



Work Package 2: Executive summary

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1. Preface

This report constitutes the executive summary of the deliverable of work package (WP) 2 of the SELFIE project. The WP leader is the *Institute for Advanced Studies (IHS)* in Vienna, and the WP co-leader is the *August Pi I Sunyer Biomedical Research Institute (IDIBAPS)* in Barcelona.

The report is structured as follows: First, an overview of the SELFIE project is provided. Next, the background to this report is given. The remainder of the report is made up of summaries of 17 thick descriptions.

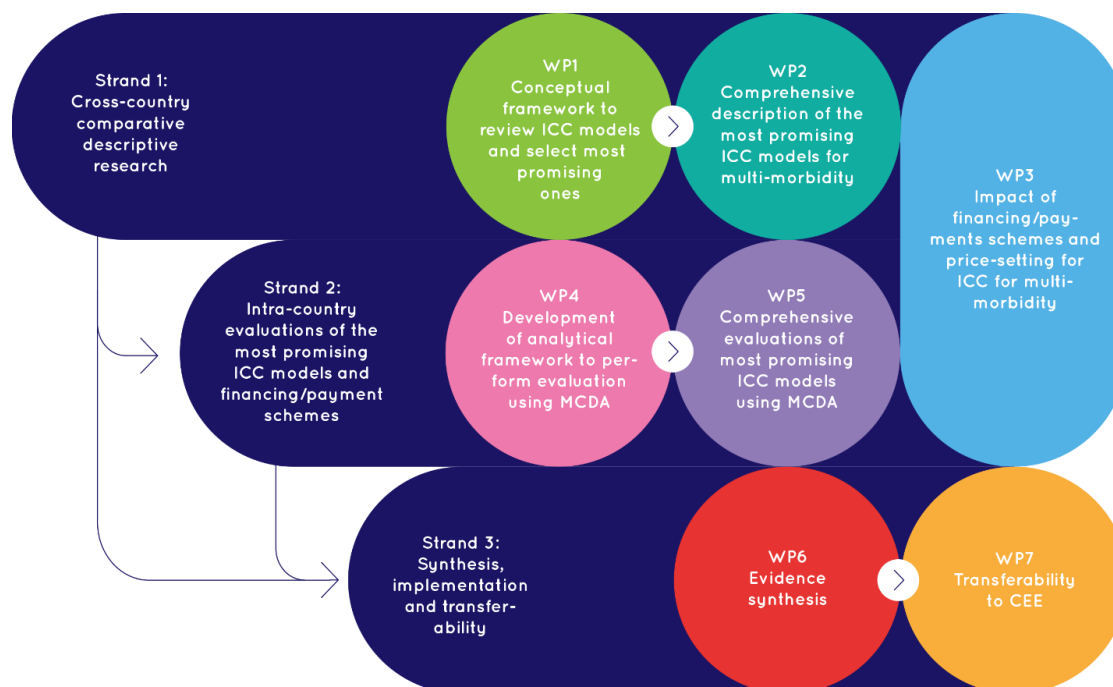
In the event that the reader should be interested in learning more about any of the 17 thick descriptions, please do not hesitate to contact the coordinators of the SELFIE project (info@selfie2020.eu), who can subsequently put you in touch with the authors of the respective thick description(s).

2. SELFIE project

SELFIE (Sustainable intEgrated chronic care modeLs for multi-morbidity: delivery, Financing, and performancE) is a Horizon2020 funded EU project that aims to contribute to the improvement of person-centred care for persons with multi-morbidity by proposing evidence-based, economically sustainable, integrated care programmes that stimulate cooperation across health and social care and are supported by appropriate financing and payment schemes. More specifically, SELFIE aims to:

- Develop a taxonomy of promising integrated care programmes for persons with multi-morbidity;
- Provide evidence-based advice on matching financing/payment schemes with adequate incentives to implement integrated care;
- Provide empirical evidence of the impact of promising integrated care on a wide range of outcomes using Multi-Criteria Decision Analysis;
- Develop implementation and change strategies tailored to different care settings and contexts in Europe, especially Central and Eastern Europe.

SELFIE strands of research and work package (WP) overview



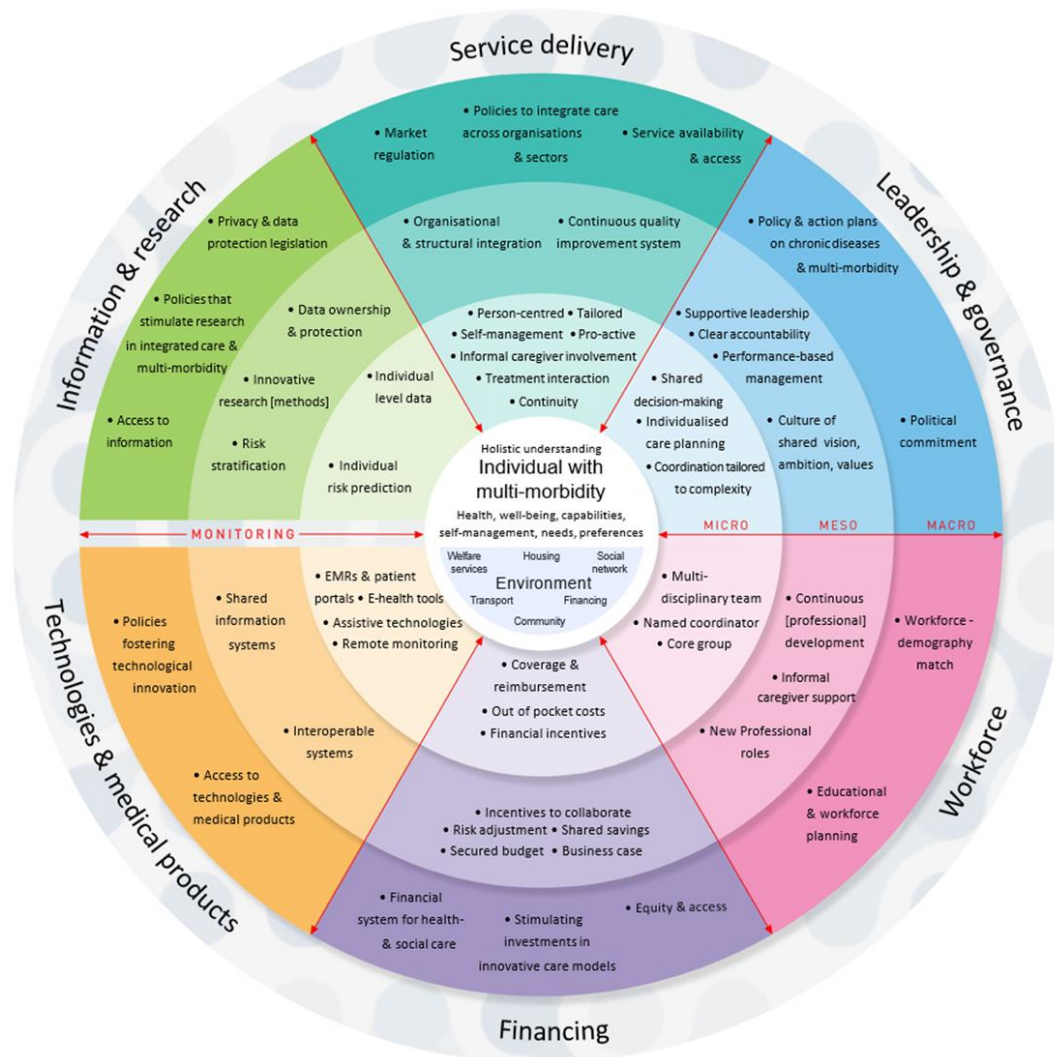
The SELFIE consortium stems from eight countries: the Netherlands (coordinator), Austria, Croatia, Germany, Hungary, Norway, Spain, and the UK.

