2.8%), only after France (2.9%).

The top ten leading causes considering DALYs (disability-adjusted-life years) in 2013 are: low back and neck pain, ischemic heart disease, diabetes, cerebrovascular disease, COPD, Alzheimer's disease, depressive disorders, lung cancer, sense organ diseases and falls. All diseases, except for ischemic heart disease and cerebrovascular disease, displayed an upward trend in the last 20 years (Global Burden of Disease Study 2013 Collaborators). Still ischemic heart disease is the top leading cause of premature mortality and disability in Spain.

After the 2008 economic crisis, the percentage of the population at risk of poverty or social exclusion has been gradually increasing. In 2014, it comprised 29.4% of the population, significantly higher than the European rate (EU-18: 23.5%). Unemployment in Spain is one of the highest in Europe with 24.5% of the population aged 15 to 74 unemployed (Eurostat, 2016b).

3.5.2 Status and development of integrated care in Spain

In Spain, the organization of the healthcare system mirrors the political organization and is devolved to the autonomous regions, which has led to the development of 17 separate regional health services (Ministry of Health Social Services and Equality, 2012). Mainly financed through taxes, regional health services in Spain provide primary and specialized care, free of charge for those citizens who displayed the status of insured (Cantero, 2014).

Table 9
Main characteristics of social and health care services in Catalonia, Spain

Dimensions		Social Services	Health Services
General structure	Power holding	Exclusive power to regional government.	Majority of power for the regional governments according to Spanish law.
	Run by	Local and regional governments.	Regional government.
Service delivery areas	Coverage	Universal coverage and free access to some services.	Universal coverage & free access.
	Funding	Funded by taxes but with co-payment for some services.	Funded by taxes. Co-payment in pharmaceutical products.
Multi-provision model	Providers	Wide range of services covered publicly by regional government and by local authorities, provided directly publicly or by the Third Sector or private providers.	Wide range of publicly covered services provided mainly in public facilities and no-for-profit private facilities.
	Budget	€2.279 million €1,878.33 million: regional government €400,67 million: local authorities	€8.500 million

Each covered person has an assigned general practitioner, who acts as a gatekeeper to the rest of the system. Healthcare providers at all levels of care are predominantly public, and most health professionals are employees with civil servant status. In general, public healthcare providers in each region are owned by a public organization, which centrally oversees the regional health service. This does not, however, prevent the Spanish system from suffering problems in the coordination and integration of healthcare between different care levels. In addition, the coordination of healthcare and social care, which is often required for chronic patients, is particularly hindered by the diversity of institutions involved in the care. In most Spanish regions, long term and social care for the elderly and disabled falls outside the remit of the health authorities, making its coordination and integration with health care quite difficult (Nuno et al., 2012).

As health and social entitlements are devolved to the Autonomous Community level, the way the integration of health and social care provision is carried out, should be approached at this level. Catalonia introduced the separation of financing and provision of health services (Mayolas and Vargas, 2003). The Catalan Health Service (CatSalut) is a public entity dependent on the Department of Health (highest health authority), buys services to suppliers of different ownership (ex., companies, corporations, foundations, non-profit institutions, etc.), which make up 70% of hospital care and 20% of primary care of the public network (Agustí et al., 2006). The rest is provided by the Institut Català de la Salut (ICS), owned by the Generalitat (Catalan government).

The public network of social services in Catalonia has a higher level of decentralisation at the local level and it is organised in two levels: (i) Basic social services run by local authorities that includes basic social teams with a gatekeeper role (1 social worker/ 5 000 inh. and 1 social care nurse / 7 500 inh) that provides prevention services, home social care, emergency care, telecare services, economic benefits and protection services, among others (Sarquella, 2016).

The regional government (e.g. at the Autonomous Communities level) has competences in both sectors, but social services are run by the regional and the local governments (e.g. at the municipality level). In the case of the health sector and as it was mentioned before, only the regional government is in charge of the purchasing and provision of health care services. Social services and health care services provide of universal coverage funded by taxes, but in the case of social services some services have co-payment (e.g., family carer, teleassistance devices, among others) while in the health care sector there is free of access to all services and pharmacy has co-payment. In the Social Care sector, there is a wide range of services covered publicly by regional government and by local authorities, provided directly publicly or by the Third Sector or private providers. In the health care sector, there is a wide range of publicly covered services provided mainly in public facilities in the case of primary care and in public as well as in private (non-for-profit) facilities in the case of specialized care. Finally the health care sector works with a budget 3,5 times higher than the social care sector.

3.5.3 Rationale for selecting the two specific sites

Both integrated care initiatives chosen in Catalonia have been identified following general inclusion criteria based on previous research (Billings and Leichsenring, 2005; de Bruin et al., 2012). In general, the focus of the integrated care initiatives should be people at least aged 65 years with multiple health and social care needs which implies complexity in their care management, and involves the collaboration of the health and social care sectors with one common aim: to keep them as long as possible in their homes.

In Catalonia, besides of meeting the inclusion criteria, both initiatives were selected because:

- They have long trajectories working in integration and coordination of health and social service provision in Catalonia. Particularly, the initiative from Sabadell is the first integrated care initiative in Catalonia.
- They have incorporated best practices in management and integrated care among basic social services and primary health care and also coordination between different levels of care (e.g., acute, intermediate and long-term care).
- There is a history of joint collaboration with the Agency of Health Care and Quality Assessment (AQuAS) and both initiatives. Previous evaluations were conducted by AQuAS. For instance, "The assessment of collaborative models in Catalonia" was a project carried out in 2014 that sought to assess different aspects on the organization and management of nine collaborative models, in Catalonia. The report with the results is published on AQuAS webpage (http://aquas.gencat.cat/ca/ projectes/mes_projectes/qualitat_atencio_sanitaria/model_collaboratiu_atencio_social_salut_catalunya/). Another project related with the evaluation of new organizational models and experiences of prevention and chronic care, taking into account the views of professionals, patients and caregivers was the "Development of a conceptual framework and of indicators to assess chronicity care". Report with results can also be found in AQuAS webpage (http://aquas.gencat.cat/web/.content/minisite /aquas/publicacions/2013/pdf/cronicitat_marc_conceptual_aquas2013.pdf).

3.5.4 Site I: Severe Chronic Patients / Advanced chronic disease / Geriatrics (PCC/MACA/ Geriatrics) from Osona

The PCC/MACA/Geriatrics is the acronym in Catalan for "Chronic Complex Patient / Advanced Chronic Disease / Geriatric patients". It is a complex regional model with the involvement of several providers from different care levels. On the one hand, the specialized care level, which looks for the integration of health and social care services along different levels of care (e.g., acute, intermediate and long-term care) and, on the other hand, the specialized care level looks also at the coordination with the primary care level and with basic social services from the City Council. Our approach as SUSTAIN researchers to this initiative is through the specialized care. Then it is defined as a hospital-based integrated care public program running since 2012, covering the Osona County. This semi-rural region is located in Barcelona province in the Autonomous Community of Catalonia. It has 154 000 inhabitants of which around 4000 are targeted by the program. The most populated city and capital of the region is Vic (n=41 952 inhabitants).

Table 10
Characteristics of PCC/MACA / Geriatrics (Severe chronic patients/ Advanced chronic disease/Geriatrics)

Objectives	1) The need of improve people's care through the integration and coordination of different services and care providers. 2) The adaptation of the services to a person-centred perspective. 3) To work on the sustainability of the model.
Services provided	Integration of social and health care within specialized care (acute-intermediate and long-term care) and coordination with primary care services and basic social services from City Council.
Target group	Patients with chronic diseases, advanced chronic diseases and over 85 years.
No. of potential clients/patients	5-6% of total population (around 7.500 – 6.000 patients).
Inhabitants	154.000
Average no. of clients per year	4.000 patients/year.
No. of staff (FTE)	Not available.
Budget per year	Not available.
Average costs per client/patient	Not available.

At Osona, health care system has always had a long tradition of geriatric and palliative care. The initiative was developed to respond to mixed needs. On the one hand an specific epidemiological situation regarding the increase number of complex chronic patients in the territory and on the other, the necessity of turning the focus into the person rather than in institutions as a result of this increase in complexity.

Two factors have contributed as facilitators of the initiative. One is the good coordination existing at the different levels of care that results from different regional agreements and multilevel strategies among various health care providers. The Osona's Integrated Health System – SISO (for the Catalan acronym Sistema Integrat de Salut d'Osona) is an association formed by all health care and social care services providers of the territory. From specialized care providers representing different care settings (e.g., General Hospital Vic Consortium [acute care], Santa Creu Hospital Foundation [intermediate care], Jaume Manlleu Hospital [long-term care], Aurea residence, among others), including also all three primary care providers and now recently social services from City Council were also included. All these providers are articulated through the Complexity Route (Ruta de la Complexitat), which is a Care Pathway. This pathway described in detail how the different institutions should be coordinated and articulated to provide social and health care for different complex chronic cases. Finally, another important aspect of this integrated care initiative, which constitutes the micro-tool for integration between and within care facilities and settings, is the individualized care plan.

3.5.4.1 Level of service integration, strengths and weaknesses

Strengths

At the cooperative level, this initiative is benefitted from an organizational network previous to the initiative itself at the institutional level, which is channeled through different agreements and several multilevel strategies. On the management level it is presented as a successful initiative, which has reached the maximum possible integration, as different companies are involved, knowing how to maximize reachable the options.

The training is a key element and one of the strengths of this initiative. Good training is important as it is linked to motivation and acknowledgement of professional's performance.

The team working is a constant reality. There is a smooth communication among the different professionals and also regarding patients and caregivers.

In regards to organizational and managerial issues, three points are worth to highlight: (i) shared governance of the specialized care; (ii) a great effort from all sectors to provide high quality of care, so guides, protocols and best practices' are promoted throughout all institutions; and finally, the change of culture is being propitiated on the basis of promoting networking between professionals.

Despite having room for improvement in this area, everyone shares the concept of "integration" itself and the change is embedded in all professionals.

There is a local IT platform shared by the specialized care settings in which professionals have access to patient's information. In addition, there is another IT platform at the Autonomous Community level, the HC3, which is shared between specialized and primary care levels.

The person-centred care is the heart of the initiative. Patients are in the hands of a coordinated and integrated team of different professionals who have a comprehensive conception of the patient. Individualized Care Plans are performed following a complete multidimensional geriatric assessment.

Weaknesses

Leadership is currently understood at a more organizational level, and mostly depends upon clinicians. The need of progressing to a wider and shared concept of leadership will help different professionals (social workers, nurses, practitioners, physiotherapists, etc.) to gain more involvement in the initiative.

There is the need to count on more time and spaces to carry on with patients' feedback sessions.

Another weak point identified is the continuity of care once the patient is back in the community. Channels of communication between specialized and primary care are not yet entirely clear.

There is also the need of improvements on the bottom-up communication. In this sense, workload is heavy, especially at the emergency room, and there is the feeling of a lack of awareness about this situation by those involved in decision-making. This fact may have a direct impact on professional's motivation.

There are good intended policies but the deployment is hardly ever done as planned. The legal framework at the regional level is still not supporting nor reflecting the shift to more integrated care models. More bottom-up dynamics are needed. In this sense, the local vision is to defend mycro-systems in front of one-size-fits-all solutions as a way of improving integration.

Although they have a great capacity to generate data, a systematic assessment of the initiative is currently not being undertaken. Nevertheless, some indicators were defined and are being used to monitoring progress towards integration.

The availability of resources is very limited and the initiative is not receiving extra funding for working in an integrated manner.

Given that the area covered by the initiative is rural-urban, an important point is the need to improve the telecommunications network as currently it does not cover all the territory and in some cases the distance to the care centre can be a handicap.

Table 11
Characteristics of social and health care integration in Sabadell, Catalonia

Objectives	Caring about social issues linked to health and wellbeing of people, families and the community with an interdisciplinary approach through the coordination of Primary Health Teams and Social Services.
Services provided	This is a primary care based integrated care initiative in coordination with basic social services from City Council.
Target group	People with multiple social and health care needs older than 65 years.
No. of potential clients/patients	113 patients
Inhabitants	50.000 inhabitants
Average no. of clients per year	Request on-going.
No. of staff (FTE)	65 professionals and administrative staff.
Budget per year	Not available.
Average costs per client/patient	Not available.

The capacity to involve the patients in the decision-making process is not yet consolidated. There is the need of "health education", in the sense of making the patients responsible for their own health status and self-care.

3.5.4.2 Areas for potential improvement & one specific improvement project

As a result of the baseline assessment four main areas for potential improvement were identified.

- Planning and care continuity: This area highlights the lack of coordination that is percept by professionals between primary and specialized care and also within the different teams. This directly impacts on the individualized plans, which sometimes do not reflect an integrated way of working. An important point in coordination at all levels is the emergency room, as it is the usual front door of the initiative and often is overflowed.

- Integration and Communication: The electronic record is shared within professionals from the specialized care (health and social) and primary care (health and social), but not with basic social services from City Council.

- Assessment of the initiative: There are large amounts of data, but there is not a systematic assessment. So far the Care Pathway has not been evaluated.

- Including patients and caregivers to the decision making process: There is participation in the individualized plans but there is room for improvement. The communication and the lack of skills for communicating with the patients and caregivers by professionals are also discussed as important.

Finally, after the voting process the area elected by the majority was the planning and care continuity.

3.5.5 Site II: Social and health care integration in Sabadell, Catalonia

Social and Health Care Integration in Sabadell is a primary health care-based initiative coordinated with basic social services of the City Council. The city of Sabadell, with 207 000 inhabitants, is an industrial city of the Vallès Occidental Region in the province of Barcelona. The provision of health at the primary care level depends on the Catalan Institute of Health, which is the main health provider in Catalonia and social services are provided by Sabadell City Council.

Three Primary Care Centres (PCC) participate in the initiative: PCC Nord, PCC Ca N'Oriac and PCC Concòrdia. From these centres, health and basic social services are provided to 47 487 inhabitants, living in the north of the city of Sabadell. This is a particularly deprived area in terms of social needs (e.g., high level of unemployment, relatively large proportion of the population living with the basic salary, among others).

The initiative started in 1994 when social care services started to work in the PCCs (so far they have only worked in administrative buildings of the City Council). The fact of sharing a common space with groups of community medicine professionals was an important first step towards a more integrated way of working. In 2013, with the deployment of the "Chronicity Prevention and Care Programme", new objectives were set and a new way of coordinating the provision of health and social services was decided.

Health and social needs are assessed by either health or social care professionals. When a patient meet criterion for entering the initiative (e.g., any general or specific health item plus any social item) the patient is identified with a code into the health system (Z60) and is signed-up into a shared agenda for being discussed in a monthly meeting. Case managing is performed in those meetings by health and social care professionals and they perform the work plan which is then attached to the health record.

3.5.5.1 Level of service integration, strengths and weaknesses

Strengths

This integrated care aims principally at facilitating that patients can stay at home in good conditions regarding health, social and safety needs.

The characteristic element in Sabadell is that they have a long tradition of cooperation between the social and health care sectors. The location of both areas in the same building definitively has contributed to this good understanding.

Among professionals, the good communication flows and the cooperation based on informal relations, is salient.

The training and the information are important aspects to make the initiative work and they are promoted from the management side.

Patients are entered to the initiative and they are coded into the electronic system (eCAP) managed by the health sector. This identification would allow making data mining relatively easy to perform.

Weaknesses

At the organizational level, they have introduced measures to facilitate meetings and common spaces. However, is not one of the priorities and the common agendas are difficult to manage, and the meetings are usually overlapped with other activities, therefore informal dynamics of discussing cases are carried out.

The communication between professionals is frequent, but not having adequate spaces or IT systems enabling direct data sharing are important barriers for integration.

The change culture also presents a great variability among professionals and complaints are usual, probably not caused by the initiative itself, but for their working conditions, particularly affected by the heavy workload. Other problems perceived are the shortage of time and the lack of acknowledgement of professional's performance, which ultimate affects professional's motivation.

The political context is important and also some changes are required at this level. For instance, The Dependency Act seems insufficient to cover all the social needs that this population has (e.g., help with housework, carers, structural modifications at home, etc).

The evaluation and the capacity to measure impact is a weak point of the initiative. The problem is that data exploitation capacities are limited.

ITs are definitely another weak point since health and social professionals have different electronic system for recording data and the information about patients and work plans is only shared during the monthly meetings. The eCAP system is considered a good registering and data collection tool, but only health professionals have access to it.

There are no economic resources specifically available for the integrated care initiative. Therefore there is a lack of material resources, such as computers and workstations that could help them improve their working conditions.

Needs assessment is performed but there is room for improvement. There are overlapped areas not only between both sectors but also within sectors (for instance, multiple blood tests to the same patient) that could be solved or minimized with better communication and coordination among professionals. These assessments also need some systematization and a regular follow-up. Depending on the state of the user or patient, it may also be necessary taking into account the needs and situation of the caregivers.