3. Background

The overall objective of WP2 is to provide a detailed description of 17 best practice integrated chronic care (ICC) models for multi-morbid persons from the eight SELFIE partner countries. These promising practices were selected in WP1 of the SELFIE project.

The methodological approach chosen to describe the 17 programmes in detail is the “thick description”, a well-established qualitative empirical approach. The information necessary for this approach was gathered through document analyses as well as qualitative interviews with several stakeholders of the respective programmes. The results were structured according to the six elements of the SELFIE conceptual framework (see Figure 1) for integrated care for multi-morbidity, developed in the course of WP1: service delivery, leadership and governance, workforce, technologies and medical products, information and research/monitoring and financing.

Figure 1: SELFIE Framework for Integrated Care for Multi-Morbidity



The programmes presented in Table 1 were selected in WP1 and described in WP2. These programmes will be researched further in subsequent SELFIE WPs.

Table 1: Overview of programmes described in this report

Austria	1. Health Network Tennengau 2. Sociomedical Centre Liebenau
Croatia	1. GeroS 2. Palliative Care System
Germany	1. Casaplus 2. Gesundes Kinzigtal
Hungary	1. OnkoNetwork 2. Palliative Care Consult Service
The Netherlands	1. Proactive Primary Care Approach for Frail Elderly 2. Care Chain Frail Elderly 3. Better Together in Amsterdam North
Norway	1. Medically Assisted Rehabilitation Bergen 2. Learning networks for whole, coordinated and safe pathways
Spain	1. Badalona Serveis Assistencials 2. Àrea Integral de Salut, Barceolna Esquerra
United Kingdom	1. Salford Integrated Care Programme / Salford Together 2. South Somerset Symphony Programme

4. Executive Summaries

4.1. Austria

Health Network Tennengau

[Astrid Segert, Susanna Ulinski, Thomas Cypionka, Markus Kraus]

The Health Network Tennengau (HNT) is a bottom-up network comprised of social and health service providers and voluntary organisations. The Tennengau region is a rural area in the state of Salzburg. The HNT has its origins in a pilot project for medical home nursing care introduced in 1995 and has since gradually evolved into a comprehensive network. Since 2003, it has been organised as a not-for-profit cooperative that currently has 29 member institutions.

Service delivery

Service delivery within the programme is divided into 6 modules: (1) the core of the network, which coordinates the entire programme, (2) a counselling service for the elderly in municipalities, (3) cooperation and exchange of information with GPs and specialists, (4) geriatric remobilisation at the hospital in Abtenau, (5) cooperation with inpatient care for the elderly and with social and psychological services, and (6) discharge management and transition care at the public hospital in Hallein.

Leadership & governance

The HNT is organised as a not-for-profit cooperative comprising social and health service providers and voluntary organisations. The governance structure of the HNT is characterised by a climate of equitable cooperation between the small and large members of the network. Much effort is required from a communication perspective to uphold the contacts between the involved partners.

Workforce

Several new professional roles have emerged as part of the programme: A senior citizen's counsellor, who has a nursing background, assesses patients' needs, provides information and coordinates social and nursing care. A discharge manager, who also has a nursing background, works in the hospital and performs discharge risk screening and organises discharges. Plans also foresee the introduction of a mobile specialised wound nurse in the near future.

Technologies & medical products

The HNT uses a secure data network for patient data. This data network links the hospital and approx. 100 regional GPs and is well received by all partners involved. Specific ICT applications to be used by patients do not form part of the programme – the network instead stresses the importance of personal relationships.

Information & research

The counselling service has already been evaluated using a descriptive analysis of questionnaire data. The results of this evaluation were positive: patients use a variety of the services offered and feel they are better informed after counselling. The discharge management module has also been subjected to an evaluation involving a descriptive data analysis, a comparison of trial and control groups, as well as pre- and post-measuring. The results in this case were mixed: the re-hospitalisation rate was found to have

decreased through discharge management, but the aims of decreasing the length of stay and the extramural costs were only attained to a partial extent.

Financing

The HNT receives annual funding from the Salzburg health fund as well as project-based funding from various sources. Financing problems are omnipresent within the programme, resulting in limited compensation for the involved partners, a lack of resources for public relations work, as well as a lack of funding at the start of pilot projects. As a consequence, the HNT relies to a high degree on voluntary work.

Sociomedical Centre Liebenau

[Astrid Segert, Susanna Ulinski, Thomas Czypionka, Markus Kraus]

The Sociomedical Centre Liebenau (SMC) is a bottom-up pioneer model providing health and social care predominantly to vulnerable and disadvantaged groups. It is situated in the socially-deprived Liebenau district in the Austrian city of Graz and was founded by three physicians in 1984. It is currently organised as a collaboration between a group practice and the Association for Practical Social Medicine.

Service delivery

All activities at the SMC are based on a “social health and medicine approach” with a focus on inequality with respect to health and social status. Its target clientele are persons with physical and mental disorders and/or social problems. The SMC is operated by a multidisciplinary team of physicians, social workers and social pedagogues. This team provides both medical care (e.g. primary medical care, psychotherapy, addiction treatment, health promotion) and social care (e.g. various counselling services, community work). A continuous holistic assessment of the patient with an emphasis on social aspects is central to the SMC’s work, along with appropriate target group communication and joint case conferences.

Leadership & governance

The SMC involves both a group practice and the Association for Practical Social Medicine, which runs several social work, social care and health promotion projects. The SMC is characterised by a flat hierarchy in the cooperation between physicians, assistants and social workers.

Workforce

The SMC employs personnel with multiple qualifications in all positions, and the entire team participates in hiring decisions. Within the programme, new roles have been assumed by “old” professions, in particular the responsible participation of all staff in joint case analyses and the assumption of wound management duties by assistants.

Technologies & medical products

The SMC uses a specifically developed electronic data gathering and processing system. ICT applications used by patients are viewed critically for reasons of equitable access. However, there is a positive attitude towards the nationwide introduction of EMRs, as these can be used to monitor patients’ medication use and thus avoid prescription medication addiction.

Information & research

No comprehensive evaluation of the SMC has been carried out so far. Programme representatives would be highly interested in an evaluation, but have not as yet had the necessary resources to do so. The SMC's physicians furthermore engage in research activities in the field of social medicine.

Financing

The SMC receives annual funding from the regional health insurance fund as well as project-based funding from various sources. Some of the work within the programme is also done on a voluntary basis. Given the lack of a financing framework for group practices in Austria, financing is a central problem. The SMC is currently in negotiations regarding its future funding.

4.2. Croatia

GeroS

[Mirjana Huić, Romana Tandara Haček, Darija Erčević, Renata Grenković]

The GeroS programme represents an integrated care model for geriatric patients with multi-morbidity. The programme is currently still in its pilot phase and has therefore not yet been fully implemented at the national level.

Service delivery

GeroS is designed as a 15-module system for monitoring and evaluating the health needs and functional ability of insured persons over the age of 65 and, in particular, geriatric patients receiving corresponding care. One purpose of the programme is the digitalisation of all health and social care records for this age group. GeroS involves primary healthcare providers, specialists, hospitals, long-term care providers, homes for the elderly and centres for social care. Individual care plans, a person-centred attitude, proactive care and risk stratification form part of the programme. Management of polypharmacy and clinical guideline interaction will also be provided once the programme has been fully implemented. The programme is based on a holistic assessment of the multi-morbid person and informal caregivers. GeroS aims to rationalize geriatric healthcare through the categorization of elderly persons in institutional and non-institutional care. Self-management interventions are supported by indirect empowerment from the Reference Centre for Health Gerontology through educational material and guidelines.

Leadership & governance

The GeroS system is a subsystem of the Central Health Information System of the Republic of Croatia (CEZIH) and, as such, is inseparably linked to the latter. All health data which already exist in CEZIH are relocated to the GeroS system once an insured person turns 65. The 15 modules are being integrated into CEZIH on a step-by-step basis. In addition to health and social care providers, several patient associations, healthcare associations and one city foundation are also involved in the programme.

Workforce

New professional roles will be developed from already established professions. New professions will be characterised by the prefix "geronto" in order to indicate that they provide specific care to geriatric persons. Currently, the programme is confronted with a lack of educators.

Technologies & medical products

The digitalisation of health and social care records via a central database lies at the heart of the GeroS programme. Most of the ICT applications intended to be used in GeroS already exist in CEZIH. However, not all modules that are intended to be part of the GeroS system have as yet been fully integrated. There are however plans to extend the integration of modules to all levels of healthcare, as well as to strengthen the connection with the social care system. Furthermore, some homes for the elderly involved with the programme use a computer system named DOGMA, which integrates all individual documents and supports cooperation between all involved professionals.

Information & research

The primary focus of the GeroS programme is to systematically collect data on various determinants from health as well as social domains. A monitoring system for the programme has already been introduced, while a quality assurance system is still to be established.

Financing

The financing and payment scheme is based on national mandatory health insurance through the Croatian Health Insurance Fund for healthcare and services in homes for elderly persons for social care. Sustainability, however, is not guaranteed, and remains a barrier to the full implementation of the GeroS system.

Palliative Care System

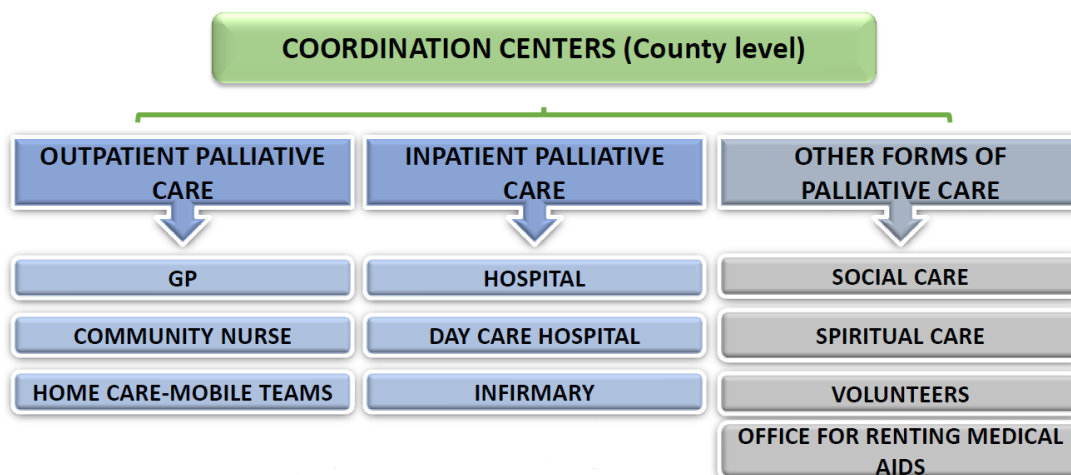
[Mirjana Huić, Romana Tandara Haček, Darija Erčević, Renata Grenković]

It is estimated that a minimum of 20% of cancer patients and 5% of non-oncological patients need palliative care in the last year of their life. The Palliative Care System is an integrated care programme specifically designed for palliative care patients; it is based on the Croatian National Healthcare Strategy and the Strategic Plan for Palliative Care 2014–2016. The system is planned to be introduced on a nationwide level, but is currently still in its pilot phase.

Service delivery

Stakeholders and resources exist in four key domains: the healthcare system, social welfare system, school/higher education system, and civil society. The Palliative Care System involves outpatient palliative care, inpatient palliative care, as well as extended forms of palliative care, as can be seen in the figure below. Coordination Centres for palliative care coordinate care between hospitals, ambulatory palliative care, (mobile) specialised palliative care teams and social care, providing vertical, horizontal and inter-sectoral cooperation and collaboration at the county level. Informal care givers and volunteers are included, as well as institutions for the renting of medical aids and devices. The care process is based on patient-centred care, organised around a palliative care patient. It is based on a holistic assessment of the palliative care patient: in addition to health care, it includes social care, spiritual care, and the individual's family.

Organisation of care in the Palliative Care System



Leadership & governance

Currently, the Palliative Care System is not fully integrated into the national healthcare system; it is a pilot-level project in different parts (counties) of Croatia. Changes in the legal framework are required for full implementation at the national level. The Committee for Palliative Care, appointed by the Ministry of Health, is responsible for further activities regarding the implementation of palliative care and the development of a new Strategic Plan for Development of Palliative Care in Croatia for the period after 2017. The strategic development of the palliative care system at national level is planned to be achieved through three key steps: 1) removing barriers to the provision of existing/potential forms of palliative care; 2) empowerment of all stakeholders in order to provide better palliative care in existing conditions; 3) improving the existing situation through the construction of new organizational structures.

Workforce

The Palliative Care System involves various professions, including physicians, nurses at different health institutions, community care nurses, psychologists, social workers, volunteers and informal caregivers, mobile teams, university staff and priests. Mobile multidisciplinary specialist palliative care teams, an example of a new innovative role in the Croatian palliative care model, are established at the county level. In Istria County, for example, the team is made up of a specialist in radiotherapy-oncology and two nurses as full-time permanent members, as well as various specialists from other medical fields as part-time members. Furthermore, the CEPAMET centre at the University of Zagreb's School of Medicine provides workshops on palliative care for different stakeholders.