There is the need of improving the safety conditions of patients at home, and better advice and accompaniment of caregivers. Home changes included. Finally, safety promotion and activities are almost inexistent, making a clear area to work on improvements.

3.5.5.2 Areas for potential improvement & one specific improvement project

Several areas were identified as a result of the exploratory interviews carried out as part of the baseline assessment. After the discussion held by all the stakeholders all problems were summarized in seven potential improvement projects:

- Improve the institutional framework
- The assessment of the initiative (indicators and instruments)
- Prevention and patient empowerment
- Shared information systems
- Formalization of meeting spaces
- Identification and organization of resources
- Patient needs assessment

After validation with the stakeholders, the projects were voted according their importance and their feasibility. After the voting, two projects were tied:

- Prevention and patient's empowerment
- The assessment of the initiative

Due to the heavy workload that professionals have it is a clear potential hazard to work in two projects at the same time. Therefore some actions have to be taken to make a final decision between both. Concerns about more immediate barriers for working in a integrated manner (e.g., shared information systems) were mentioned by some participants after the workshop. Fortunately, currently there is an initiative from the health department in the context of the PIAISS which will help the initiative to adapt the current information system into a more suitable system for integration.

3.5.6 Discussion and conclusions

The PCC/MACA/Geriatrics is a hospital-based initiative articulating specialized care together with primary care and social services from the City Council. This initiative has an organisational network (e.g., one general hospital, one intermediate care hospital, one long-term care hospital and one residence) previous to the initiative itself at the institutional level, which is channeled through different agreements and several multilevel strategies. There are lots of teams of good willing professionals working but there is the need to implement policies that are focused on promoting and facilitating shared leadership. In this sense, differences in the way social and health care sector work should be smooth out to achieve better integration. In addition, more top-down approaches are expected by professionals to improve integration. There is lack of coordination between specialized and primary care, which is translated into difficulties in the continuity of care.

The Social and Health Care Integration in Sabadell is a primary care based initiative, which integrates primary care and basic social services from the City Council. This is a bottom-up initiative with a long trajectory of working together between both sectors and the fact of sharing a common space strongly facilitates integration. Motivational level is high and there is a good understanding among professionals. However, main barriers are the lack of sharing electronic information on the patients which impacts on the way of working, as currently they have set up a shared agenda to discuss cases in formal meetings, but due to workload and different degree of professional's motivation, these meetings are not respected. Thus integration is done on informal ways what causes discomfort and low professional engagement with the initiative. Other aspects felt as important: the lack of all kind of resources, the need of time to do a high-quality assessment of patient's needs and, finally, to improve the involvement of patients and caregivers in the decision making process.

Baseline interviews were relatively easy performed in both sectors, although sometimes information from the social services was somewhat scarce to build an overview of the whole initiative.

In regards to the workshops, the general impression for both was positive. In Osona, there were some difficulties in understanding the participatory approach. So the improvement project was only broadly defined. In Sabadell, at the beginning the gap between the social and the health professionals was perceivable (they spoke in terms of "them" and "us). However, towards the end they used more inclusive expressions and their final impressions expressed hope and willingness for improvement.

The length of the workshops was not appropriate for chronic patients who could not afford to be away from home so many hours as well as for caregivers who had to make different arrangements to leave the patient with someone else. Moreover the dynamic and the kind of topics discussed during the workshop were especially of the interest and in terms of professionals' and managers' perspectives, giving too little space for problems and issues raised by patients and caregivers.

Integrated care models are gradually being implemented in Catalonia. While there is a policy framework for integration (PIAISS), its full deployment has not started yet. Traditionally, the health sector is the strong sector in Catalonia and there are some differences with social services. So our approach, as SUSTAIN researchers aiming at work with both sectors – health and social-, could have been better planned. Our first contact with the initiative was through the health sector and only after a while we reached the social services sector. This approach generated some difficulties at the beginning within the social services sector as SUSTAIN was considered too health-oriented.

Previous sessions at all levels (micro-meso and macro) explaining the project and presenting its objectives would be advisable as the work during the workshops was somewhat difficult for some participants who did not know about SUSTAIN objectives and methodology.

The baseline assessments have been useful to gain knowledge about different aspects of both initiatives. Stakeholders from both integrated care initiatives have shown to be motivated for working together in an improvement project. In Osona, there is the need of some preliminary meetings before the steering group meeting to help stakeholders to translate the broad selected improvement area (planning and continuity of care) into one feasible project. In Sabadell, a preliminary meeting will also take place with main stakeholders (health and social care managers) together with members of the PIAISS to align the improvement project with the deployment of the PIAISS and also to define the members of the steering group.

3.6 The Netherlands

Manon Lette, Nick Zonneveld, Annerieke Stoop, Simone de Bruin, Caroline Baan, Giel Nijpels, Henk Nies and Mirella Minkman

3.6.1 Demographic background

Early 2016, the Netherlands has more than 17 million inhabitants. Natural growth is still a more important factor than immigration. In the future, mortality rates will outdo the birth rates, and population growth will be mainly due to immigration. Like other European countries, also the Dutch population is aging. Both the proportions of people aged 65 years and aged 80 years and older are expected to increase (Statistics Netherlands, 2011, 2014, 2015). Although life expectancy at birth in the Netherlands has increased over the years (81.2 years in 2012) (Netherlands Institute for Social Research, 2015; Poos, Bruggink, and Nusselder, 2014), at the same time also the number of people with chronic diseases has increased. In people of 75 years or older, about 50% is multimorbid. In 2010, there were about 700.000 frail older people. It is expected that their number will increase up to 1.2 million in 2030 (Van Campen, 2011).

3.6.2 Status and development of integrated care in the Netherlands

At present, several integrated care initiatives have been established in the Netherlands. There is much variety in their approach, scope, target groups, stakeholders involved and reach (varying from disease-specific to approaches focusing on multimorbidity/frailty or population-oriented approaches across the domains of health care, social care and prevention).

Innovations in integrated care took place at different levels: the system level, organisation/service level, professional level and clinical level (Valentijn et al., 2015); a few innovations will be described below. With regard to system innovations, population health management initiatives are one of the most challenging system innovations. Characteristics and needs of a defined population in a defined area or region are the starting-point for organizing and integrating prevention, care and support. Healthcare providers, insurers and other stakeholders such as municipalities and representatives of citizens / patients are working jointly to achieve sustainable care and support (Struijs, Drewes, Heijink, and Baan, 2015). Also the launch of the National Care for the Elderly Programme in 2008 was an example of a system intervention aiming at innovation accompanied by research to improve care for older people with complex care needs (Beter Oud, 2016).

In terms of organizational innovations in care for older people, a wide variety of new services has been developed, operating across sectors. An example of these types of innovations are the integrated case management programs combining assessment, support and coordination (Glimmerveen and Nies, 2015; Van Hout et al., 2010).

The initiation of community social teams is an example of innovation at the professional level. These teams of professionals in health and social care provide support to people with multiple problems in different domains in life (e.g. health, social needs, income, participation in society, housing). The above described examples of innovations are not isolated innovations, but are related to changing paradigms of what the care process itself is all about: the dialogue between the older person, his or her social network and the professional. Person-centred care is an upcoming concept that is gaining adherence (Boshuizen et al., 2014), in line with previous developments of proactive care with a large contribution of/role for self-management.

3.6.3 Barriers to coordination and integration

At the system level, the most prominent barriers to coordination and integration are separated legislation and funding structures, which is not unique for the Netherlands. At present, care for older people is governed by three main systems, each with its own legislation, governance structure and quality management system. Furthermore, decentralization of several long-term care services from the national government to municipalities needs further refinement. Responsibilities of municipalities and the other stakeholders are not yet fully established and collaboration of health and social care providers with municipalities is still limited.

At the professional level, coordination, service allocation and integration of care and support are hindered by the fragmented system. Also inter-professional collaboration is not self-evident. For example, information sharing between health and social care systems, providers involved (e.g. to share individual care plans, patient files etc.) and professions is still complex. Joined or connected information systems are upcoming, but fully and well-developed forms are still unique.

Finally and maybe in importance first, user involvement is still very low. Moreover, because of contracting structures and procedures, freedom of choice of services and professionals is limited. In general, more attention is being given to transparency of client experiences but using clients' experiences and shared decision making in integrated care can still be improved.

3.6.4 Rationale for selecting the two specific sites

In the Netherlands, there are several integrated care initiatives focusing on older people with multiple health and social care needs. We selected the initiatives "The Geriatric Care Model West-Friesland" and "Walcheren Integrated Care Model", for, amongst others, the following reasons:

Both initiatives have been part of the National Care for the Elderly Program. During this program, regional networks have been set up in collaboration with stakeholders (e.g. GPs, practice nurses, home care organizations, hospitals, municipalities, social care organizations, older people and their family caregivers) and were motivated to innovate current services in order to improve quality of care for older people.

Table 12
Characteristics of the GCM

Objectives	Improving quality of life and quality of care for frail older people living at home, by early detection of potential health and social care problems to support them living at home for as long as possible.
Services provided	The practice nurse from GP practice visits the older people at home and uses the Resident Assessment Instrument (RAI) to assess older people's situation. Based on the RAI results, a personal care plan is designed by the practice nurse. 2nd home visit: the practice nurse discusses with the older person from which care and support services the older person may benefit. Based on the older person's needs and preferences, the practice nurse adapts and finalizes the personal care plan and distributes it among involved health and social care professionals to initiate the required care and support services. In complex situations, the older person is discussed in a multidisciplinary consultation meeting, including involved health and social care professionals, i.e. per GP practice: practice nurse, GP, elderly care physician, pharmacist, physical therapist, home care and/or community nurse, case manager for people with dementia and the family caregiver.
Target group	Frail older people living at home in the region West-Friesland
No. of potential clients/patients	About 20 to 25 people of the 2350 people in an average GP practice are eligible to receive care according to the GCM.
Inhabitants	The region West-Friesland has over 200.000 inhabitants
Average no. of clients per year	Currently, 800 frail older people receive care according to the GCM in West-Friesland.
No. of staff (FTE)	55 general practices (60%) in West-Friesland work according to the GCM. In those GP practices, both the GP and the practice nurses are involved in the GCM and they collaborate with a multidisciplinary team. The geriatric team, a permanent and paid team (a practice nurse & an elderly care physician), organizes these multidisciplinary consultations and is responsible for training and coaching of GPs and practice nurses.
Budget per year	Unknown
Average costs per client/patient	Unknown

Since improvement of current practice is central in SUSTAIN as well, we expected stakeholders to be motivated to further collaborate.

Both initiatives involved older people in the design of the initiative. A participatory approach including older people is central in SUSTAIN as well, and we therefore expected to be able to build further on the previously established relationships.

3.6.5 Site I: Geriatric Care Model

The Geriatric Care Model (GCM) is a multifaceted intervention based on the Chronic Care Model, which is initiated from the GP practice. It is a model for shaping an outreaching, proactive approach of care and support for frail older people in order to provide care that is tailored to their needs. The GCM aims to enable productive interactions between activated, informed frail older people

and proactive, prepared health care professionals by combining in-home geriatric assessments with management by expert geriatric teams (Muntinga, 2015).

The GCM has its origins in nursing home care. Considering the positive experiences in the nursing home setting and the increasing complexity of older people's situation living at home, the GCM was adapted for the primary care setting. GPs were not used to work in a multidisciplinary and proactive way. The GCM, however, aimed at realizing a more proactive, preventive and multidisciplinary way of working in primary care, in order to support older people living at home for as long as possible. In 2010, the GCM was implemented in 20 general practices in West-Friesland and 15 GP practices in Amsterdam.

The implementation of the GCM in the first general practices was funded by the Netherlands Organisation for Health Research and Development, as part of the National Care for the Elderly program. Until recently, the health insurer financed the core tasks of the GP and practice nurse within the GCM through temporary agreements. This reimbursement covers the time spent by the GP and practice nurse on their core tasks within the GCM reasonably well. However, this module does not cover the costs of development of the GCM, training of staff, and mentoring and coaching provided by the geriatric team. Until now, these costs have been covered by other care organizations involved. Another issue is that the possibility of receiving funding from the health insurer through this module not yet widely known among GPs. As such, not all GPs in West-Friesland receive reimbursement. The insurer aims to embed the financing of care to older people more structurally through bundled payment of integrated care for older people. Clarity about whether this will to happen is expected in 2017.

Until October 2015, the geriatric team, consisting of a practice nurse and an elderly care physician, was managed directly by the regional GP organization in West-Friesland (WFHO). From October 2015, the WFHO has an executive organization called the umbrella organization for primary care West Friesland (ZWF), which is responsible for all operational activities and project management, including managing the roll-out of the GCM and the geriatric team. During the implementation and evaluation of the GCM in the first GP practices, a network consisting of older people had been established. After the evaluation was finished this network ceased to exist, but made way for a new regional network of older people. The WFHO and ZWF inform this network about their activities to enable them to ask (critical) questions as they aim to involve elderly associations and networks of older people in their projects and activities.

3.6.5.1 Strengths and weaknesses

Both the care user and family caregiver we interviewed were extremely satisfied with the care and support they received. According to them, specific strengths include the outreaching and proactive nature of the care delivered by the GP/practice nurse and the way they tailor their care to their individual needs. They felt taken seriously, informed and involved in the care process to the extent they are comfortable with. They believed that the different health care professionals involved in their care process are sufficiently informed about their situation.

From the professionals' viewpoint, specific strengths also included their prevention-orientation and patient-centeredness. They approached this by proactively mapping all frail older people and their needs, and setting the older person and their network central in their approach. Using the RAI (resident assessment instrument) enables them to identify older people's needs on various domains. Professionals are able to compare RAI results with the personal care plans, and they also monitor adherence to personal care plans, outcomes, hospitalizations and user- and carer satisfaction. Furthermore, professionals and managers indicate that collaboration and communication between different healthcare professionals attending the multidisciplinary consultation meetings is satisfactory. They experience the short communication lines between different healthcare professionals as very efficient.

With regard to their way of working, the professionals indicated that all staff members in their practice are always well informed and involved in all activities in the practice, and that they have very high standards in their way of working. There is a high motivation in their practice to deliver the best possible care and they are always motivated with improvements and innovations.

Weaknesses with regard to the current way of working in West-Friesland were mainly put forward by professionals and managers. The main issues were related to collaboration and integration with home care, social care and municipalities, financing of the initiative and IT infrastructure. Managers and professionals felt that there are several issues when it comes to collaboration and communication between different professionals. First of all, collaboration is very dependent on people. Motivated people investing in these collaborative networks are important for success. However due to changes in staff and care contracts with different care organizations each year, the networks built are often fragile, which makes investing in collaborating relationships difficult and not worthwhile.

Second, professionals and managers indicated that the collaboration between primary care professionals and social care and support professionals not attending the multidisciplinary consultation meetings is challenging. Furthermore, due to the development towards ageing in place, GPs care for older people in increasingly complex situations, concerning not only health problems but also problems relating to social care and support. This increases the workload in primary care, especially since it is not always clear to the GP where to refer the patient to in case of problems relating to social care and support.

Third, home visits and needs assessments among older people are performed by several different professionals, who may provide contradictory advice. GPs do not feel recognized and supported by professionals from other domains in being the coordinating actor in the care delivery process. They indicate a need for a clear and transparent definition and division of roles, responsibilities and facilities in geographical areas.

Another pressing point is funding; both professionals and managers feel that budgets are tight. They would prefer to receive more structural funding, in order to be able to invest in extra staff and housing. This could then relieve some of the professionals' workload, which they indicate is very high at the moment. The relationship between the healthcare insurer and the regional GP organization is difficult. Managers indicate that a shared vision between different professional organizations on how care and support for older people should be organized is necessary, along with strong leadership so that this vision can also be conveyed to others, in order to strengthen their position towards the insurers. However, it remains difficult to come to a shared vision between different organizations, because it seems that it is hard for organizations to look beyond their own expertise.

With regard to information technology, both managers and professionals indicate that the RAI, although the RAI assessment tool has great potential and that it collects valuable data, needs improvement in terms of digitalization and linking with the electronic GP information systems and pharmacy and hospital data registries. This would decrease the burden of double data entry and facilitate information sharing between professionals from different organisations.

3.6.5.2 Areas for potential improvement

Several potential areas for improvement came forward from the exploratory interviews. These were: integration of health and social care services (collaboration, clear division of roles and responsibilities, developing a shared vision), sustainable funding, room for knowledge development, evaluation of changes and innovations and the improvement of IT infrastructures to better facilitate communication between different professionals.