Technologies & medical products

ICT applications such as electronic health records, internet applications, mobile phones and telemedicine are planned to be used in the future to enable sustainable links between the palliative care network. Currently, the Palliative Care System does not use a common IT system at the national level. However, some counties are already using special software to identify and monitor palliative patients.

Information & research

The introduction of continuous systematic data collection within the Palliative Care System as well as a national registry of palliative care patients are planned. A system to monitor target attainment according to the Strategic Plan for Development of Palliative Care is not yet fully established. However, questionnaires have been sent to primary healthcare centres, hospitals and counties to evaluate the extent to which certain elements of the Palliative Care System have already been established. The results are mixed: While some elements (e.g. cooperation with other institutions) have been widely established, others have not yet found their way into practice.

Financing

The financing and payment scheme is based on the national mandatory health insurance through the Croatian Health Insurance Fund for healthcare and services in homes for elderly persons for social care. Beyond regular funding, the Croatian Health Insurance Fund provides additional funds for 10 pilot projects in primary healthcare centres. Supplementary funding is also provided by some counties.

4.3. Germany

Casaplus

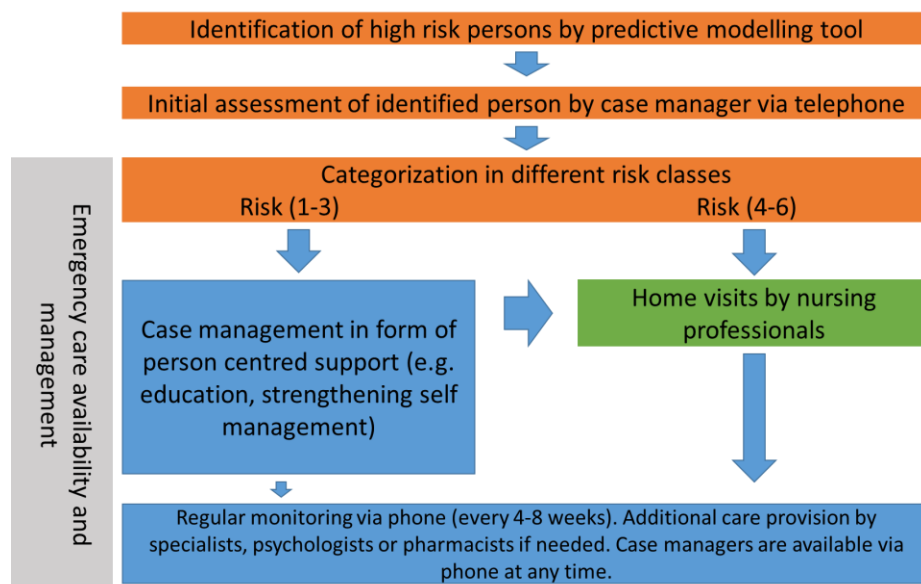
[Verena Struckmann, Anne Spranger, Sabine Fuchs, Ewout van Ginneken]

In order to improve and reorganise healthcare services for elderly people with multiple chronic diseases, the Casaplus case management programme was founded in April 2007. It addresses people over the age of 55 years with multiple chronic conditions and a high risk of hospital admission(s) within the next 12 months. The overall aim of the programme is to provide comprehensive, easy accessible and high-quality case management.

Service delivery

Service delivery within the Casaplus programme involves identification of high risk persons, an initial assessment, categorisation into risk classes and subsequent case management tailored to the individual person. The figure below provides further details on the process of service delivery.

Process of service delivery in the Casaplus programme



Leadership & governance

Contracted primarily by company-related health funds, Medical Contact AG (MeCo) set up the Casaplus programme, which covers multi-morbid persons throughout Germany. In 2016, 17 active service contracts between MeCo and the statutory (mostly company-related) and private sickness funds across Germany were in place. Further cooperation agreements are in place between MeCo and 177 local outpatient nursing services to conduct home visits.

Workforce

Trained case managers inform, advise, support and monitor the well-being of the elderly, multi-morbid persons enrolled in the programme. A nursing background and several years of work experience are prerequisites for becoming a case manager in the Casaplus programme. The case managers are the main

care providers, work according to current clinical practice guidelines, adapt immediately to the needs of the respective multi-morbid patient and share decision making. As part of the Casaplus care team, nursing professionals visit enrolled patients at home to assess the possible risk of falling, social risks and the risk of malnutrition. Informal carers are included in the care trajectory from the beginning, if applicable and required. Other professionals are also consulted if necessary: GPs, specialists, psychologists, pharmacists and care managers at the participating sickness funds. MeCo funds continuous training for case managers and nursing professionals.

Technologies & medical products

The Casaplus programme has developed an online platform to support regular communication between Casaplus case managers and nursing professionals. Access is restricted to the aforementioned professionals. Case managers use a documentation template as a tool to structure the information gathered during the initial assessment and during the regular telephone counselling. A personal electronic health record (EHR) is thus created for every patient enrolled in the Casaplus programme. The EHR data is used by case managers for care coordination, but not shared. Tools targeted at patients, for instance remote monitoring or access to their personal health record, are not used in the Casaplus programme.

Information & research

External and internal scientific evaluation has been an essential part of the programme since its inception. The focus of the evaluation is on the triple aim. The evaluation is conducted by MeCo using a pre-post evaluation with propensity score matched pairs of competency goals (health status, impairment, doctor-patient relationship, sustainability of behaviour change), care goals (quality of life, care status, utilization of outpatient care, utilization of supplementary services) and economic goals (costs for the utilization of inpatient care, pharmaceutical cost). The evaluation results of the 2014 client survey are positive: for instance, 97% of the participants are satisfied with the Casaplus programme, and 94% reported that the case manager provides useful advice. The programme results in annual savings per person compared to matched control.

Financing

It is important to note that the usual reimbursement schemes between statutory health insurers and MeCo are not replaced within the Casaplus programme. The contract agreement stipulates a profit-sharing of the yearly average hospital cost savings between MeCo and the sickness funds. Initially, MeCo and the participating sickness funds implemented a pay-for-performance model, but this did not yield the anticipated results. A constant capped payment amount per insured is used.

Gesundes Kinzigtal

[Verena Struckmann, Anne Spranger, Sabine Fuchs, Ewout van Ginneken]