The workshop with stakeholders included a GP representative, a representative of an organization providing care for people with dementia, a representative of a social care organization, representatives of two home care organisations and a representative of regional network of older people. During the workshop, the focus of the discussion broadened from the GCM to integrated care in West-Friesland in general, including other collaborative networks in the region. In addition to the above mentioned improvement areas, additional potential areas for improvement concerning person-centredness were mentioned. The discussion soon focused on the importance of **using the older person's needs and preferences as a starting point** (e.g. wellbeing, living a meaningful life) and stakeholders concluded that to better meet these needs, **integration of health and social care and support** is essential. Stakeholders indicated several issues that need to be tackled, such as getting to know the different health, social and informal carers involved in a community and defining who has which responsibilities. Suggestions on how to approach this included:

- forming a team with the older person and his health, social and informal carers;
- setting up a communication system in which all health, social and informal carers involved in the care process for an older person have access to up to date information;
- setting up some sort of buddy system for older people with someone of their choice who can function as their 'advocate' (this could be someone from the existing health, social or informal carers involved).

In order to define a concrete improvement project and form a plan of action, a second workshop will be scheduled.

3.6.6 Site II: Walcheren Integrated Care Model

The Walcheren Integrated Care Model (WICM) is an integrated health care model for older people (75+) and their informal carers. The WICM is specifically organized around general practices. The model aims to increase the independence of older people and keep them at home for as long as possible. In practice, the model is characterized by its person-centred approach, its strong prevention orientation and the central role of the GP. The WICM is implemented in several general practices in the Walcheren region. In the Netherlands, the WICM is known as a 'best practice'. Many other Dutch regions are interested in the working methods of the WICM as well.

The Integrated Care Foundation in Zeeland is an independent organisation, which brings together multiple healthcare providers. The WICM focuses on good cohesion in integrated care for frail older people living at home. On a local level, GPs, practice nurses, geriatric physiotherapists, case managers for people with dementia, mental health care practice nurses and home care nurses of three home care organisations are working together to deliver integrated care. The programme is funded by a health insurer. In the future, the stakeholders involved in the initiative would like to cooperate more with the municipalities in the region of Walcheren and involve them as partners. In 2016, the programme manager of the Integrated Care Foundation in Zeeland would like to explore the possibilities with the policymakers of the municipalities.

The Integrated Care Foundation in Zeeland carries out multiple healthcare programmes. The Walcheren Integrated Care Model is employed in the 'Care for older people programme'.

3.6.6.1 Strengths and weaknesses

According to the programme manager of the Integrated Care Foundation in Zeeland, the strength of the Walcheren Integrated Care Model is its ideology. The professionals in the programme work well coordinated, with a focus on prevention (all people of 75 and older in the Walcheren region receive the preventive GFI-survey) and a person-centered approach. In the monthly multidisciplinary consultation meetings, professionals focus on the person behind the patient, including his or her needs.

Table 13
Characteristics of the Walcheren Integrated Care Model

Objectives	The WICM focuses on good cohesion in integrated care for frail older people living at home, in order to: • increase their independence; • keep them at home for as long as possible; • maintain or improve their physical condition.
Services provided	• Frail older people are actively identified with a special survey (Groningen Frailty Indicator or GFI): all 75+ people in the Walcheren region receive this survey. • The practice nurse from the GP practice visits the older people at their homes and identifies their needs and demands using the Easycare instrument. • Together with the client and the informal carer the practice nurse develops a personal care plan. • The practice nurse discusses the care plan and the main objectives on a weekly basis with the GP and the geriatric specialist. • In the monthly multidisciplinary consultation meetings, in which the GP, practice nurse, geriatric physiotherapist, casemanager for people with dementia, mental health care practice nurse and home care nurse participate, the care plan is discussed and care and support is integrated around people's needs and coordinated across the different professionals. • Providers of prevention activities, cure, care and social services work together from the first contact with the client till the delivery of care and support.
Target group	Frail older people living at home, for instance suffering from chronic illnesses like dementia or multi-morbidities.
No. of potential clients/patients	10,000 people 75+
Inhabitants	The Walcheren region has approximately 114,000 inhabitants
Average no. of clients per year	Unknown
No. of staff (FTE)	A high percentage of general practices and healthcare providers in the Walcheren region participate in the programme. However, at this moment it is unknown how many FTE is involved.
Budget per year	Unknown
Average costs per client/patient	Unknown

Besides that, the programme manager mentions the supportive leadership of a number of GPs; these GPs implement the Walcheren Integrated Care Model enthusiastically in their practices. Also the independent position of the Integrated Care Foundation is seen as a strength: the foundation has no financial interests in the Walcheren Integrated Care Model. The programme manager thinks that the non-supportive national policy is a weakness. In the Netherlands there are silos (social support, health insurance and long-term care) in legislation and funding, which impedes collaboration.

Also the non-sustainable funding of the initiative is seen as a weakness. The initiative is being funded by a temporary 'older people module' by a health insurer. This implies that general practices receive a fixed budget per older client participating in the programme. The module is evaluated annually by the health insurer, and then it is decided whether or not is well be continued.

Professionals and the programme manager indicated that the strengths of the initiative are the pragmatic leadership of the programme manager (pragmatically connecting

different stakeholders), the support of the GPs and the willingness to innovate of all participating organisations. They also think that the Walcheren Integrated Care Model has resulted in better coordination between (multidisciplinary) professionals, an increased focus on person-centredness and a more preventive thinking and working style in practice. The professionals suggest that the few learning and training opportunities (for professionals), the non-supportive national policy in the Netherlands and the insufficient sustainable funding are weaknesses of the initiative.

From the service user's and informal carer's point of views, strengths and weaknesses of the initiative are mostly related to the direct contact with the involved professionals. The service user and the informal carer indicate that they experience the care and support delivered by the GP and his practice nurse positively. They find that the GP and his practice nurse are easily approachable and give personal attention to their case. The service user has a lot of trust in the GP and his practice nurse.

At the same time, they are less positive about the care provided by the home care nurses. According to the service user and informal carer, the home care nurses are often not sufficiently informed. The service user also mentions that the home care nurses often change shifts, so she sees a lot of different faces.

Finally, the informal carer does not receive any support in caring, which is confirmed by the professionals.

3.6.6.2 Areas for potential improvement

The following areas for improvement have been mentioned in the baseline interviews: defining the roles and tasks of involved organisations further and rethink and organize the funding of the initiative, IT infrastructure and learning opportunities for professionals.

First, both the programme manager and the professionals mention insecure funding as a potential risk for the continuation of the programme. Currently, the programme is being funded by a health insurer. However, the funding is part of a special project. No structural agreements have been made. Another point, mentioned by the programme manager, is that there are no clear agreements about roles and tasks between the collaborating organisations yet. According to the respondents, this makes it unclear who takes responsibility for what when decisions (for instance about funding) have to be made. The respondents think that a clear definition of roles and tasks within the programme might also be a good first step to more secure funding.

Second, the IT infrastructure in which the professionals have to work does not support them sufficiently in their daily work. The professionals of the different organisations work in different registration software, which makes the exchange of information difficult. In other words: the professionals are delivering integrated care, but their IT infrastructure is not integrated yet. Both the professionals and the programme manager think that a more integrated IT infrastructure would contribute to the efficient delivery of integrated care. For instance: connecting the different registration software or using the same registration software.

Third, despite the fact that the professionals work from a collaborative ambition, their approaches in practice differ in the Walcheren Integrated Care Model and they did not get any extra training. In the baseline interviews the professionals indicate that they might benefit from new learning opportunities.

In the stakeholder workshop 44 topics for improvement were mentioned. After a lively discussion, the participants clustered these topics in 5 main themes:

1. Again, **insecure funding** is mentioned as a potential risk for the continuation of the programme. The current funding is part of a temporary project of a health insurer and no structural agreements for the future have been made. Another point made in the workshop is that there are 'financial silos' in the Dutch health and social care system. According to the stakeholders, these silos result in more complexity and uncertainty. The participants of the workshop suggest that the participation of a health insurer in the SUSTAIN project steering group could clear things up. A representative of the (funding) health insurer was invited, but was unfortunately not available.

2. According to the participants of the workshop, another potential improvement project is the **clear definition of roles and tasks**. As also mentioned in the baseline interviews, there are no agreements about roles and tasks between the collaborating organisations yet. The stakeholders highlight that there are a lot of professionals involved, but that it is often unclear which professional takes responsibility for what. For instance: GP's do not always know which professional to contact in what situation and which professionals actually join the multidisciplinary consultation meetings.

3. The stakeholders also see room for improvement in the field of **temporary day care**. In some cases older people in Walcheren need temporary day care or shelter. For instance when there is a temporary crisis situation at home with their partner, or when they are coping with temporary health issues. In most cases these patients can safely return home after a couple of days. In Walcheren there are some facilities, but their availability varies. Additionally, the provided information about these facilities is not always clear.

4. Another mentioned area for improvement is the **role of the patients and their informal carers**. Stakeholders think that patients and their informal carers can be more empowered. It is not clear yet how the professionals in the WICM can facilitate that patients and their informal carers take more control in their lives and situations and what kind of support could be provided.

5. The fifth area of improvement refers to a specific profession. According to the participating stakeholders, the **role of the elderly care specialist** is not clear yet. Elderly care specialists can support GP's and provide a different perspective in complex cases and situations. However, this is not organised yet.

3.6.7 Discussion and Conclusion

Both the Geriatric Care Model (GCM) in West-Friesland and Walcheren Integrated Care Model (WICM) in Zeeland are primary care based initiatives aiming to maintain or improve outcomes in frail older people (i.e. quality of life, physical functioning) and improving quality of care, ultimately to increase their independence and keep them at home for as long as possible. In both initiatives, GPs and practice nurses are collaborating with a multidisciplinary team that include (geriatric) physiotherapists, home care and community nurses, and case managers (in case of dementia). In the GCM, additionally, an elderly care physician, pharmacist, and family caregiver are involved. In the WICM additionally practice nurses specialized in mental health care are involved.

Strengths of both initiatives are their proactive and preventive approaches (e.g. home visits to assess older people's needs), their person-centered focus (e.g. care plans tailored to individual needs), care coordination by organizing multidisciplinary consultations between health professionals involved, and high motivation among professionals and managers from the different organizations to collaborate and/or to work in a proactive way. An additional strength of the WICM is good leadership of the initiative by a program manager.

The two initiatives encounter similar challenges in their current way of working, one of which is information exchange between health and social care workers involved. There are no shared IT systems in place yet, although in both initiatives there is a wish to develop these. Other issues include insecurity about sustainable funding and the lack of clear agreements about roles and tasks of professionals from the different organizations involved (e.g. professionals from the GP practice, professionals from home care organizations, social care organizations, and municipalities).

Seeing that both initiatives struggle with similar issues, it is not surprising that the potential areas for improvement, which came forward during the stakeholder workshops, are similar as well. Reducing these potential improvement areas to topics within the stakeholders' own span of control, both sites are looking for ways in which to empower older people and put their needs and preferences central, and at both sites there is a need to define roles and responsibilities of health, social and informal carers involved.

Reflections on the process

In both initiatives, interviews with the different stakeholders took place in a positive atmosphere. In the GCM, managers from the regional GP organization were slightly reticent towards investing time in the SUSTAIN project due to difficulties in the negotiation process with the health insurer, that was taking place at that time, about available budget for providing services from the GCM. As such, also the continuation of the GCM in its current form was uncertain. A couple of months later, the negotiations got stuck and the managers decided to postpone active participation in the SUSTAIN project.

The new strategy includes a more smaller-scaled approach focusing on one or two municipalities within this region, based on the contacts we already have there. Different stakeholders within these municipalities (i.e. GP practices, social care organization, home care organization, municipality, representatives of older people, case management organization) were approached to get acquainted, to discuss the project and explore their willingness to participate in the SUSTAIN project and identify potential areas of improvement of the current way of working. Eventually, several stakeholders from primary care, home care and social care were invited to the stakeholder workshop, as well as a representative for older people. The community social care team was also invited, but was not able to make it to the meeting. During the workshop, participants' views on what care and support for older people should look like were very much aligned, but their views on how to achieve it differed. This resulted in a lively discussion, which quickly focused on one potential improvement area. However, before defining a concrete improvement project, participants indicated to need some time to think and to explore what types of actions would be in their span of control. All agreed to schedule a new meeting, for which the community social care team will also be invited.

In the WICM, the research team gets active support from a program manager who is highly motivated to participate in the SUSTAIN project. It is a benefit to have one contact person (and a single entry point) in the initiative. On the other hand dependence of the network and personal contacts of one person can also be seen as a limitation since the research team is highly dependent on the time this person has to initiate meetings with different stakeholders and to get required information. Therefore, the biggest challenge in the WICM is getting and keeping in touch with all key stakeholders. This is mainly because the key stakeholders do not have much time. The strategy of the research team is to use scheduled meetings of existing steering groups and to organise attractive workshops with inspiring speakers and relevant information on a good time and location, all tailored to the needs of the key stakeholders. The first WICM stakeholder workshop was well visited. Representatives of GP practices, municipalities (social care) and multiple (home) care providers were present. The stakeholders had lively discussions, which led to a number of potential improvement projects. In the next meeting, which will take place in August or September 2016, the stakeholders will define a concrete improvement project and commit to roles and tasks.

Lessons learned

- Within the WICM and GCM different methods have been used to identify frail older people in an early stadium, e.g. using criteria such as age, multimorbidity and medication use, using a case-finding tool (PRISMA-7 and GFI-survey) or using the GP's intuition.
- Both professionals and older people have positive experiences with structured needs assessments in the home environment.
- The WICM and GCM are perceived as very person-centred approaches. A personal care plan, a key element in both models, is developed based on the needs assessment

in consultation with the older person. The older person's needs, preferences and priorities regarding his/her care process are thus taken into account and evaluated regularly.

- In the GCM, a geriatric team informs all GP practices who start to work according to the GCM approach about the way of working, and trains practice nurses with regard to motivational interviewing, needs assessments, developing a care plan and consulting with the GP and the older person during this process. Moreover, intervision meetings for practice nurses and training days for physicians are organized to elaborate on different aspects of the GCM according to their needs.

3.7 United Kingdom

Esther de Weger and Jenny Billings

3.7.1 Demographic background

In 2012, an estimated 15 million people in England had a long-term condition (LTC) with LTCs being more prevalent in older people—58% of people aged 60 and over compared to just 14% of people aged 40 and under. Similarly to other Western countries, the number of people with LTCs is expected to rise as the number and proportion of older people continues to rise. Over the last 40 years, the median age of the UK population has increased from 33.9 to 40.0 in 2014. This increase is caused by the growth in population at older ages. The population aged 65 and over has grown by 47% since 1974 to make up nearly 18% of the total population by 2014 and the number of people aged 75 and over has increased by 89% over the last 40 years (now making up 8% of the population) (Office for National Statistics 2015). Alongside this rise in LTCs, there has also been an increase in life expectancy. In 2012, it was estimated that boys could expect to live to 79 years and girls to 83 years. By 2032 it is expected to increase to 83 and 87 respectively (Kings Fund, no date).

Like most other European countries, the UK is also becoming more diverse with rising numbers of people identifying with minority ethnic groups in the most recent Census (in 2011). While the white ethnic group is decreasing in size, it is still the majority ethnic group at 48.2 million (about 86%) (Office for National Statistics 2012). The Census showed that the largest non-white ethnic groups were "Asian: Pakistani, Indian, Bangladeshi" at 6.8% of the population and "black" at 3.4% of the population (Institute of Race Relations, 2016a).

Understanding the demographic makeup of the UK is important as health is significantly determined by socio-economic background. For instance, improvements in life expectancy are not equal across different groups (Buck and Maguire 2015). Men and women in the highest socio-economic class are living, on average, seven years longer than those in the lowest socio-economic class, and more of those years are disability free (Kings Fund, no date; Buck and Maguire, 2015). Health inequalities also persist across different ethnic groups. For instance, minority ethnic groups as a whole are more likely to report ill health and experience ill health earlier than white British people (Institute of Race Relations, 2016b).

3.7.2 Level of development of integrated care in the UK

The National Health Service (NHS) provides health care free at the point of need and is funded directly by taxation (NHS Choices, 2016). NHS organisations provide primary health care services (e.g. general practice, dentists, pharmacies, and the NHS 111 telephone service), secondary health care services (e.g. planned hospital visits, rehabilitative care, community health services, mental health services), and acute care (e.g. emergency departments).

Social care services are means tested. Local authorities carry out needs assessments in order to assess whether residents qualify for social care services like help maintaining independence at home (e.g. help getting out of bed, home adaptations and preparing meals). The amount residents pay towards their social care depends on the value of their assets (Kent County Council, 2016a; Kent County Council, 2016b).

This organisational separation of health and social care services has contributed significantly to the fragmentation of care currently being experienced in the UK causing patients to experience a lack of seamless care (Shaw et al., 2011).