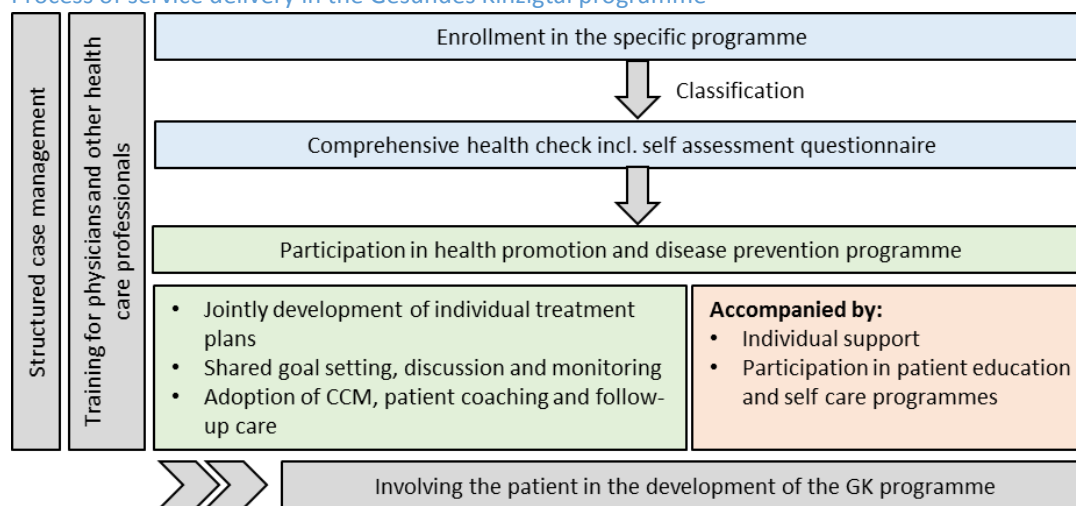
The Gesundes Kinzigtal (GK) model was founded in 2005 and is situated in the State of Baden-Württemberg, in the rural area of Southwest Germany. The GK model pursues a population-based approach that organizes care across all health service sectors and indications. The GK model is designed around the “triple aim” approach: improving the health of the population in the Kinzigtal region, improving the individual patient’s experience of care and, at the same time, reducing the per capita

costs of care. The overall aim is to foster patient self-management and enhance shared decision-making through individual care plans and shared goal agreements between the physicians and the patients.

Service delivery

After a patient has enrolled in the GK programme, a comprehensive health check is conducted. Based on this assessment, an individual care plan is developed in conjunction with the patient. Further details on the process of service delivery and accompanying measures can be found in the figure below.

Process of service delivery in the *Gesundes Kinzigtal* programme



Leadership & governance

Governance in the GK case is composed of the local physician network (MQNK), which owns 66.3% of GK GmbH, and OptiMedis AG, an independent health management organisation, which owns the remaining 33.7% of GK GmbH. Since the GK model prioritises strong stakeholder consensus building, the management organisation acts as a regional integrator and is responsible for the coordination of all providers in the network. Collaboration agreements are in place with sickness funds, GPs, nursing homes, community groups, 'World of Health', physiotherapists, hospitals and pharmacies. In addition to the usual healthcare providers, cooperations are also in place with 38 community groups, e.g. gyms or associations for persons with disabilities. Networking among participating providers and healthcare facilities is a priority in the GK programme.

Workforce

The GP is the main care provider, and patients are registered with a physician of their choice. This physician is named the 'doctor of trust' and acts as a healthcare coach. The patient and the physician jointly develop a treatment plan and set treatment goals, which are revised regularly. The introduction of a new professional role is currently in development. This new professional ("coordinator") will coordinate the care process and support the work of the GPs, with whom they will collaborate closely. Professionals in the GK programme receive continuous professional training, mainly at the 'Healthy Kinzigtal Academy' training and education institute.

Technologies & medical products

All participating physicians and other healthcare providers like outpatient nursing care services and hospitals have access to the electronic health record (EHR) and the cockpit reports. The EHR comprises a

standardized form of documentation, medical regime, information about allergies and intolerances, diagnosis and findings. The system-wide EHR enables information exchange, transparency and an improvement in the quality of care. Moreover, physicians use the cockpit reports, which contain, for instance, information on cost and performance, as digital benchmark information to compare the prescribing behaviour of the participating GPs. The use of benchmark information on drug prescriptions by means of the electronic patient files is innovative for Germany.

Information & research

Since the start of the contract (November 2005), comprehensive, scientific internal and external evaluations have formed an essential part of the GK model. The biannual written patient survey reveals that both the efficiency of services as well as people's experience with care provision have improved in the GK. So far, external and internal evaluations have shown that the interventions of the GK have resulted in better health outcomes compared to usual care: a reduction in hospital admissions of 20%, reduction in morbidity costs of 20% and a 10% lower mortality rate compared with other regions of Baden-Württemberg not enrolled in the GK model. Since the implementation of the GK model, the founders have proven the economic sustainability of the shared health gain approach and the corresponding shared savings contract. Overall costs have developed favourably compared to expected costs, with annual savings amounting to €5.5 million in 2013.

Financing

Without replacing the previous reimbursement schemes and financial flows between health insurers and individual healthcare providers, Gesundes Kinzigtal GmbH is now accountable for the whole (i.e. trans-sector) healthcare service budget for all people insured by AOK BW and LKK BW and living in the Kinzigtal region. Savings have to be realized in the Kinzigtal region compared to German standardized costs and to a reference period prior to the intervention. If savings occur, they are shared between the fund and OptiMedis AG. OptiMedis AG then shares its part of the savings among the physician network. The other service providers are not part of the shared savings. Providers (physicians, physiotherapists, nursing homes) receive an additional annual payment for the time they invest in the programme and the additional time they spend on patient care and follow up.

4.4. Hungary

OnkoNetwork

[János G. Pitter, Marcell Csanádi, Kata Csetneki, Zoltán Kaló, Mariann Moizs, Imre Repa, Antal Zemplényi]

OnkoNetwork is a local initiative in Somogy county aimed at improving clinical outcomes via timely access to quality assured, unfragmented healthcare.

Service delivery

For patients entering the centre with a suspected diagnosis of a new solid tumour, diagnostics must be completed in 30 days, and therapy must be initiated within a further 2 weeks. The same time goals apply for patients with multi-morbidity, with personalized diagnostics and stabilization of comorbidities in the 30-day window. Individual patient preferences regarding their treatment options are acknowledged. Since this model seeks to improve the severe coordination deficits within the healthcare system in Hungary, other aspects of care e.g. social, physical and mental needs and preferences, do not form part of its focus.

Leadership & governance

The OnkoNetwork is characterised by its strong leadership, who are fully committed to clear goals, in particular timely diagnosis and therapy initiation. Furthermore, accountability is ensured through escalating levels of quality assurance referrals, from technical clarifications to top management interventions.

Workforce

New professional roles have been established within the programme with respect to both physicians and non-physicians. For example, the new role of OnkoNetwork administrators, who have a non-physician assistant or administrator background, has been introduced. These administrators take over administrative tasks from department physicians, allowing the latter to allocate more of their time to professional tasks, including communication with patients. Furthermore, OnkoNetwork ensures that physicians work together as a multidisciplinary team when deciding on the recommended treatment.

Technologies & medical products

A tailored IT system for individual patient path monitoring and management has been developed as part of the OnkoNetwork programme. However, interoperability with other medical IT systems poses a challenge: data transfers across the systems are not fully automated, and have to be supplemented manually by the OnkoNetwork administrators.

Information & research

Due to the relatively short lifetime of the project (started in November 2015), no outcome analyses have been conducted so far. Beyond routine clinical data collection in the hosting institutions, OnkoNetwork specifically collects data on all enrolled patients through its tailored IT system. Data on patient experience are limited and currently focus on timely and equal access to care. OnkoNetwork does not collect patient-level economic data; this is only done by the national healthcare payer.