Over the years, different approaches have been touted as the solution to the fragmentation of care. Multidisciplinary care was a major concern in the 1960s, partnership working in the 1970s, shared care and disease management in the 1980s and 1990s. During the 2000s the focus shifted towards whole system working, for example with integrated delivery networks and integrated care pathways. The most recent policies are building on the whole system working approach from the 2000s by aiming to reduce the barriers between providers and commissioners through policies such as primary care co-commissioning (NHS England, no date, a).

3.7.3 Overarching barriers to coordination and integration

There is a wide array of papers discussing the various enablers and barriers to integrated care. For example, overcoming multi-disciplinary confusion, lack of role clarity, and lack of mutual trust, the roles and responsibilities of all team members must be clearly identified and communicated with shared and evidence-based protocols and best practice guidelines, alongside care pathways and decision-making tools (Howarth et al., 2006; Freeman et al., 2000; Robben et al., 2012; Suter et al., 2009). To tackle funding problems, significant upfront investment is required for the implementation of new care models and integrated services, as well as IT systems (Suter et al., 2009). From an organisational perspective, a change in culture (away from tribalism or "silo-working") is needed (Best et al., 2012) alongside alignment in leadership and governance, shared HR rules and policies at organisational levels are needed (Glendinning et al., 2002; Rand Europe, 2012).

3.7.4 Rationale for selecting the two specific sites

- Both sites fulfil the SUSTAIN study criteria
- For balance, we selected one site based in the NHS (The "Over 75 Service" at Sandgate Road Surgery) and one site was based in social services ("Discharge Home to Assess: Swale")
- Sites that were at different levels of integration.
- The site selection was a joint decision with key stakeholders (e.g. Kent County Council, South Kent Coast CCG, Thanet CCG).
- We met with stakeholders at potential sites before making our final selection to ensure staff at the two sites were motivated to change and understood what would be required of them.

3.7.5 Site I: Discharge Home to Assess: Swale

Discharge 2 Assess (D2A) services discharge users from acute and community hospitals as soon as they are medically fit. Within the D2A model, assessments are carried out in the hospital by a multidisciplinary assessment team, while care coordinators support users and their families throughout the discharge process. Prior to discharge, care packages are put in place and in-house reablement and rehabilitation services are usually included within the care package (Health Foundation 2013; Monitor 2015). In other D2A services in the UK, the model is supported by trusted assessments between health and social care services to avoid duplication of assessments as such duplication often leads to delays in discharge (Health Foundation 2013; Monitor 2015).

The Discharge to Assess: Swale (D2A: Swale) service is clearly committed to providing person-centred care to enable users to live as independently as possible and as close to home as possible; their corresponding vision is "own home is best". To support the D2A model, Swale social services established two separate but related pathways with a "step up, step down" function. Pathway 1 supports users whose needs can be safely met at home and Pathway 2 supports users who are not yet ready to return home and require further rehabilitation and/or reablement input before being discharged home.

The current D2A: Swale manager had been concerned for some time about the poor patient outcomes and the large number of users being placed into permanent care homes unnecessarily. It was not until Swale Social Services received one-off funding from Swale CCG to improve the flow from the local community hospitals and to reduce the number of beds needed, that the manager was able to further develop and implement her vision of Swale's version of a D2A model. The initiative is managed by Swale Social Services and is governed and funded by Kent County Council. Because the service works closely with rehabilitation and other community health services, Swale CCG as commissioners of local health services, also have significant input regarding the care model and care pathways of D2A: Swale.

Key stakeholders include GPs, Medway Acute Hospital, Sittingbourne Memorial Hospital, the Integrated Discharge Team Kent Community Health NHS Foundation Trust (who provide the majority of community health services like district nurses) and voluntary organisations.

Table 14
Characteristics of the Discharge to Assess: Swale

Objectives	Objectives regarding on users and carers • To improve outcomes for users and carers • To enable users to regain optimum function quickly and as near to home as possible • To promote and support self-management • To enhance person-centredness Organisational objectives • To reduce the number of social care and nursing placements • To improve efficiency and patient flow from hospitals • To provide health and social care rehabilitation and enablement and to work collaboratively on clearly defined pathways • To provide resources to support community based "wrap around" services, assessments and therapies.
Services provided	Pathway 1: discharge home to assess service with "wrap around" community teams providing assessments to specify ongoing care needs. Provides support with personal care and coping with LTCs through enablement and therapy programmes. Pathway 2: discharge to "bedded" community resource if user continues to require 24 hour nursing care, rehabilitation and daily medical review. Provides social care enablement or health rehabilitation in appropriate bedded unit with a clear plan and agreement to return to own home. Length of stay is up to three weeks. Pathway 2 links to Pathway 1 as users are transferred to Pathway 1 services as soon as it is safe to do so.
Target group	Users aged 65 and over in the Sittingbourne and Sheppey locality
No. clients/patients	TBC during steering group meetings
No. of clients per year	TBC during steering group meetings
No. of staff (FTE)	TBC during steering group meetings
Budget per year	TBC during steering group meetings
Average costs per client	TBC during steering group meetings

3.7.5.1 Level of service integration, strengths and weaknesses from different viewpoints

The evidence from the baseline assessment suggests that D2A: Swale is vertically integrated with clear coordination between social care teams (e.g. enablement team). An overarching aim of D2A: Swale therefore is to improve the level of integration by enabling horizontal integration with the local health and voluntary services. Social services would like this horizontal integration to be supported by a pooling of health and social care funding to enable more complex cases to be dealt with in users' own home. The fact that the vision ("own home is best") is shared across the local health and care economy should act as an important enabler.

Strengths

D2A: Swale staff and leaders are very clearly person-centred. Staff go the extra mile for their users and have a clear understanding of what person-centredness means. They also have knowledge of how national policies like the Care Act 2014 help them to provide person-centred care.

The team is made up of highly professional workers who are supported by strong and positive leadership. This makes them highly motivated to change and to build on the current successes of the service by making it more multidisciplinary across the local health and care economy.

Weaknesses

Some of the most important challenges that the service faces are contextual. For example, the cold financial climate has led to seriously constrained funding and staffing levels across the health and care economy. This impacts on the sustainability of any new project or service and could potentially limit the reach of the SUSTAIN improvement project. For instance, the lack of funding available will likely mean that the SUSTAIN improvement project cannot improve on the IT infrastructure which is currently outdated and not fit-for-purpose due to its incompatibility across the different services. Related to the difficult financial situation, is the performance fatigue that staff (and especially leaders) are experiencing as they regularly have to provide detailed evidence on their performance.

3.7.5.2 Areas for potential improvement

Positively, there was a strong consensus over the weaknesses which can and should be tackled through the SUSTAIN improvement project. A major focus was the lack of coordination and communication across the different agencies. For example, it was felt that a more coordinated approach with community services (with a stronger focus on the voluntary sector) would help enable users' independence at home. Furthermore, staff had highlighted the importance of a "single trusted assessor" to help tackle the lack of information sharing between agencies and the duplication of user assessments (copying other D2A models in the UK).

Table 15
D2A: Swale Areas for Improvement

Area for improvement	Solution
Leadership	Because the service spans across different teams and sectors, it is vital to allow for **one senior person to make decisions across those different teams and sectors**. This manager must have the backing from the leaders in the different sectors, including the CCG, to make the necessary decisions.
High ward staff turn-over	This means that awareness of "Home First" is difficult to maintain. **Creating a communication strategy** which takes into account the need to "keep putting the message out there" is important to maintaining referrals into the service.
One point of contact telephone service	To keep the service as simple as possible for ward staff, implement **"one point of contact" telephone service** to conduct the initial triage/risk screening. Staff manning the "one point of contact" telephone service should also take on more administrative functions (e.g. sorting out patient transport and arranging equipment) to free up health and care practitioners to focus on patients' health and care needs.
Patient transport	Develop a **plan for patient transport to avoid delay** and ensure patient transport is available in the morning and afternoon (seven days a week if possible).
Cut-off times for dis-charges from the ward	Give the wards a **later cut-off time for discharges** (e.g. 3pm each day) to enable patients who have ward rounds after 12pm to still be discharged home on the same day. Also ensure that ward staff inform the service when patients are actually discharged.
Shared vision and "Framework of Agree-ment"	Ensure that all services in the local health and care economy share the vision that Pathway One users have a right to enablement and that services are able to hand over to each other if appropriate **(Everybody for Enablement)**
Memorandum of Understanding (MoU)	Develop an MoU for voluntary services supporting the new service. **Select three main providers** (rather than having to pick and choose form a multitude of providers) **to "act as a bridge"**. These providers could, for example, provide support after the maximum length in service of six weeks, or to conduct the initial holistic assessment in patient's homes to ensure the two hour target is met. The MoU will need to be underpinned by the **"trusted assessor"** principle.

Table 16
Characteristics of the Over 75 Service

Objectives	• To reduce avoidable unplanned admissions • To improve practice availability (e.g. through same-day telephone consultations) • To provide enhanced and person-centred care • To improve care coordination and care navigation • To improve users' self-management
Services provided	• Risk stratification: identifying patients who are at high risk of avoidable unplanned admissions • Case management register of users most at risk of hospital (re)admission • Holistic care plans • Proactive care and support • Tand A&E attendances • Dementia screening in care homes • Internal reviews of unplanned (re)admissions. Notifications send to CCG as appropriate
Target group	• Users aged 75 and over • Vulnerable, housebound, frail patients • Patients living alone with little social or family support • Patients with multiple complex and/or mental health needs • Patients at high risk of hospital (re)admission
No. of potential clients/patients	202 annually
Average no. of clients per year	TBC during steering group meetings
No. of staff (FTE)	One nurse, 15-20 hours per week of administrative support.
Budget per year	TBC during steering group meetings
Average costs per client/patient	TBC during steering group meetings

Separately, many had expressed frustration over the lack of out of hours coverage from, for example, hospital pharmacy and the difficulty of engaging secondary care services, which caused delays in users' discharges to hospital and access to important services (e.g. mental health services). The improvement project should therefore consider ways in which such services could be better aligned with D2A: Swale.

During the second and final workshop, which concluded the baseline assessment, the stakeholders agreed on the areas for improvement as described in table 15.

3.7.6 Site II: The Over 75 Service (Sandgate Road Surgery)

In 2015, NHS England introduced the programme "Enhanced Service" (ES) which is designed to enable CCGs and GP practices to reduce avoidable unplanned hospital (re)admissions and A&E attendances by improving services for vulnerable patients and those with complex physical and/or mental health needs, who are at high risk of hospital (re)admission (NHS England, 2015a-e; NHS England, no date, b; NHS England, 2016). NHS England set aside a total national budget of £162 million for ES. CCGs are expected to use this funding to commission additional primary care services or community health services which GP practices in the local area have prioritised (NHS England, 2015a-e). Locally, South Kent Coast CCG (the commissioner for local health services) decided to use the ES funding to invest £5 per each patient on the Sandgate Road Surgery list to enable the surgery to develop their "Over 75 Service" (approximately £75,000). Like any GP practice participating in the ES programme, the "Over 75 Service" has had to comply with key components, including for example risk stratification, proactive case management, review of unplanned admissions and hospital discharge processes.

The "Over 75 Service" at Sandgate Road Surgery is hoping to go beyond the scope of the service specifications for ES services by integrating the "Over 75 Service" more clearly into the local health and care economy by establishing clear multidisciplinary care pathways and working practices (e.g. shared or integrated assessments).

The "Over 75 Service" was borne out of the national ES programme and is funded via South Kent Coast CCG. As such, the service specifications follows the national programme described above. The "Over 75 Service" is managed by a lead GP, but the day-to-day running is done by a practice nurse. Sandgate Road Surgery is accountable to South Kent Coast CCG. This means, for example, that they are required to escalate any major issues to the CCG, and to submit data regarding the number of hospital admissions of patients on the "Over 75 Service" caseload.

The Surgery also has to report how they are spending ES funding to further improve the "Over 75 Service".

One of the most significant challenges the "Over 75 Service" faces at the moment is a lack of awareness of the service across the local area, which hinders the extent to which other practitioners are willing to collaborate. Key stakeholders for the "Over 75 Service" include paramedics, district nurses, intermediate care team, health navigators, out-of-hours services, community mental health team, social services and the voluntary sector.

3.7.6.1 Level of service integration, strengths and weaknesses from different viewpoints

The "Over 75 Service" has the potential to be a great enabler of integrated care for older, more vulnerable people in the local area. For example, the risk stratification strategy and its corresponding register of the most at risk patients and the use of proactive care planning could see the "Over 75 Service" as leading the integration of care for this patient group. Unfortunately, due to a significant lack of awareness of the service, the level of integration with other services is limited. For example, Sandgate Road Surgery schedules monthly multidisciplinary meetings to discuss the patients most at risk of (re)admission, but these meetings are poorly attended.

Strengths

Staff at the "Over 75 Service" are clearly person-centred. They work flexibly by going beyond the service specification set by NHS England, enabling users' needs to be considered more holistically with a clear focus on improving the quality of life and wellbeing of patients. Furthermore, the service imposes no time limit on users' length in the service. Compared to other enhanced services, the "Over 75 Service is performing well as it has reduced admission rates further than others.

Weaknesses

As with the D2A: Swale service, some of the most important challenges that the "Over 75 Service" faces are contextual. Again the cold financial climate has led to seriously constrained funding and staffing levels across the local health and care economy. This is compounded by the fact that the local community health services are currently going through a period of major change. The original organisation delivering community health services (Kent Community Health Foundation Trust) has lost key contracts to another provider, Virgin Care. This means that many of the stakeholders (e.g. district nurses) are in the process of being transferred to Virgin Care with different terms and conditions. This has made it difficult to engage such stakeholders in an improvement project that (arguably) does not impact them directly.

Such contextual issues are expected to have an impact on the reach of the SUSTAIN improvement project as caseloads of services across the local area are stretched, which impacts on stakeholders' ability to collaborate. Such issues may also limit the scope of the SUSTAIN improvement project. For instance, the lack of funding available means improvements to the IT infrastructure may not be possible.

3.7.6.2 Areas for potential improvement

An important part of the work going forward will be to continually engage with the wider "Over 75 Service" stakeholders, with the support of South Kent Coast CCG to raise awareness of the service in the local area. The stakeholder engagement should also be used as an opportunity to create a shared vision and pathway for the wider health and care economy and more specifically for the "Over 75 Service".

Elatedly, stakeholders expressed an interest in creating shared training opportunities for practitioners in the local area to raise awareness of other practitioners' roles and responsibilities and other team's remits and pathways. It was thought that shared training opportunities (like shadowing and "best practice forums") would broaden practitioners' skill-ranges and thus even help relieve workforce pressures.

Finally, everyone agreed that a more coordinated approach with social care services, intermediate care services, mental health services and pharmacies would be necessary to prevent more crises and hospital admissions. Better information sharing enabled by properly attended monthly multidisciplinary meetings for patients considered most at risk of unplanned admissions, shared care plans and shared assessments were seen as central to a more coordinated approach.

During the second workshop, which concluded the baseline assessment, the stakeholders agreed on the areas for improvement as described in table 17.

3.7.7 Discussion and Conclusion

We have described the D2A: Swale as a service which aims to discharge users from acute and community hospitals as soon as they are medically fit. The D2A: Swale service carries out assessments in hospital, while care coordinators support users and their families by setting up care packages to support users' independence at home. While the "Over 75 Service" focuses on avoiding hospital (re)admissions by carrying out risk profiles and providing proactive care.

The analysis has shown that staff at both sites are highly person-centred and motivated to improve the level of integration at their services, but both sites are hindered by common problems in the field of integrated care, including a lack of coordination and communication across agencies, a lack of information sharing and a lack of clarity around each other's job roles and remits. These common problems are compounded by the cold financial climate, which has led to, for example, a lack of sustainable funding and changes to providers of care in the local health and care economy. However, motivation and willingness to participate in the SUSTAIN project remains high at both sites, though at this stage, we expect the implementation of the improvement project will be easier at D2A: Swale that at the Over 75 Service due to a lack of awareness of the latter.

Table 17
Over 75 Service Areas for Improvement

Area for improvement	Solution
Patient group	It was decided that the improved "Over 75 Service" (O75) would focus on housebound patients.
Leadership	Because the service will likely span across different teams and sectors, it is vital that the person who leads the O75 SUSTAIN improvement project has the backing from the leaders in the different sectors to make the necessary decisions across those different teams and sectors.
Shared vision and "Framework of Agreement"	Ensure that all services in the local health and care economy share the same vision.
Shared system to identify housebound patients	Develop a clear set of (evidence based) criteria around housebound patients to effectively identify and refer such patients across health and social care teams.
Seamlessly sharing information	Develop a plan to allow for the seamless sharing of information across services and teams to enable better care coordination and the development of a "trusted assessor" model.
Integrated pathways	Develop clearly defined and integrated pathways around "housebound patients"
Shared care protocol	Develop a strategy to allow for a shared care protocol by e.g.: • Implementing a joint management plan with a lead care coordinator for housebound patients • Holding regular MDT meetings, enabled by remote communications technology (e.g. Skype, WebEx, Facetime)
Patient transport	Develop a plan for patient transport to enable service-users to attend health and social care appointments.
Communication strategy	Creating a communication strategy which takes into account the need to keep raising the profile of the O75 Service is important to maintaining referrals into the service.
Aims & Outcomes	• Improved health outcomes • Improved wellbeing • Improved self-management • Prevention of deterioration and maintenance of health • Prevention of crisis • Improved access to services • Improved coordination and reduction of duplication • Implementation of the "trusted assessor" model

Reflections on the process

While our sites were eager to sign up to become part of the SUSTAIN project, it has not always been easy to maintain that level of interest; most likely due to the problems arising from the cold financial climate. For example, we found it easy to schedule interviews for the manager and professional for the baseline assessment, but had difficulties engaging the sites to recruit users and carers. It is worth noting that we gathered rich and useful data through the professional and manager interviews, but found the carer and user interviews less rewarding at this baseline stage. This may be due to the fact that the users and carers we interviewed were either not aware of the fact they were enrolled in a specific initiative, or were not aware of the all the details of their care package and the various organisations and professionals involved.

When it came to stakeholder groups, they were also quite unfocused and it was sometimes difficult to maintain concentration on the service to be developed. This was due in part to the multi-disciplinary and multi-sectoral nature of the service and the group (lots of different perspectives) and that the initiatives are quite complicated.

Going forward the context will be very influential regarding the success or failure of the implementation of the set of improvements. Keeping stakeholders engaged over a relatively long period of time with a shifting context that is likely to involve even more financial cut backs will not be straightforward. Also, the uncertainties regarding the new provider at Swale (Virgin) may mean further workforce changes that may not be compatible with the continuation in SUSTAIN.

However, we suspect that the implementation of the SUSTAIN improvement project will be a relatively easier process at the D2A: Swale initiative than at the "Over 75 Service" as D2A: Swale is more fully embedded within the local health and care economy. To mitigate any issues with the "Over 75 Service", we will be doing more intensive stakeholder engagement to raise awareness of the initiative across the local health and care economy.

Lessons learned

- The context needs to be formally recorded. We feel the data partners will benefit from guidance on how to write up field notes to capture important contextual information as we go forward into the implementation phase.

- Because the researchers are not a priority for managers and practitioners, we have found it important to visit the sites more frequently than expected and keep regular email contact in order to maintain the relationship. We are also providing evidence scans that we will use for the improvement plan and can add to the toolbox. This helps, even though it is difficult to arrange meetings with groups of busy staff.

- We found that being flexible with the stakeholder group workshop agenda allowed us to adapt to the groups' needs well and ensured that we obtained information relevant to the local context. This was also necessary to create focus on the service. This was reflected in the positive feedback we received from the groups' stakeholders.

- We have decided to use a structured approach for the second stakeholder group to assist with the need to develop a clear improvement plan at that time. We will work with the initiative managers before the second stakeholder group to develop a decision tree/logic model of how they see the service being rolled out in an ideal situation, describing for example the patient journey through the service. At the next stakeholder group we will use this to see how this can be rolled out and where the improvements need to take place.

- In future, it would be helpful to develop a template for writing up the minutes and actions of the workshop beforehand to ensure we are able to keep accurate and comparable records of the workshops.

4. COMPARATIVE ANALYSIS OF INTEGRATED CARE DELIVERY AT FOURTEEN SITES IN SEVEN EUROPEAN COUNTRIES

Annerieke Stoop, Simone de Bruin, Gerald Wistow, Georg Ruppe, Paulina Wosko

European health systems are facing the challenge to offer care and support to an increasing number of older people living at home with multiple health and social care needs. In response to this, a diverse range of integrated care initiatives is being implemented to structure and coordinate proactive care.

The previous chapter summarized for each of the seven countries in the SUSTAIN project the status and development of integrated care in general, the characteristics of two participating integrated care initiatives and the barriers, facilitators and improvement areas reported by local stakeholders of the initiatives. Within the SUSTAIN project, we aim to develop a framework for a comparative analysis across the different sites, including the national contexts for integrated care within which the fourteen initiatives are operating. This implies a continuous search throughout the entire SUSTAIN project in which we explore how to compare and analyze data from a variety of countries and integrated care initiatives. These objectives require regular data analyses across the entire project to establish emerging findings and underlying themes.

This chapter provides an initial starting point for those processes of comparative analysis. It is based on a content analysis of the national reports (chapter 3 above), supplemented by primary data from the exploratory interviews and stakeholder workshops conducted by each of the SUSTAIN research partners. While reading this chapter, it is important to keep in mind that this comparative analysis is primarily based on data from only two integrated care initiatives in each of the seven countries, which was provided by a small number of local stakeholders at each site.

The next paragraph is an overview of the status and development of policy for integrated care in the seven participating countries. We then focus on the fourteen integrated care initiatives that are part of SUSTAIN, including their interpretation of the SUSTAIN core domains, i.e. person-centeredness, prevention orientation, safety and efficiency. Thereafter, we provide an overview of barriers and facilitators towards integrated care reported by stakeholders at the fourteen sites. The last section summarises the potential areas for improvement identified by stakeholders and how these relate to the facilitators and barriers they have experienced.

4.1 Status and development of policy intentions for integrated care across Europe

The move towards integrated care for older people with multiple health and social care needs is dependent of nation-specific conditions, and therefore the status and development of policy intentions for integrated care provision vary considerably among the participating European countries in the SUSTAIN project (Gress et al., 2009; WHO, 2015b). Nevertheless, a number of generic themes have emerged from our cross-national analyses. Table 18 shows the main characteristics of the development and status of policy for integrated care provision across the seven participating European countries: governance of health and social care system, implementation process and spread of integrated care, focus of integrated care and funding mechanism for integrated care.

The table shows that in most countries, the Ministry of Health has the ultimate responsibility for the health care sector and often determines the general legislative framework at the system level. In some countries, regional or local governments are responsible for the actual provision of health care services, while in some other countries this responsibility lies at the national level. Furthermore, in a number of countries, the social care sector is also under responsibility of the Ministry of Health, while in other countries, this is under responsibility of another Ministry (e.g. Social Affairs).

	Governance of health and social care system	Implementation process and spread of integrated care	Focus of integrated care	Funding mechanism for integrated care
Austria	National and regional: Ministry of Health is responsible for general framework legislation. Regional governments responsible for provision health and social care services.	Top down: the implementation of a major health reform and ensuing regulations addressing coordination and integration within the health system caused the rolling-out of discharge management and disease management projects.	Key focus on disease management (health system). The concepts of palliative care (multi-disciplinary teams, patient-orientation, holistic approach) have a potential to serve as a general model for person-centred care, though integration in mainstream provision of long-term care to be seen.	Structural: Diagnosis Related Groups (DRG) - funding. Project based: the establishment of Regional Health Funds stipulated so-called 'reform pools' for implementation of projects.
Spain (Catalonia)	Regional: health and social entitlements are devolved to each of the 17 Autonomous regions. In Catalonia, the health care sector is under responsibility of the Catalan Health Service (CatSalut). Social services are under responsibility of the Catalan Social Services system. Social services are also organized at the municipality level. Both sectors work independently from each other.	Bottom up and top down: coordination and integration between sectors is mainly carried out at the meso (organisational) and micro (staff) levels through good willing professionals and managers who strongly believe in an integrated care model. The Catalonian government has created the Interministerial Social and Health Care Interaction Plan, a policy framework for the impulse of an integrated care model in the Catalan territory.	Integration between primary care and basic social services is the most frequent model for delivering person-centered care. There are though few advanced models in the territory that incorporate the coordination of different care levels (acute, intermediate and long-term care) in which disease management is a key characteristic.	The initiatives do not receive extra funding for working in an integrated way.
Estonia	National: Ministry of Social Affairs is responsible for general framework legislation and provision of health and long term care services. Local governments responsible for provision social care services.	Top down and bottom up: Ministry of Social Affairs is responsible for the development and implementation of overall health and long-term care policy. The family doctor is the key person referring patients to nursing care services and in referrals to a local government social worker for welfare services.	The organisation of integrated services focuses on the coordination network in which the case management concept plays an important role. Integrated care should include both health care and welfare services; today it is not working yet.	Structural: Nursing and home nursing care are mainly funded by the government funded Health Insurance Fund. The majority of welfare services are financed by local government budgets. There are also other funding possibilities: the service user's out-of-pocket payments, donations, private sector investments, etc. Specific integrated care funding is missing in Estonia.
Germany	Responsibilities for health and long-term care insurance are under the remit of the Federal Ministry of Health. The current administration has implemented a number of reforms towards long-term care, long-term care training and staffing, entitlements, prevention and easing telemedicine.	There is growing political endorsement for integrated care and a more efficient use of resources. A competitive call for proposals under an innovation funding scheme (The Innovation Fund) encourages new forms of care for older people, disabled, mentally ill people, and it fosters multi-professional, collaborative care networks.	Multi-speciality group practices (MVZs) combine physician, care, and social services. They can be physician-led, hospital-led, or managed by a municipality. Today, 20% of physicians already work in MVZs where care is provided in a seamless, integrated fashion, supported by information technology.	From 2004-2009 seed money was offered to incentivize population-oriented integrated care pilots. Today's MVZs are living proof of a paradigm shift at the time and a policy-initiated change in service delivery. The Innovation Fund builds upon the financial support of pilots but is geared towards sustainability and scalability of integrated forms of care.

Table 18
Development and status of policy for integrated care across Europe

	Governance of health and social care system	Implementation process and spread of integrated care	Focus of integrated care	Funding mechanism for integrated care
Norway	At the national level, the Ministry of Health and Care Services has ultimate responsibility for the healthcare sector. At the regional level, four regional health authorities are responsible for hospital/specialist care. Primary care services (GPs, home/institutional nursing) are organized at the municipal level.	Bottom up and top down: Initial projects were small and local. Some nation-wide initiatives have since been launched. A recent national healthcare reform aims to strengthen coordinated health services delivery between hospitals and municipalities, and is influencing the activities of the two SUSTAIN coordinated care sites in Norway.	Long term care and the integrated care initiatives encompassing this sector are structured around reducing/managing levels of disability in service users, with some provisions for disease-specific specialized care.	Structural: municipalities received some financial support from the central government to strengthen their healthcare infrastructure under the current reform.
The Netherlands	National and local: the Ministry of Health, Welfare and Sports is responsible for policy on health and social care services, and as such determine the general legislation framework at the system level; different governance and funding structures exist for long term, social and acute care. In 2015, decentralisation of several long-term and social care and support services to local authorities took place. Since then, local authorities are responsible for the provision of these services.	Top down and bottom up: several developments are implemented top down, e.g. health care standards and bundled payment of diabetes, COPD, CVD, and pioneer sites for population health management, the National Care for the Elderly Program. Simultaneously, an increasing number of bottom-up initiatives is emerging.	Shift from disease specific programs and case management, towards programs for people with multimorbidty/frailty and nowadays towards population health management initiatives. For a number of target groups 'health care standards' have been developed. For diabetes, COPD and CVD care, this is accompanied by a bundled payment system. For elderly care, some pilot regions for bundle payment have been chosen.	Mainly project-based funding (e.g. The Netherlands Organisation for Health Research and Development), and in some regions structured funding from health insurers.
United Kingdom	The National Health Service (NHS) provides health care free at the point of need and is funded directly through taxation. The NHS is overseen by NHS England and the Department of Health. Social care services are means tested by local authorities. Social care provides services like help maintaining independence at home.	Top down: national policies and development of pioneering integrated care/funding models. Bottom up: integration of care between services implemented at meso and micro levels through supportive commissioners and staff members with strong interest in integrated care.	Recent policies are focusing on whole system approaches aiming to reduce barriers between health and social care, providers and commissioners, with the aim of improving integrated, person-centred care.	The organisational separation of health and social care has contributed to the fragmentation of care. No additional funding is provided to improve level of integration. However, the Better Care Fund (2013) aimed to create a single local pooled budget to incentivise the NHS and local governments to work more closely together (even though it did not provide any additional money) (NHS Confederation, no date).

Table 18
Development and status of policy for integrated care across Europe

Often these ministries work independently from each other. The regional and local governments are often responsible for the actual provision of social care services. In the UK and Estonia, social care is both governed and organized by local authorities.

With regard to the implementation process and spread of integrated care across the participating countries, in all countries it is developments both at national or regional (policy) level that have initiated the movements towards (or strengthening of) integrated care, e.g. through new regulations, new funding schemes or the support of pioneer initiatives. In addition, in several countries, for instance Spain (Catalonia), the Netherlands and the UK, there is an increasing number of integrated care initiatives emerging bottom-up (at meso and micro level), often through supportive commissioners and staff members with strong interest in integrated care.

Furthermore, the table shows two different developments with regard to the focus of integrated care across the participating countries, even though the ambitions seems to be similar. On the one hand, some countries are moving from single disease management programs and case management, towards programs for people with multi-morbidity/frailty and population health management initiatives. On the other hand, in some countries the focus of integrated care seems to be structured around a specific aspect of care, for instance hospice and palliative care.

Concerning the funding mechanism for integrated care across the countries that are part of SUSTAIN, health care and social care sectors are organized and financed separately in almost all countries. There is often no system-wide funding for integrated care; funding is either project-based aiming to encourage new forms of (integrated) care or there is no additional funding specific for improving the integration of care. In Norway, however, municipalities receive structural financial support from the central government to strengthen the health care infrastructure under the current reform, aimed at promoting coordinated health service delivery between specialist care (hospitals) and primary care (municipalities).

4.2 Integrated care initiatives participating in SUSTAIN

The fourteen sites participating in the SUSTAIN research reflect the great diversity of integrated care sites across Europe (Cash-Gibson and Rosenmoller, 2014; van der Heide, 2015). The initiatives focus on different aspects of care for older people living at home: proactive primary care for frail older people, care for older people admitted to or being discharged from hospital, nursing care for frail older people, care for people with dementia and palliative/end-of-life care. The care sites discussed in Text box 1 speak of the diversity across the initiatives.

Text box 1

One of Austria's initiatives is the Coordinated Palliative Care service including mobile palliative care teams supporting and accompanying patients and their families at the end of life, while one of the initiatives in the UK, Discharge to Assess: Swale, is organized around hospital discharge. Another example is an initiative in Sabadell in Spain (Catalonia), which is a primary care based integrated care initiative in coordination with basic social services where, during monthly meetings, eligible individuals are identified and their care needs are discussed.

The initiatives also differ in other aspects besides the types of care services provided to older people. These characteristics include for instance: the driving force behind the different initiatives, the stakeholders/organizations involved, the initiatives' primary and secondary objectives, their target groups and the duration of the care services (i.e. for a certain period of time or an unlimited period).

To get a better understanding of how the initiatives compare to each other, we have clustered them according to care setting and stakeholders/organizations involved. This clustering process was designed to help us making (general) comparisons between the initiatives, in the light of SUSTAIN's ambition to identify what works for whom, in what context and with what outcome. Even so, we note that health and social care systems and the sectors in which the initiatives are embedded differ across the countries, and that the classification that we make in the next section will not be valid for all countries or fully reflect the situation in all countries.

Thus, we clustered the driving forces according to the following care settings, i.e. primary care sector, hospital care sector, community and social care sector, and the long-term care sector. The primary care sector consists of all care services provided by a GP practice (e.g. GP, practice nurse), but also by care professionals such as dieticians, physiotherapists, occupational therapists and pharmacists. The hospital care sector covers services from the (acute and community) hospital. The community and social care sector consists of outpatient services and social support/welfare services, including adult day services and food services, aimed at promoting independent living at home. The long-term care sector consists of care services provided by specialized long-term care institutions or home care organizations that are separate from community or social care sector services.

The majority of the initiatives emerged at the interface of two or more care sectors, mostly the hospital care sector and the community and social care sector, or the primary care sector and the community and social care sector. A small number of initiatives are founded in one care sector (i.e. the Geriatric Care Model in the Netherlands and the Over 75 Service in the UK are based in the primary care sector; German initiatives are based both in the primary and long-term care sector). However, in these initiatives, multiple health and social care professionals from different organizations and care sectors are involved.

Within the different care settings, several organizations are involved in collectively providing integrated care to frail older people living at home. Table 19 shows the number and diversity of organizations involved per initiative. It should, however, be noted that it does not provide any indication of the degree or intensity of integration and coordination. In many initiatives, a GP practice and a coordinating/ multidisciplinary team specific for the initiative are represented. Also several site-specific organizations participate in the initiatives, which do not fit within one of the current organization types as shown in Table 19, for instance paramedics in the Over 75 Service and the geriatric physiotherapist in the Walcheren Integrated Care Model. More detailed information about these site-specific organizations can be found in chapter 3, which describes each site in more detail.