Financing

There is no specific coverage or reimbursement for OnkoNetwork services from any external source; the low operational costs are financed from the hospital's budget. Furthermore, there are no specific incentives for the participating professionals. Instead, the staff is motivated by the immaterial values represented by the project.

Palliative Care Consult Service

[Antal Zemplényi, Marcell Csanádi, Kata Csetneki, Zoltán Kaló, Ágnes Csikós, János G. Pitter]

The Palliative Care Consult Service (PCCS) programme is the first initiative in Hungary to provide palliative care within an acute care hospital (Medical Centre). The programme supports patient pathway management across providers (e.g. between acute care and home care).

Service delivery

The palliative care consultation service process consists of several steps. After a hospital physician requests consultation, an introductory assessment is conducted by the coordinator of the consultation service. Holistic assessment of the patient's need is a core element of the programme, which covers not only clinical information, but also physical and mental status, pain and other symptoms as well as performance status, social, spiritual and cultural aspects. The assessment aims to offer a treatment plan that is in line with the preferences of the patient and his/her family members. Further care is organised based on this treatment plan. The consultation service also includes subsequent patient follow-ups.

Process of service delivery in the Palliative Care Consult Service



Leadership & governance

The multidisciplinary programme team serves as a bridge between the clinical departments, home-based hospice palliative care, institutional hospice care and home-based social care to achieve a higher level of coordination in the palliative care process for seriously ill patients. Furthermore, there is a strong commitment to the programme on the part of the Medical Centre's management. Formalised agreements regarding the cooperation with partners do not as yet exist.

Workforce

The multidisciplinary team consists of a palliative coordinator, a physician and a psychologist; a dietician and a physiotherapist are also available. Cooperation among providers is facilitated by an overlap in human resources, since the members of the team work for multiple providers in parallel. Furthermore, the PCCS team is involved in under- and postgraduate medical education to support knowledge transfer for future physicians. The programme, however, faces risks with regard to staff retention, due to burnout, low income and the lack of priority in health policy.

Technologies & medical products

As part of the programme, the hospital's electronic referral system has been improved to support consultation requests and to keep record of the electronic documentation.

Information & research

The PCCS programme regularly analyses its activity, including the number of consultations, reasons for referral, time data on entering and leaving the palliative care process and leading symptoms at enrolment. Pain and performance status is also assessed and internal satisfaction surveys of the clinical department are carried out. However, no evaluation of the effects and outcomes has been conducted so far.

Financing

Currently, no direct reimbursement is provided for the operation of palliative consult services. The programme was initially funded by EU grant, which was a great incentive in the early phase. Additionally, an internal financing methodology is used to provide sufficient funding for its operation. The enhancement of the programme will require a dedicated financing method for the reimbursement of palliative consult services.

4.5. The Netherlands

Proactive Primary Care Approach for Frail Elderly (U-PROFIT)

[Fenna Leijten, Melinde Boland, Maaïke Hoedemakers, Apostolos Tsiachristas, Antoinette de Bont, Roland Bal, Maureen Rutten-van Mölken]

The Utrecht Proactive Primary Care Approach for Frail Elderly (U-PROFIT) is a nurse-led intervention for frail elderly (>60) living at home. The overarching aims are to transition from reactive to proactive elderly care, to preserve daily functioning, to improve quality of care and health and to reduce costs.

Service delivery

The care process in the U-PROFIT approach consists of two steps: 1) a screening that makes use of routinely collected data in Electronic Medical Records (EMRs) (U-PRIM), and 2) an elderly care nurse-led programme (U-CARE). The U-PRIM screening allows primary care centres to identify potentially frail elderly on the basis of polypharmacy, multi-morbidity and/or a lack of contact with the GP practice (consultation gap) based on the routine healthcare records. An elderly care nurse is in charge of using U-PRIM and contacting potentially the frail elderly for further holistic assessment. In U-CARE, the elderly care nurse goes on to provide integrated and tailored care, by taking the findings from the holistic assessment and the preferences of the frail elderly [and his/her informal caregiver] to create an individualised care plan. The care needed is provided in collaboration (e.g., multidisciplinary team meetings are held) with the GP and other relevant disciplines (e.g., elderly care physicians, pharmacists and mental health services).

Leadership & governance

The main role in the programme is assumed by primary care centres, which collaborate with home-care organisations, nursing homes and the municipality. In the current implementation of the U-PROFIT approach, eight primary care centres have set up collaborations within and beyond health care. Variation exists between the types and formalisations of these collaborations, and some centres have practice nurses and others district nurses working as the elderly care nurse. The predominant health insurer in the Utrecht region is Zilveren Kruis Achmea (around 50% of the population), who has been involved in the U-PROFIT approach since its early stages.

Workforce

Elderly care nurses are a new professional role filled by GP practice nurses and district nurses who have received special training and act as case managers and care coordinators. The nurses have been trained to use thirteen evidence-based care pathways upon indication: falls and mobility, physical functioning, nutrition and malnutrition, mood and depression, loneliness, cognition, incontinence, polypharmacy, vision impairment, hearing loss, caregiver burden, pain and sleep.

Technologies & medical products

Within the programme, EMR data are used to screen frailty. However, the programme faces issues surrounding access to the EMR by non-primary care centre professionals due to organisational gaps and privacy issues.

Information & research

The U-PROFIT approach was initially implemented in the form of a cluster-randomised controlled trial (cluster-RCT). The results of which were extensively described in two PhD theses. In the cluster-RCT, U-PRIM screening in combination with nurse-led U-CARE (1) was compared to U-PRIM screening only (2), and to customary care (3). The effect evaluation was mixed: almost no differences were found between groups (1) and (2), but the primary outcomes (e.g. Activities of Daily Living) were better than in group (3). The evaluation with respect to cost-effectiveness had positive results.

Financing

The current implementation is being financed via three sources: an implementation grant from the Netherlands Organisation for Health Research Development (Dutch: ZonMw), two modules are funded by the health insurer Zilveren Kruis Achmea for case management of frail elderly and collaboration in primary frail elderly care, and by internal investments made by the primary care centres themselves.

Care Chain Frail Elderly (CCFE)

[Maaïke Hoedemakers, Fenna Leijten, Melinde Boland, Apostolos Tsiachristas, Antoinette de Bont, Roland Bal, Maureen Rutten-van Mölken]

The care programme Care Chain Frail Elderly (CCFE) targets vulnerable older persons living at home with complex care needs. These older persons are registered in one of three large care groups in the south of the Netherlands that include many GP practices. Person-centred integrated care in the CCFE is mainly provided by a GP, a nurse practitioner specialised in elderly care, an elderly care physician and a district nurse. The programme aims to improve functional ability, health status and well-being, and prevent or postpone nursing home admission.