Text box 2

The Walcheren Integrated Care Model in the Netherlands consists of a collaboration between the primary care and hospital care sector, in which GPs, practice nurses, district nurses, geriatric physiotherapists, case managers for people with dementia, mental health care practice nurses and home care nurses of three home care organisations are working together to deliver integrated care. An improvement project about better collaboration with the hospital is started. Cooperation with social care on professional level is still in a premature phase.

The initiative in Surnadal municipality in Norway was developed as a collaborative project with three hospitals (for in/outpatient and emergency care), five neighboring municipalities (for GP consultations, rehabilitation services, short/long-term institutional stays, and home services), and three organizations: the regional health authority of Mid-Norway, a university and a research organization. The initiative takes place at the interface of the primary/community care sector (which is a combined sector in Norway since they are both part of municipal services) and the hospital care sector. There is a good and well-established way of working between internal partners making users whose care needs fall within the initiative's system experience relatively smooth transitions through the initiative's care pathway. However, the collaboration and communication with other sectors involved in service provision (e.g. social housing, GPs) is considered as an important area for improvement.

The Over 75 Service at Sandgate Road Surgery in the UK takes place in the primary care sector, though several key stakeholders are involved, including paramedics, district nurses, intermediate care team, health navigators, out-of-hours services, community mental health team, social services and the voluntary sector (e.g. Age UK, Salvation Army). The service is managed by a lead GP, but the day-to-day running is done by a practice nurse. One of the most significant challenges the initiative faces is a lack of awareness of the service across the local area, which hinders the extent to which other practitioners are willing to collaborate.

In all initiatives, several stakeholders/organizations and care sectors are involved in the care process, even if the initiative emerged from one care sector. The examples below (Text box 2) illustrate the variety of care sectors and stakeholders/organizations involved in the initiatives and the variation in the strength of the collaboration between the stakeholders/organizations involved.

4.3 Interpretation and understanding of SUSTAIN core domains by sites

Since the key domains of the SUSTAIN project, i.e. person-centredness, prevention orientation, safety and efficiency, play a central role in evaluating the performance of the initiatives and the impact of the improvement projects, Table 20 shows how local stakeholders define the key domains and the way they currently address or aim to address the key domains in the integrated care initiatives.

In all initiatives, local stakeholders defined person-centred care as focusing on the user's needs. How they address this differs across the initiatives, for instance by developing a person care plan together with the user and the carer or conducting a multidimensional geriatric assessment, including assessment of values and preferences.

Prevention-orientation means, one the one hand, focusing on avoiding further deterioration of the current condition or crises such as falls or readmissions. This is addressed, for instance, by looking out for hazards (e.g. loose rugs) in the user's home by staff or by ensuring all practitioners involved in a user's care plan are aware and understand the user's medication plan when the user is discharged from hospital. On the other hand, prevention-orientation means working in a proactive way and focusing on preservation of autonomy and quality of life. For instance, enhancing participants' physical resources and activating coping abilities to continue living at home independently might be addressed by helping patients to exercise alone and eat a healthy diet.

In several cases, there is an overlap in the definition for safety and prevention-orientation, with regard to avoiding crises. This might be addressed by, for instance, an electronic system that alerts when there are risks on the medication (e.g., duplication, interactions). Furthermore, safety is often defined as living safely at home. This might for instance be addressed by installing a safety alarm at home or by mapping a user's home with regard to safety and security.

In several initiatives, efficiency was defined a good collaboration and communication between staff members. This is, for instance, addressed by an in-depth quality handbook in which well-developed specific roles and responsibilities are laid out for the staff members on every level. Efficiency is also related to care processes such as fewer hospital admissions and fewer avoidable physician visits. Furthermore, efficiency is defined as providing the best possible care with the available (often limited) resources, while meeting organisational and user objectives.

	Austria		Spain (Catalonia)		Estonia		Germany		Norway		The Netherlands		United Kingdom	
	CPC	GPZ	OSO	SAB	ALU	MED	CWB	RMT	SUR	SON	GCM	WICM	DH2A	O75
GP practice (organization)	+	+	+	+		+		+	+	+	+	+		+
Home care organization	+	+				+	+		+	+	+	+		
Hospital	+		+		+	+		+	+	+	+	+	+	
Pharmacy	+				+		+				+			
Organization supporting people with dementia		+			+						+	+		
Long-term care institution/care home	+		+		+	+	+		+					
Social care organization/services		+	+	+	+	+	+	+			+	+	+	+
Municipality/local government		+	+	+	+			+	+	+	+	+	+	
Health insurer					+	+		+			+	+		
Integrated care team/ coordinating team	+	+			+	+	+	+	+	+	+		+	+
Volunteer organizations	+						+				+		+	+
Other (context-specific organization)	+	+			+		+	+	+	+	+	+	+	+

Table 19
Involved stakeholders

4.4 Barriers and facilitators to coordination and integration at fourteen integrated sites in Europe

This section presents the facilitators and barriers of integrated care as reported by stakeholders at the fourteen sites participating in SUSTAIN. Despite considerable differences in the characteristics of the sites and the contexts that surround them, several barriers and facilitators were similar. Table 21 provides a brief overview of the facilitators and barriers experienced at the sites.

We have organized the barriers and facilitators into four interrelated levels, namely: system level, organisational level, staff level and client level (Valentijn et al., 2015). The system level concerns the health and social care system. The organisational level refers to the organisational context in which the staff members provide services. The staff level relates to the actual delivery of care and support by health and social care professionals. The client level concerns the older people and their family caregivers to whom services are provided.

Although the levels are depicted separately from each other in Table 21, barriers and facilitators at different levels are often related to each other. The system level influences the organisational level, which in turn influences the staff level, which is related to the client level. However, for analytical purposes, we categorized the levels in an attempt to unravel the complexity of interrelated facilitators and barriers.

4.4.1 Barriers to coordination and integration experienced at the fourteen sites in Europe

Initiatives participating in the SUSTAIN project encountered several similar bottlenecks to coordination and integration of care and support; the most frequently reported are explained here in more detail. First, at all sites, stakeholders mentioned organisational complexity due to organisational and administrative separation within health organizations and between health and social care organisations, causing stakeholders have to deal with a large and diverse group of institutions (also see Table 19). In most cases, this was perceived as an important barrier, because it undermines good communication and information exchange between the organizations and the professionals involved, and creates lack of consensus and clear agreements about roles and responsibilities of professionals from the different organizations. In a number of initiatives, for instance in Spain (Catalonia), Norway and the Netherlands, stakeholders indicated that the way of collaboration and communication differ among organizations involved. Communication and collaboration between organizations delivering care within the same care setting (e.g. primary care sector) seemed to be smoother than collaboration and communication between organizations from different care settings.

		Person-centeredness	Prevention orientation	Safety	Efficiency
Austria	GPZ	The designation of individual patients to one contact person; conceiving the patient as a 'subject'.	Avoid further deterioration and complications at home as well as avoidance of hospital stays.	Safety of medication; prevention of falls; no abuse.	Good collaboration and communication.
	CPC	The person is at the centre by definition, not symptoms.	Avoid substantial decrease in quality of life.	Safety for staff is address strain factors, driving training, general prevention; safety for patients: medication safety.	Efficient cooperation with other social and mobile care providers was regarded as essential.
Spain (Catalonia)	OSO	*Definition:* Focus on covering the caring needs of the patient, rather than the disease. *Example:* a multidimensional geriatric assessment, including assessment of values and preferences.	*Definition:* Anticipatory mentality; being proactive and in terms of health surveillance and continuity. *Example:* Telecare device for contacting the emergency department in case of a crisis.	*Definition:* The willingness to avoid negative effects, based on the principle of no-harm; avoiding avoidable errors, avoiding malpractice; feeling safe at home. *Example:* Medication review to avoid interactions.	*Definition:* Efficiency is understood under the patients' perspective and the sustainability of the system; accomplishing functions in an agile, positive, productive and benefitting way for the patient. *Example:* Changing unplanned caring for planned caring.
	SAB	*Definition:* Placing the needs of the user in the centre. *Example:* Identification and labelling of patients with multiple social and health care needs.	*Definition:* Working in a proactive manner, from the beginning. *Example:* Advices on how to avoid falls at home.	*Definition:* Following the guidelines and evidences regarding home prevention, hospitalisation; safe conditions regarding food, medication, physical aspects, sociability etc.; feeling safe at home. *Example:* Electronic system that alerts when there are risks on the medication (e.g., duplication, interactions).	*Definition:* Providing the best results with the available resources; achieve the same results with the minimum resources. *Example:* avoid duplication of blood tests, prescription of safe and effective medications.
Estonia	ALU	*Definition:* Care provision needs to be coordinated based on people needs and expectations. *Example:* Assessment of needs is based on person's health, physical, emotional and psychological condition.	*Definition:* Prevention of bedsores, falling and common cold. *Example:* Measures for preventing falls (security gates, bed guards, etc.). Every autumn people undergo prophylactic course of garlic pills and C vitamin.	*Definition:* Strong focus on safety in care provision. *Example:* Measures for preventing falls; medication safety, sores etc. Quality commission.	*Definition:* Organisation has a strong leader and work is team-based. *Example:* In-depth quality handbook, where well-developed specific roles and responsibilities are laid out for the staff members on every level.
	MED	*Definition:* All activities are based on patient condition and his/her needs. *Examples:* During preparation of care/ treatment plan user needs and opinion is always taken in to consideration.	*Definition:* Plan to decrease possible risks are put in place together with user and carer. *Example:* During preparation of treatment plan variable risks are taken into consideration (falling, hospitalisation, complications etc.).	*Definition:* Evaluation of possible risks is conducted during home visits. *Example:* Instructions created for safe service providing and create treatment plans based on that instructions.	*Definition:* Good collaboration and communication between staff, GPs, hospitals and users. *Example:* Staff has well-developed specific roles and responsibilities.

Table 20
Interpretation and understanding of SUSTAIN core domains

		Person-centeredness	Prevention orientation	Safety	Efficiency
Germany	CWB	*Definition:* Goal setting together with the patient, family members and/or caregivers. Treatment objectives then aligned with findings from professional assessments. Focus is on quality of life and patient preferences. *Example:* Client may choose senior choir session over therapy session.	*Definition:* Prevention orientation means focus on nutrition, exercise, structured daily activities, social engagement, pharmaceutical management etc. *Example:* Therapists and nurses provide guidance and advice to strengthen physical ability. Volunteers provide time for social activities.	*Definition:* Living safely and independently at home but closely monitored. *Example:* Clients are cared for in assisted living facilities and barrier-free, accessible apartments.	*Definition:* Reduced burden on nurses, fewer hospital admissions, reduced length of stay in hospital, and fewer avoidable physician visits. *Example:* Therapists act as navigators, monitoring client's health status. Resources from three different insurance types – health, long term care, rehabilitation – are pooled to deliver personalized services to the clients.
Norway	RMZ	*Definition:* The complex-therapy program is tailored to each participant's individual health and care needs. *Example:* Program and care plan are co-designed with client, carer, GP, and geriatric nurse.	*Definition:* To enhance participants' physical resources and activate her coping abilities to continue living at home independently. *Example:* The complex therapy program helps patients to exercise alone and eat a healthy diet.	*Definition:* Living safely and independently at home but closely monitored. *Example:* Medication plan is monitored by home health nurse paying visits. Home adaptation for fall prevention.	*Definition:* The complex therapy program is designed to keep older patients out of the hospital as long as possible. *Example:* RMZ clinic serves as bridge between primary and hospital care, keeping costs down.
	SUR	*Definition:* Person-centeredness places emphasis on the user as being at the center of the activities and can decide what type and how much care he/she receives. The patient contributes to shaping service provision. *Examples:* The staff, in delivering care, emphasize what is important to the user; services are customized to the user's needs.	*Definition:* Examples such as avoiding hospital admissions, falls, and listening to the patient are part of a preventive way of working. *Examples:* A prevention-oriented way of working was one of the reasons why the project in Surnadal was established. The HPH team has a plan for the care/systematic way of working/use of checklists.	*Definition:* Examples such as medication reviews, preventing fire and falls in the home, and supporting users in dealing with medication are part of safety. *Example:* Mapping of user's home with regard to safety and security.	*Definition:* Efficiency could mean many things, for example, some staff members are more scrupulous than others. *Example:* Hiring experienced/qualified staff, a systematic way of working with clearly defined roles and responsibilities for staff and use of checklists; co-location of staff.
	SON	*Definition:* Services are not to be imposed on the user; what is important to the user should be identified, and the user sets his/her goals. *Examples:* The staff make an effort to deliver services in accord with what is important to the user, but they sometimes face challenges from the Application Office–who review and approves users' applications for Everyday Rehabilitation at Home (ERH) services.	*Definition:* Avoiding readmissions and falls are examples of a prevention oriented way of working. *Examples:* The staff look out for hazards (e.g., loose rugs) in the user's home; and they work with users to develop their sense of mastery and independence.	*Definition:* Medication reviews, and preventing abuse and fire and falls in the home are part of safety. *Example:* Users have a safety alarm and are encouraged to call the staff if a need arises—and the staff respond immediately. Staff review users' medications and check users' homes for safety.	*Definition:* It has to do with the staff's ability to work well under pressure. *Examples:* An effort is made to organize and distribute the roles and responsibilities of staff in a manner that encourages efficiency, but some imbalances persist.

Table 20
Interpretation and understanding of SUSTAIN core domains

		Person-centeredness	Prevention orientation	Safety	Efficiency
The Netherlands	GCM	*Definition:* Shared decision-making and focus on the needs of the user. *Example:* Developing a care plan based on structured needs assessment and discussing care plan with the older person.	*Definition:* Prevent further deterioration of current condition, and preservation of autonomy and quality of life. *Example:* Identifying all frail older people in their general practice using a case-finding tool (PRISMA-7).	*Definition:* Living safely at home, and self-efficacy and independence in all domains of life. *Example:* Giving attention to living safely at home (e.g. falling) during needs assessment.	*Definition:* Short lines of communication between professionals, and clear definitions of roles and responsibilities. *Example:* Multidisciplinary consultations in which several health professionals get together to discuss complex cases.
	WICM	*Definition:* Focusing on the person behind the patient, and his/her wishes and needs. *Example:* A personal care plan is made, together with the client and the informal carer.	*Definition:* Early awareness of vulnerability (and possible reasons), not only medically, also socially. *Example:* Frail older people are identified with the Groningen Frailty Indicator (GFI) survey.	*Definition:* How frail older people live in their own homes and whether that is still safe, firstly for themselves, secondly for their environment. *Example:* The WICM uses the safety criteria of the Dutch government, however: every individual case is different.	*Definition:* Frail older people are the starting point, they must be able to live their lives as they want, without being interrupted by our working processes. Working together and making good arrangements to organize that as efficient as possible. *Example:* Quick working processes, older people need only to tell their story, needs and wishes once.
United Kingdom	DH2A	*Definition:* Understanding the individual and acknowledging their needs and wishes to ensure that the user is supported and involved in the way that they want to be supported. *Example:* Focusing on users' holistic needs to enable them to live as independently as possible as close to home as possible. Empowering the user by providing them with information and options.	*Definition:* Prevention is about stopping blockages (e.g. falls, social isolation, carers no longer coping) from happening before they reach crisis point through better coordination and communication. *Example:* Ensuring all practitioners involved in a user's care plan (e.g. GP, carer, district nurse) are aware and understand the user's medication plan when the user is discharged from hospital.	*Definition:* Ensuring users and carers remain safe within their homes & communities. *Example:* Working collaboratively with "Staying Put" who conduct home safety checks.	*Definition:* Ensuring teams work in a way that saves the organisation money, while still improving services and meeting organisational and user objectives. *Example:* Emphasis on enabling users to be discharge home sooner to improve their outcomes and shorten length of stay (and reduce delayed discharges from hospital).
	O75	*Definition:* Understanding the user's needs and providing the services and the care that are most appropriate and in line with their wishes. *Example:* Emphasising users' empowerment and self-management based on a user's holistic needs.	*Definition:* Avoiding crises for users by preventing a problem further down the line. *Example:* Advanced care planning in place to ensure services will be in place when a crisis does happen.	*Definition:* The term encompasses a broad range of issues including, medication safety, falls prevention, neighbourhood safety. *Example:* Ensure all practitioners are aware of care plan and medication plan and checking users' medication to ensure no out-of-date or inappropriate medication remains in their homes.	*Definition:* Ensuring practitioners are working in an efficient way is important. *Example:* Emphasis on preventing hospital admissions and ensuring users are cared for in the community.