Service delivery

The three care groups (PoZoB, DOH and SGE) have adopted a pro-active approach to case finding for frail elderly in the community. They do so with a primary care core team consisting of the GP, nurse practitioner and district nurse. In some cases, the elderly care physician and a dementia case worker also form part of the core team. A holistic assessment of the frail elderly is conducted by the nurse practitioner during a home visit. Depending on the needs identified during the home visit, the nurse practitioner involves and consults other disciplines in the neighbourhood, such as (geriatric) physical therapists, occupational therapists, social workers, elderly care physicians (primary care), geriatricians (secondary care), dementia case workers, welfare consultants and informal care support. An individual care plan is developed by the nurse practitioner in conjunction with the frail elderly and their informal caregiver(s) and based on his/her goals. There are structural multidisciplinary team meetings in which the GP, nurse practitioner, district nurse and elderly care physician always take part. They are joined at these meetings by other relevant professionals as required. The frail elderly and informal caregiver also participate in this team meeting. During the meeting, a case manager is assigned to serve as the contact point for the frail elderly and his/her informal caregiver. An electronic medical record is compiled and includes the individualised care plan. This record is accessible by all professionals involved with the frail elderly.

The six key elements of the care programme, as specified by the care groups, are as follows: (1) early diagnostics by case finding, (2) care coordination, (3) multi-disciplinary team meetings with an individualised care plan, (4) polypharmacy, (5) transfer care, and (6) community network.

Leadership & governance

Currently, three different care groups are collaborating to develop the CCFE and are working to arrange bundled payment. The care groups work on behalf of the GPs who implement the approach in daily practice. Furthermore, the health insurer is an important stakeholder in the development and continuation of the care programme. The community network is also central in the care process, in particular in the collaboration of health and social care.

Workforce

The CCFE is characterised by a separation of care coordination and case management: the respective tasks are assigned to either the nurse practitioner or the district nurse. The programme involves an elderly care physician, who acts in primary care to support and “educate” the GP. Furthermore, the focus of the programme is on unburdening rather than transferring care to the informal caregiver.

Technologies & medical products

A specific ICT structure (Care2U) connects all chain partners at various access levels. In the context of information, the CCFE focuses on structuring care and communicating with one another, rather than on merely sharing information.

Information & research

Currently, the CCFE primarily uses process indicators to measure the progress of implementation. In addition, an ongoing evaluation is being conducted by the insurer.

Financing

An important role in the CCFE, as is inherent to care chains, is the development of sustainable financial support. Two major health insurance companies are involved in the financing schemes for the CCFE. The predominant payment system that has been used is a newly developed bundled payment system for elderly care. Through this bundled payment system, included frail elderly are not confronted with any additional or different out-of-pocket costs than they would have been if these same services had been provided for in usual care. One of the health insurers is conducting an evaluation of the bundled payment system in collaboration with the care groups and is looking into possibilities for the continuation of the CCFE from 2017 onwards. The care programme will be continued in 2017, for which a similar bundled payment applies as in 2016. However, the ongoing evaluation by the insurer will provide input for the method of financing from 2018 onwards.

Better Together in Amsterdam North (BSiN)

[Melinde Boland, Fenna Leijten, Maaïke Hoedemakers, Apostolos Tsiachristas, Antoinette de Bont, Roland Bal, Maureen Rutten-van Mölken]

The Amsterdam North area is characterised by a large proportion of individuals with a low socio-economic status, a lack of appropriate interventions and relatively high healthcare costs. Thus, in line with triple aim goals, there was a need in Amsterdam North to improve the population’s health, to improve the experience of care and to reduce costs. This resulted in the development and

implementation of the 'Better Together in Amsterdam North' approach (Dutch acronym: BSiN). The BSiN programme targets persons with complex needs in multiple life domains.

Service delivery

Providers from each of the organisations involved in the BSiN alliance can request that an individual be 'triaged' to determine whether they can be included in the BSiN programme and what type of care they need. Triage entails holistically assessing the individual and discussing him/her in a multidisciplinary team meeting to determine the level of care that is needed and which organisation can best provide it. The Self-Sufficiency Matrix (SSM) is used for assessment. This helps determine problem areas and needs in the following life domains: finances, daily activities, housing, relationships at home, mental health, physical health, addiction, activities of daily living, social network, social participation and justice. Four quadrants are distinguished after triage: 1) self-sufficient (no care needed), 2) care coordination needed, 3) client support needed, and 4) case management needed. Each of the organisations in the alliance can provide staff who will be trained to work as case managers and work thereafter as such on a part-time basis alongside their regular work. In the case management quadrant, care is integrated and coordinated, an individualised care plan is drawn up together with the person, and progress is routinely monitored by the case manager. The person of interest is actively involved, and a focus is placed on his/her own abilities in solving problems. A typical case management trajectory takes six months to one year.

Leadership & governance

The programme is provided for by an alliance of 12 providers in the primary healthcare (GPs), secondary healthcare (hospitals), mental health services, welfare (debt services case managers, social workers) and social security (municipality return-to-work coordinators, home-care services and youth care) sectors. Besides the care providers, three other actors are involved in the BSiN approach and provide advice (and financial support) for the programme: the health insurer Zilveren Kruis Achmea, the municipality of Amsterdam and the research organisation TNO.

Workforce

Within the BSiN programme, professionals from different organisations and different sectors serve as case managers alongside their day-to-day work. A case manager has an integrated and holistic view of the problems of the respective person and coordinates and supports the care provided from multiple sectors, organisations and providers. The required case management training is provided by the programme.

Technologies & medical products

The whole process – from enrolment, triage and case management through to the closing of the trajectory – is supported by an ICT portal. This portal includes documents and tools to support enrolment, triage and case management. Examples include an enrolment form, including holistic assessment by the SSM, online multi-disciplinary team discussion by the triage team, registration of the individual care plan and registration of appointments.

Information & research

The preliminary short-term (six months) results of the BSiN approach demonstrated improved self-sufficiency in the case management group in comparison with the control group.

Financing

Structural financing has been arranged for 2016 via the predominant health insurer in the region (Zilveren Kruis Achmea) and the municipality of Amsterdam. Long-term contracts are being prepared for the period 2017-2020.

4.6. Norway

Medically Assisted Rehabilitation (MAR) Bergen

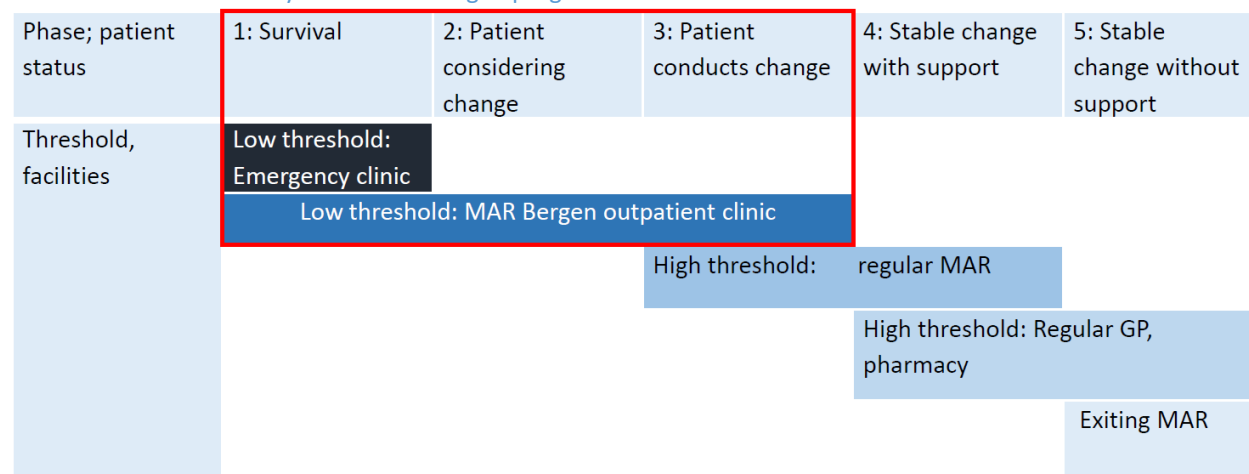
[Rune Ervik, Tord Skogedal Lindén, Jan Erik Askildsen, Sabine Ruths]