Table 20
Interpretation and understanding of SUSTAIN core domains

Table 21
Barriers and facilitators to coordination and integration

	Barriers	Facilitators
System level	• Lack of adequate and/or sustainable funding • Separation within health systems and between health and social care systems	• Supporting national/ regional policy • Financial incentives for innovative forms of care
Organisational level	• Difficulty collaborating with professionals from other organizations (lack of coordination and communication) • Lack of well-defined roles and responsibilities • Difficulty sharing information (e.g. no joint IT systems, privacy issues) • Lack of monitoring and evaluation of the initiative	• Strong leadership • Training and coaching opportunities
Staff level	• High workload staff	• Motivated/committed staff • Person-centred and prevention oriented way of working
Client level	• Low involvement of patients and carers	

Second, at all sites stakeholders reported that they encounter issues with funding of the integrated care initiative, partly because of the organisational complexity and separation within health organizations and between health and social care organisations. Funding mechanisms for integrated care are very different across the participating countries, although in almost all countries, the government and/or health or long-term care insurer (partly) fund the implementation of the initiatives. However, while resources for necessary activities are available for one of the initiatives in Estonia, in all other initiatives, the availability of resources for providing integrated services is very limited, and the initiatives in Spain (Catalonia) do not even have funds specifically earmarked for them. In addition, several projects providing coordinated and integrated care have temporary funding structures, creating a sense of insecurity about the initiatives, while the sustainability of the programs is partly dependent on security of structural funding.

Related to this is the high workload experienced by staff. Due to constrained funding and difficulties in recruiting and retaining skilled nursing staff (for example because of poor remuneration), staff struggled with understaffing and hence disproportionate workloads. This in turn leads to less time and energy available to receive training and coaching. Furthermore, it negatively influences the delivery of coordinated care since the pressure of a high workload constrains staff's willingness and capacity to seek and invest in alignment with other health and social care professionals. A stakeholder of one of the initiatives in the Netherlands indicated that structural funding is necessary to invest in extra staff and workplaces, which might relieve some of the professionals' high workload.

Also (partly) related to financial constraints, is the lack of or non-optimal functioning of shared IT systems between care providers involved (e.g. to share individual care plans, patient files etc.) which results in inefficiencies in coordinated care planning and delivery. In one of the initiatives in Spain (Catalonia), however, health professionals have access to IT platforms, which are shared with all health care providers at the local and regional level (i.e. Autonomous Community level); yet basic social services do not have access to this IT platform.

4.4.2 Facilitators to coordination and integration experienced at fourteen sites in Europe

In addition to the just described barriers, the stakeholders at the sites also mentioned some facilitators to coordination and integration of care. First, at many sites, staff have high workplace motivation and are very willing to improve (the level of integration of) their services. However, as described above, high workloads and financial constraints may negatively affect their motivation.

Secondly, stakeholders of several initiatives indicated that staff were supported by strong and positive leadership/ management, which was motivating and acted as an important bridge between the stakeholders from different organizations involved. In one of the initiatives in the Netherlands, however, managers indicated that there will be a gap in leadership with the retirement of one of the initiators of the initiative, yet strong leadership is necessary to develop a shared vision between care organizations to strengthen their position towards the insurers.

A third facilitator to coordination and integration of care mentioned by several stakeholders is the proactive/preventive and the person-centred approach towards delivery of care. Within both initiatives in the Netherlands, different methods have been used to identify frail older people at an early stage, for example, using criteria such as age, multimorbidity and medication use, using a case-finding tool (PRISMA-7 and GFI-survey) or using the GP's intuition. In one of the initiatives in Austria, the managers and the professionals stressed that focusing on the person rather than the symptoms is central to care delivery. Also in one of initiatives in Norway, staff and management acknowledged that person-centredness and prevention-orientation are central aspects in their way of working. However, according to the staff and the users and carers, this initiative is underperforming in the area of person-centeredness, considering that the users and carers were not sufficiently involved in goal setting and care planning and some of the users' needs were not met.

Text box 3

Several initiatives encounter lack of adequate and/or sustainable funding of the integrated care initiative. In Germany, a new national innovation fund encourages health insurers and service providers to submit innovative projects in the fields of care for older people, care for disabled people, and geriatric care, as well as new collaborative consortia (integrated care, multi-professional networks of care).

Most initiatives encounter problems with the lack of or non-optimal functioning of shared IT systems between care providers involved. In one of the initiatives in Spain (Catalonia), there is a local IT platform shared by the specialized care settings in which professionals have access to patient's information. In addition, there is another IT platform at the Autonomous Community level, the HC3, which contains the health records and is shared between specialized and primary care levels.

Furthermore, some of the exploratory interviews showed that carers and users were not sufficiently involved in goal setting and care planning. In one of the initiatives in the Netherlands, the practice nurse involves the older person in the decision making regarding his/(her care process by developing a care plan based on a structured needs assessment and then discussing this care plan with the older person using motivational interviewing techniques. The older person's needs, preferences and priorities are thus taken into account and evaluated regularly.

Above-mentioned barriers and facilitators indicated that initiatives might encounter an issue in a certain area whereas other initiatives work on this issue or are embedded in a facilitating context with regard to this specific issue. The examples below (Text box 3) show experiences from SUSTAIN initiatives that might be a response to certain barriers or issues encountered by other initiatives participating in SUSTAIN.

4.5 Areas for potential improvement at fourteen sites in Europe

Based on exploratory interviews and the first workshops, fields for potential improvement were explored, which led to a variety of possible improvement projects suggested by stakeholders at the sites. The sites differ in where they are in the process of defining a specific improvement project. Some sites have just held their first stakeholder workshop in which potential fields for improvement were explored, whereas other sites have already selected one field for improvement, and some sites have already planned a steering group meeting for further development and implementation of one specific improvement project.

The focus of the (potential) improvement projects might be categorized into the organizational, staff level and client level. Although the contexts in which the fourteen initiatives operate and their characteristics differ, as discussed in sections 4.1 and 4.2, similar areas for improvement were mentioned. As shown in the barriers to coordination and integration, several initiatives encounter problems in the communication and coordination across participating (health and social care) organizations. As a result, many of the (potential) projects aim to improve communication and collaboration across involved professionals/organizations, including information sharing (within and between organizations), defining roles and responsibilities, and stakeholder engagement to raise awareness of the initiative across the local health and care system. However, stakeholders indicate that both issues with IT systems and funding might challenge the implementation of these projects. In addition, there were a number of project proposals at the organizational level, in which stakeholders indicated an interest in evaluating the performance and impact of the initiative.

At the staff level, two improvement projects focus on offering (shared) training and competence building for involved professionals. Furthermore, a number of projects focus on improving the patient's situation, i.e. prevention and patient empowerment, involving users and informal carers in the care process and providing users information about services.

4.6 Next steps

This chapter shows that the factors that either facilitate or impede the implementation of integrated care are often similar in the different initiatives, despite apparent differences in the characteristics of the sites and the contexts that surround them. In line with similar facilitators and barriers at the sites, also similar areas for improvement were mentioned. In the next phase in the SUSTAIN project, the implementation of the selected improvement projects at the different sites, SUSTAIN's research partners will keep track of the processes at the sites and the impact of the improvement projects, and discover the extent to which these are related to the characteristics of the sites and the contexts that surround them. Observations will be shared

with sites, and exchanged between sites to facilitate that sites can learn from each other's experiences. Furthermore, overarching analyses will be undertaken to compare data from the different sites to robustly identify what works for whom, in what context and with what outcome.

During this first phase of the SUSTAIN project, we recognised that availability and consistency of the data collected, for comparative purposes varied to some extent. We intend therefore to give further attention to our guidelines for data collection and analysis (while taking into account characteristics of the initiatives and local contexts), in the course of the entire SUSTAIN project to be able to compare the initiatives and draw reliable conclusions.

5. CONCLUSION

Georg Ruppe, Paulina Wosko, Nhu Tram, Borja Arrue

The project partners from seven countries represented in the SUSTAIN project have collected data between September 2015 and May 2016 and established working relationships with two integrated care initiatives in their respective country (Austria, Estonia, Germany, Norway, Spain, The Netherlands and the United Kingdom). These initiatives were selected based on their level of integration, objectives of the initiative and target group. Baseline assessments were then carried out in each country to understand the status and development of integrated care in the partner countries and where improvements were needed.

This SUSTAIN European Report presented thus the fourteen sites with their characteristics, their status and level of development of integrated care, their areas for potential improvement and finally the selected improvement project per site that will be implemented and evaluated during the next stages of the research process.

Addressing the challenges associated with an ageing population and motivated in part by the need to contain healthcare costs, various national reforms were designed to improve care for older people, such as the Norwegian Coordination Reform or the National Care for the Elderly Programme in the Netherlands. Whereas national support is considered a major asset, most of the time, the implementation at the local level of these programmes or reforms is hindered by a number of barriers.

Although the fourteen initiatives are spread in seven different countries, some barriers mentioned by the local stakeholders are very similar and comprise in particular the following aspects: financial support, idiosyncratic division of responsibilities, fragmented governance structures, lack of communication flow between local stakeholders and a lack of cooperation between health and social workers. The financial support ensures not only the continuity of the local initiative, but also has an important impact on the quality of the provided service. Due to budget constraints, staff are often overburdened, which means they spend less time communicating with the patients, which is undermining the person-centered approach, and with other staff members, which impedes the information flow about the user within and between professional groups. Moreover, overburdened staff are often denied any opportunity to undergo extra training.

Each site was asked to select an improvement plan, depending on the identified weaknesses. The related objectives comprised the following aspects: improvement of the communication methods by developing a shared ICT system that allows information transfer between and among the sectors; increase the involvement of user and carers in care planning; set up of indicators and instruments to assess the initiatives; implement a better integrated approach with other sectors and specialists; a clearer focus on prevention and patients' empowerment; enhancing awareness raising about the existing initiative among providers; and creation of a common space where staff can meet and discuss the patient's case.

The selected improvement plans seem feasible and replicable in other European countries. Nonetheless, the context will play an important part in the success or failure of the set of improvements' implementation. Moreover, keeping the stakeholders engaged over a relatively long period of time with a potentially shifting context will not be straightforward.

However, the future research process in SUSTAIN will be widely dependent on the close cooperation between SUSTAIN partners and the individual sites. It is therefore of utmost importance to underpin this cooperation by enhanced networking and consulting to accompany the implementation and monitoring of individual improvement projects. The experiences during the initial stage of the research project will be an important starting point.

5.1 Selected lessons learned with respect to the research process

During the individual baseline assessments the researchers in the seven countries gained a number of insights how to select a "good practice site" with a potential for improvement in integrated care that could actually be developed and implemented:

- A potential "good practice site" should not be in status of a timely limited project itself but should represent a sustainable initiative with an appropriate organisational infrastructure.
- The health and care services of the selected site should have reached a certain level of integration and co-operation with professional partners already.
- It is important that the responsible management of the site understands and fully supports the process of developing and implementing an improvement project. This commitment should be underlined by a 'letter of interest'.
- A site should have the capacity to meaningfully collaborate with an external partner (e.g. SUSTAIN), and staff must be able to define and implement an improvement project for their initiative, also in terms of funding and personnel resources. Lack of or limited funding, staff shortages, and inadequate motivation by staff or management are major risks that may threaten the successful implementation of the improvement project.
- Selected sites must designate at least one contact person who can serve as a liaison between the external partner and the site to facilitate communication and coordination when organising collaborative activities.

Based on the experiences made the following lessons can be learned when preparing and performing a stakeholder workshop or steering group in the future, e.g. by other partners in other countries:

- The composition of the participants is crucial. It is therefore important to invest time and effort in recruiting and briefing the key-stakeholders and to attract key decision-makers to represent the individual stakeholders.
- It is useful to involve stakeholders responsible for funding, both from within the selected organization and from third parties. This might open new opportunities for funding improvement projects.
- Stakeholders should be invited by management of the selected initiative using existing networks and relationships. This will facilitate commitment, participation and the establishment of a working relationship.
- As a research organization it is necessary to remain flexible in the light of initiatives that are faced with time and/or budgetary constraints. It might be necessary to adjust time schedules or the entire agenda of workshops to accommodate participants' needs while also ensuring that the goals of the workshop are met. A short and focused agenda is more likely to work well than a long one involving too many activities. Do not ask too much time and/or energy of the participant!
- Expectations and general framework conditions need to be defined and communicated well (what do we expect from them, what can they expect from us).
- A phase of irritation and confusion is normal in each group process. Such irritations need to be taken seriously and, even if they need additional time, they have priority! However, keep your objectives in mind and bring the discussion 'back to the roots' at a point where general misunderstandings (e.g. 'the entire system needs to be changed') have been clarified.

6. REFERENCES

Agustí, E., Casas, E., Brosa, F., Argimón, JM. (2006). Aplicación de un sistema de pago basado en la población en Cataluña. In: Ibern, P. (Eds.). Integración asistencial: fundamentos, experiencias y vías de avance. Barcelona: Masson.

Barr VJ, Robinson S, Marin-Link B, Underhill L, Dotts A, Ravensdale D, Salivaras S. (2003). The expanded Chronic Care Model: an integration of concepts and strategies from population health promotion and the Chronic Care Model. Hosp Q. 7:73-82.

Best A., Greenhalgh T., Lewis S., Saul J.E., Carroll S., Bitz J (2012) Large-System Transformation in Health Care: A Realist Review. *The Milbank Quarterly.* 90 (3) 421-456.

Beter Oud. (2016). *The National Care for the Elderly Programme* Retrieved from http://www.beteroud.nl/ouderen/dutch-national-care-programme-for-the-elderly.html.

Billings, J. and De Weger, E. (2015). Contracting for integrated health and social care: a critical review of four models. *Journal of Integrated Care.* 23: 153-175.

Billings, J., Leichsenring, K. (2005). Integrating Health and Social Care Services for Older Persons. Evidence from Nine European Countries. Public *Policy and Social Welfare.* 31.

Boshuizen, D., Engels, J., Versleijen, M., Vlek, H., Rebel, M., and Driessen, S. (2014). *White paper: how to be successful in delivering person-centred care? (in Dutch).* Utrecht, Vilans.

Buck D., Maguire D (2015) Inequalities in life expectancy. Changes over time and implications for policy. The King's Fund.

Cantero, MJ. (2014). [More on the Royal Decree-law 16/2012 and its urgent measures to guarantee the sustainability of the National Health System in Spain]. *Gac Sanit.* 28(5):351-3.

Cash-Gibson, L. and Rosenmoller, M. (2014). Project INTEGRATE - a common methodological approach to understand integrated health care in Europe. *International Journal of Integrated Care.* 14: 1-11.

Central Intelligence Agency (2015). The World Factbook Norway. Retrieved from https://www.cia.gov/library/publications/the-world-factbook/geos/no.html.

Curry, N., Harris, M., Gunn L.H., et al (2013). Integrated care pilot in north-west London: a mixed methods evaluation. *International Journal of Integrated Care.* 13: 1-5.

De Bruin, SR., Versnel, N., Lemmens, LC., Molema, CC., Schellevis, FG., Nijpels, G., et al. (2012). Comprehensive care programs for patients with multiple chronic conditions: a systematic literature review. *Health Policy.* 107(2-3):108-45.

Epping-Jordan JE, Pruitt SD, Bengoa R, Wagner EH. (2004). Improving the quality of health care for chronic conditions. *Quality and Safety in Health Care.* 13:299-305.

Eurostat: your key to European statistics. Population (demography, migration and projections). http://ec europa eu/eurostat/web/population-demography-migration-projections/statistics-illustrated 2016a [cited 2016 Jan 14].

Eurostat: your key to European statistics. Employment and Unemployment. http://ec europa eu/eurostat/web/lfs/statistics-illustrated 2016b [cited 2016 Jan 14].

Federal Ministry of Labour, Social Affairs and Consumer Protection (2015). Informationen zum Pflegegeld. Retrieved from https://www.sozialministerium.at/cms/site/attachments/1/1/8/CH3434/CMS1451986636107/pflegegeld_leicht-lesen.pdf.

Freeman M., Miller C., Ross N (2000) The impact of individual philosophies of team work on multi-professional practice and the implications for education. Journal of Interprofessional Care. 14 (3) 237-247.

Garcia-Armesto, S., Abadia-Taira, MB., Durán, A., Hernández-Quevedo, C., Bernal-Delgado, E. (2010). *Spain Health system review: Health Systems in Transition.*

Giannakouris, K. (2008). *Ageing characterises the demographic perspectives of the European societies* - Issue number 72/2008 - Product - Eurostat. Retrieved 15 March 2016, from http://ec.europa.eu/eurostat/en/web/products-statistics-in-focus/-/KS-SF-08-072.

Glendinning C., Hudson B., Hardy B., Young R (2002) *National Evaluation of Notifications for the Use of the Section 31 Partnership Flexibilities in the Health Act 1999: Final Report.* National Institute of Health and National Primary Care Research & Development Centre.

Glimmerveen, L., and Nies, H. (2015). Integrated community-based dementia care: the Geriant model. *International Journal of Integrated Care, 15 (6). 15(6).*

Global Burden of Disease Study 2013 Collaborators. (2015). Global, regional, and national incidence, prevalence, and years lived with disability for 301 acute and chronic diseases and injuries in 188 countries, 1990-2013: a systematic analysis for the Global Burden of Disease Study 2013. *Lancet.* 386(9995):743-800.

Gress, S., Baan, C.A., Clanan, M., Dedeu, T., Groenewegen, P., Howson, H., Maroy, L., Nolte, E., Redaèlli, M., Saarelma, O., Schmacke, N., Schumacher, K., van Lente, E.J., Vrijhoef, B. (2009). Co-ordination and management of chronic conditions in Europe: The role of primary care - Position paper of the European forum for primary care. *Quality in Primary Care.* 17:75-86.

Health Foundation (2013) *Improving patient flow: How two trusts focused on flow to improve the quality of care and use available capacity effectively.* Retrieved from http://www.health.org.uk/publication/improving-patient-flow.

Heløe, L.A. (2010). *Health services at one level of governance?* [Helsetjenesten under ett forvaltningsnivå?]. Stat & Styring, (4), 9-15. Retrieved from https//www.uio.no/.

Hofmarcher, M. and Quentin, W. (2013). Austria: Health system review, *Health Systems in Transition,* 15(7), 1-291.

Howarth M., Holland K., Grant M.J (2006) Education needs for integrated care: a literature review. *Journal of Advanced Nursing.* 56 (2) 144-56.

Institute of Race Relations (2016a): *Ethnicity and Religion Statistics.* Retrieved from http://www.irr.org.uk/research/statistics/ethnicity-and-religion/.

Institute of Race Relations (2016b): *Health and Mental Health Statistics.* Retrieved from: http://www.irr.org.uk/research/statistics/health/.

Jackson, C.L., Nicholson, C.N., Doust, J., Cheung, L., O'Donnell J. (2008) Seriously working together: integrated governance models to achieve sustainable partnerships between health care organisations. *The Medical Journal of Australia. 188 (8) 57-60.*

Keese, M. and Manca, F. (2015, July). *How does Norway compare? OECD Employment Outlook 2015.* Retrieved from http://www.oecd.org/norway/Employment-Outlook-Norway-EN.pdf.

Kent County Council (2016a): How to get social care help from us. Retrieved from http://www.kent.gov.uk/social-care-and-health/care-and-support/how-to-get-help.

Kent County Council (2016b): Paying for care and support. Retrieved from http://www.kent.gov.uk/social-care-and-health/care-and-support/paying-for-care.

Kingsfund *(no date). Future Trends.* Retrieved from http://www.kingsfund. org.uk/time-to-think-differently/trends / demography#messages.

Leichsenring, K., Billings, J. and Nies H. (2013). Long Term Care in Europe – Improving Policy and Practice. Basingstoke: Palgrave Macmillan.

Mayolas, E., Vargas, I. (2003). La Sanitat en Catalunya: situació actual i perspectives de futur. In: Cambra Oficial de Comerç. Memòria Econòmica de Catalunya: any 2002. Cambra Oficial de Comerç, Indústria i Navegació de Barcelona (Eds.) (p.279-295).

Ministry of Health, Social Services and Equality. *National Health System, Spain 2012.* Retrieved from http://www.msssi.gob.es/en/organizacion/sns/docs/sns2012/SNS012__Ingles.pdf.

Monitor (2015) *Moving healthcare closer to home.* Retrieved from https://www.gov.uk/guidance/moving-healthcare-closer-to-home.

Muntinga, M. E. (2015). Together toward transition, implementing a comprehensive care program for frail, older people in primary care (PhD thesis). Amsterdam, VU University Amsterdam.

NHS Choices (2016): *The NHS Structure explained.* Retrieved from http://www.nhs.uk/NHSEngland/thenhs/about/Pages/nhsstructure.aspx.

NHS Confederation *(no date)*: Details of 2016-17 Better Care Fund released by Department of Health. Retrieved from http://www.nhsconfed.org/resources/2016/01/details-of-201617-better-care-fund-released-by-department-of-health.

NHS England (2014) Understanding The New NHS: A guide for everyone working and training within the NHS.

NHS England (2015a) Enhanced service specification. Avoiding unplanned admissions: proactive case finding and patient review for vulnerable people 2015/16.

NHS England (2015b) Providing proactive care and avoiding unplanned admissions for vulnerable people: A Programme of Action For General Practice.

NHS England (2015c) The *Forward View* Into Action: Planning for 2015/16.

NHS England (2015d) *New care models – vanguard sites.* Retrieved from https://www.england.nhs.uk/ourwork/futurenhs/new-care-models/.

NHS England (2015e) *Supporting the vanguards.* Retrieved from https://www.england.nhs.uk/ourwork/futurenhs/new-care-models/support/.

NHS England (2016) Improving referral pathways between urgent and emergency services in England.

NHS England *(no date, a)*: Primary Care Co-Commissioning. Retrieved from https://www.england.nhs.uk/commissioning/pc-co-comms/.

NHS England *(no date, b)*: Better Care Fund Planning. Retrieved from https://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/.

Nuno, R., Sauto, R., Toro, N. (2012). Integrated care initiatives in the Spanish Health System/Experiencias de integracion asistencial en el Sistema Nacional de Salud de Espana: Abstracts from the Third Spanish Conference on Chronic Care, San Sebastian, 19-20 May 2011/ Resumenes de Comunicaciones al III Congreso Nacional de Atencion Sanitaria al Paciente Cronico, Donostia-San Sebastian, 19 y 20 de mayo del 2011. *Int J Integr Care.* 12(Suppl 2):e35.

OECD. (2011). Estonia: Long-term Care. Retrieved from http://www.oecd.org/estonia/47877618.pdf.

OECD. (2015a). Economic Survey of Estonia 2015 - OECD. Retrieved 1 April 2016, from http://www.oecd.org/eco/surveys/economic-survey-estonia.htm.

OECD. (2015b). Norway: Human development indicators. Human Development Report 2015. Retrieved from http://hdr.undp.org/en/countries/profiles/NOR.

Office for National Statistics (2012) Ethnicity and National Identity in England and Wales: 2011.

Office for National Statistics (2015) *Annual Mid-year Population Estimates, 2014.* Retrieved from http://webarchive.nationalarchives.gov.uk/20160105160709/http://www.ons.gov.uk/ons/rel/pop-estimate/population-estimates-for-uk--england-and-wales--scotland-and-northern-ireland/mid-2014/stb---mid-2014-uk-population-estimates.html.

Paat, G., and Merilain, M. (2009). *Long-Term Care in Estonia – Enepri.* Retrieved 1 April 2016, from http://enepri.eu/publications/long-term-care-in-estonia/*Palliative Care Team Graz and surroundings.* Retrieved from http://www.palliativbetreuung.ac.at/cms/beitrag/10088285/2964637/.

Poos, M., Bruggink, J., and Nusselder, W. (2014). *National Public Health Compass. Healthy life expectancy summarized (in Dutch).* Retrieved from http://www.nationaalkompas.nl/gezondheid-en-ziekte/sterfte-levensverwachting-en-daly-s/gezonde-levensverwachting/de-gezonde-levensverwachting-samengevat/.

Praxis, and TNS Emor. (2015). Vanemaealiste ja eakate toimetuleku uuring 2015. Retrieved 1 April 2016, from http://www.praxis.ee/tood/vanemaealiste-ja-eakate-toimetuleku-uuring-2015.

Riigi Teataja. (2001). Tervishoiuteenuste korraldamise seadus (Health Services Organisation Act). Retrieved from https://www.riigiteataja.ee/akt/110032011009.

Ringard, Å., Sagan, A., Saunes, I.S., and Lindahl, A.K. (2013). Norway: Health system review. *Health Systems in Transition,* 15(8): 1-162. www.euro.who.int/__data/assets/pdf_file/0005/95144/E88821.pdf.

Robben S., Perry M., van Nieuwenhuijzen L., et al (2012) Impact of Interprofessional Education on Collaboration Attitudes, Skills, and Behaviour Among Primary Care Professionals. *Journal of Continuing Education in Health Professions.* 32 (2) 196-204.

Romøren, T. I., Torjesen, D. O., and Landmark, B. (2011). Promoting coordination in Norwegian health care. *International Journal of Integrated Care, 11*(5). URN:NBN:NL:UI:10-1-101575 / ijic2011-127.

Røthing, M., Malterud, K., and Frich, J. C. (2015). Family caregivers' views on coordination of care in Huntington's disease: a qualitative study. *Scandinavian Journal of Caring Sciences.* 29(4), 803-809.

Sarquella, E. (2016). Claus per comprendre els serveis socials en escenaris d'atenció integrada. Dissertation at: Hospital Pere Virgili on 4-3-2016.

Schmidt, A.E., Winkelmann, J., Rodrigues, R. and Leichsenring, K. (2015). Lessons for regulating informal markets and implications for quality assurance – the case of migrant carers in Austria, *Ageing & Society.* 1-23.

Servinski, M. (2012). The Population of the European Union 2061. Quaterly Bulletin of Statistics Estonia. Retrieved from http://de.slideshare.net/Statistikaamet/eesti-statistika-kvartalikiri-12010-quarterly-bulletin-of-statistics-estonia-22010.

Shaw S., Rosen R., Rumbold B (2011) *What is integrated care?* Nuffield Trust Rand Europe, Ernst & Young LLP (2012) *National Evaluation of the Department of Health's Integrated Care Pilots.* Retrieved from http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/what_is_integrated_care_research_report_june11_0.pdf.

Statistics Netherlands. (2011). *Older people live independently at home for longer (in Dutch).* Retrieved from http://www.cbs.nl/nl-NL/menu/themas/bevolking/publicaties/artikelen/archief/2011/2011-3434-wm.htm.

Statistics Netherlands. (2014). *Population projections data (2012-2060*). Retrieved from http://statline.cbs.nl/StatWeb/publication/?VW=T&DM=SLNL&PA=81593NED&D1=a&D2=0&D3=0-1,3,8,13,18,23,2.

Statistics Netherlands. (2015). *Limitations in daily functioning of older people (in Dutch).* Retrieved from http://www.cbs.nl/nl-NL/menu/themas/gezondheid-welzijn/publicaties/artikelen/archief/2015/beperkingen-in-dagelijkse-handelingen-bij-ouderen.htm.

Statistics Norway. (2015, December 11). Population in urban areas. *[Befolkning og areal i tettsteder, 1. januar 2015]*. Retrieved from http://www.ssb.no/befolkning/statistikker/beftett/aar/2015-12-11.

Statistik Austria (2016). *Demographisches Jahrbuch 2014*. Retrieved from http://www.statistik.at/web_de/services/publikationen/2/index.html?includePage=detailedView&sectionName=Bev%C3%B6lkerung&pubId=539.

Struijs, J., Drewes, H. W., Heijink, R., and Baan, C. A. (2015). How to evaluate population management? Transforming the Care Continuum Alliance population health guide toward a broadly applicable analytical framework. *Health Policy, 119*(4), 522-529.

Suter, E., Oelke, N.D., Adair, C.E., Armitage, G.D. (2009). Ten Key Principles for Successful Health Systems Integration. *Healthcare Quarterly Toronto*. 13: 16-23.

Swartz, K. (2013). Searching for a Balance of Responsibilities: OECD Countries' Changing Elderly Assistance Policies. *Annual review of public health, 34*, 397-412.

Tjerbo, T., and Kjekshus, L. (2005). Coordinating health care: lessons from Norway. *International Journal of Integrated Care,* 5(4).

Uittenbroek R.J., Reijneveld S.A., Stewart R.E., et al (2015) Development and psychometric evaluation of a measure to evaluate the quality of integrated care: the Patient Assessment of Integrated Elderly Care. *Health Expectations.* [Epub ahead of print].

Valentijn, P. P., Boesveld, I. C., van der Klauw, D. M., Ruwaard, D., Struijs, J. N., Molema, J. J., . . . Vrijhoef, H. J. (2015). Towards a taxonomy for integrated care: a mixed-methods study. *International Journal of Integrated Care, 15*, e003.

Van Campen, C. (Ed.) (2011). *Frail older people (in Dutch*). The Hague, the Netherlands Institute for Social Research/SCP.

Van der Heide, I., Snoeijs, S., Gabriella Melchiorre, M., Quattrini, S., Boerma, W., Schellevis, F., et al. *Innovating care for people with multiple chronic conditions in Europe: an overview*. Utrecht: NIVEL; 2015.

Van Hout, H. P., Jansen, A. P., Van Marwijk, H. W., Pronk, M., Frijters, D. F., and Nijpels, G. (2010). Prevention of adverse health trajectories in a vulnerable elderly population through nurse home visits: a randomized controlled trial. *Journals of Gerontology Series A: Biological Science and Medical Science, 65*(7), 734-742.

Wagner EH, Bennett SM, Austin BT, Greene SM, Schaefer JK, Vonkorff M. (2005). Finding common ground: patient-centeredness and evidence-based chronic illness care. *Journal of Alternative and Complementary Medicine*. 11 Suppl 1:S7-15.

Winkelmann, J., Schmidt, A.E. and Leichsenring, K. (2015). 'Regulating migrants as a low-cost solution: The formalisation of a dual care labour market in Austria'. In: N. Morel and C. Carbonnier (Eds.) At your service? The political economy of household services in Europe. Basingstoke, Palgrave Macmillan. (p. 172-195).

Wisløff, N. F., Agledal, S. A., Hillesund, E., Lurås, H., Buschmann, E., Windspoll, R. J., Sellæg, W. F., Haga, D., Kolås, G., and Åm, T. (2005). Fra stykkevis til helt: En sammenhengende helsetjeneste. Lobo Media AS: Norway.

World Health Organization. (2015). Norway: WHO statistical profile. Retrieved from http://www.who.int/gho/countries/nor.pdf?ua=1.

World Health Organization (WHO) (2015b). *WHO global strategy on people- centered and integrated health services: Interim Report.* Geneva: WHO.

7. ANNEX

7.1 Appendix I: Baseline assessment instruments

Title	Qualitative/ Quantitative
Service-user interview schedule	Qualitative
Carer interview schedule	Qualitative
Exploring contextual issues with managers and professions	Qualitative
Characteristics of the initiative	Quantitative
Stakeholder analysis	Quantitative
Stakeholder group Workshop 1 design	Qualitative

Instruments are available from the authors.

7.2 Appendix II: Baseline assessment analysis templates

Title	Qualitative/ Quantitative
Template for analysing baseline interviews	Qualitative
Database Baseline Interview User	Quantitative
Database Baseline Interview Carer	Quantitative
Database Exploring contextual issues with manager	Quantitative
Database Exploring contextual issues with professional	Quantitative
Database Characteristics of Initiative	Quantitative

Instruments are available from the authors.

7.3 Appendix III: Consortium partners

Project management:
Caroline Baan, Simone de Bruin, Giel Nijpels

Project partners:
Austria
Österreichische Plattform für Interdisziplinäre Alternsfragen (OEPIA)
Kai Leichsenring (until March 2016), Georg Ruppe, Paulina Wosko

Belgium
Age Platform Europe
Borja Arrue, Maude Luherne (until April 2016), Nhu Tram

Catalonia (Spain)
L'Agència de Qualitat i Avaluació Sanitàries de Catalunya (AquAS)
Gabriela Barbaglia, Carme Carrion (until April 2016), Laia Domingo, Mireia Espallargues Carrera

Estonia
SA Poliitikauuringute Keskus Praxis
Reelika Ermel, Eneli Mikko, Ulla-Karin Nurm, Gerli Paat-Ahi, Riina Sikkut

Germany
Stiftung Gesundheit
Peter Müller and Sophia Schlette

Ireland
European Health Management Association (EHMA)
Jeni Bremner (until April 2016), Michele Calabro', Usman Khan, David Smith,

The Netherlands
VU University Medical Centre
Manon Lette, Giel Nijpels

National Institute for Public Health and the Environment (RIVM)
Caroline Baan, Simone de Bruin and Annerieke Stoop

Vilans
Mirella Minkman, Henk Nies, Nick Zonneveld

International Foundation for Integrated Care
Nick Goodwin, Anne Hendry, Fiona Lyne, Viktoria Stein

Norway
Universitetet i Oslo
Eliva Atieno Ambugo, Terje Hagen, Silje Kathrine Vaage

United Kingdom
University of Kent
Jenny Billings, Erica Gadsby, Esther de Weger

London School of Economics and Political Science
Gerald Wistow

SUSTAIN

Sustainable tailored integrated care for older people in Europe

Paulina Wosko and Georg Ruppe (Editors)
Austrian Interdisciplinary Platform on Ageing / OEPIA

Vienna, June 2016