MAR Bergen is a treatment programme for opioid addiction at Haukeland University Hospital, Health Enterprise Bergen. In general terms, MAR is defined as an “interdisciplinary specialized treatment for opioid addiction, where requisition of addictive medicine in a fixed dose (substitution treatment) is a partial measure in an overall rehabilitation pathway”. At a national level, MAR treatment covers around 8,000 patients, with MAR Bergen covering around 1,000 of these.

Service delivery

The programme is being developed in collaboration between specialist healthcare services and municipal health and social care. The MAR Bergen model is of particular interest because of its emphasis on low-threshold access. The patients are in a phase where survival is the key objective, and the programme is aimed at patient support to promote change in opioid intakes. The patients typically have several diagnoses, both mental and physical, in addition to addiction, and often live in problematic conditions. The substitution treatment (i.e. requisition of addictive medicine in a fixed dose) is care-oriented, and considered as an ‘entrance ticket’ to further treatment. An overview of the process of service delivery in the MAR Bergen programme is given in the figure below.

Process of service delivery in the MAR Bergen programme



Leadership & governance

Treatment is organised in outpatient clinics at the specialist health service in collaboration with social services for the municipality as well as GPs. Special advisors are supposed to receive a supporting leadership in their role as frontline personnel meeting the patients. A major challenge is posed by the contrast between the care-oriented culture of the social services in the municipality and the disease-treatment oriented culture of the specialist health services.

Workforce

The programme has developed a new professional role of special advisor, usually a nurse or a social worker, who serves as the patient's regular contact person with MAR. The MAR Bergen core team includes a physician, who is a specialist in addiction medicine, a psychologist and the special advisor. The programme faces challenges regarding time allocation, since there is a trade-off between contact with individual patients and the expansion of and competence building within the programme.

Technologies & medical products

EMRs are developed for the programme, providing data that can be used for evaluation. The shared use of medical records by specialist and social services is, however, problematic.

Information & research

No systematic evaluation of MAR Bergen has been carried out so far aside from studies investigating specific medical interventions. However, from 2017 onwards individual data will be collected systematically, and a survey will be carried out. The Bergen Addiction Research group also aims to establish a Biobank.

Financing

The programme is financed through a combination of fixed block grants and fees, which depend on activity. Treatment activity can be underreported, resulting in lower income than budgeted given the patient population. Patients are also frequently unable to pay their own contribution to the scheme due to their financial circumstances.

Learning networks for whole, coordinated and safe pathways (Learning networks)

[Rune Ervik, Tord Skogedal Lindén, Jan Erik Askildsen, Sabine Ruths]

Learning networks are a national programme focusing on older persons enrolled in home nursing services or short-term stays in nursing home, e.g. after a hospital stay. Learning networks aim at facilitating person-centred approaches and improved patient pathways through multidisciplinary teams. They focus on functional ability rather than on disease and impairment, and new patterns of interaction represent a culture change.

Service delivery

Assessment of patient functioning based on validated tools, individual follow-up informed by the patient's own goals, and the involvement of the patient's GP are key elements of service delivery in the learning networks.

Process of service delivery in the learning network

Week 1: Patients that have been hospitalised	Week 1: All patients, including those discharged from hospital	Week 2: All patients	Week 5: All patients
Municipality and hospital plan discharging together by phone/ video/ meeting	Assessment of patient functioning by PSFS or COPM	Follow up by GP/ nursing home doctor	New assessment of patient functioning by PSFS or COPM
Preparation of discharge together with patient/family	Follow up directed by what matters to the patient		Assessment of patient's experience with follow up by interview or questionnaire
Necessary assistive equipment is ordered for the patient to manage his/her own situation best possible			
Case summary (medical report) surveyed before meeting with patient			
The patient is familiar with the primary contact person responsible for follow up			

Leadership & governance

The programme is owned by KS (the Norwegian association of local and regional authorities) and has been implemented in 35 out of 428 municipalities so far. The programme includes user involvement, leadership, re-ablement, core competence, organization, measurements, management support and management involvement. There is a high level of political commitment both within municipalities and at the national level. Patient pathway is a keyword in the Norwegian Coordination Reform.

Workforce

As a minimum, the municipal multidisciplinary primary healthcare improvement teams are comprised of a GP and a nurse. Other primary care professionals (e.g. a physiotherapist, an occupational therapist) and a social worker are also involved if appropriate. A designated primary contact person (coordinator) is responsible for individual patient follow up.

Technologies & medical products

Some municipalities have introduced electronic white boards showing the status for all involved patients. This is a shared information system designed to raise awareness.

Information & research

No scientific evaluation has been conducted so far. The idea and practice of generic patient pathways is based on previous empirical research and the development of the so-called Orkdal model in Central Norway. Municipalities collect data on whether the service delivery items are conducted, data from assessment tools and data on patient experience.

Financing

The learning network is financed through the participating municipalities' general budgets. There are no direct financial incentives. In a longer-term perspective, potential savings for municipal assistance, institutional care or hospitalisation may be expected.

4.7. Spain

Badalona Serveis Assistencials (BSA)

[Claudia Vallve, Jordi Piera, Joan Carles Contel, Isaac Cano, Erik Baltaxe, Carme Hernandez, Josep Roca]

Since the year 2000, Badalona Serveis Assistencials (BSA) has been providing healthcare and social support services with a patient-centred approach through the Care Model for Patients with Complex Chronic Conditions (MAMCC) programme. BSA serves a population of 236,000 citizens living in a suburban area of Barcelona. The MAMCC puts the person at the centre, integrating healthcare and social services and providing 24-7-365 emergency support.

The target candidates for inclusion in the MAMCC programme are frail, elderly citizens often with several chronic disorders. They usually live at home and fail to show their needs for care and support to avoid the risk of exclusion due to illness or disability of any kind. The BSA services also coach informal (family members, friends, neighbours) and formal (professionals) caregivers who provide assistance to the patient on a regular basis. MAMCC's core skills lie in the management of multi-morbidity and cognitive impairments. The main aims of the programme are to promote independent living by offering support to prevent institutionalisation and avoidable hospitalisation.

Service delivery

The programme is composed of various medical services – Case Management Nurse (CMN), Medical Attention at Home (AtDom), Hospital at Home (HaH), Nursing Homes Attention (NH AtDom) and Palliative Attention (PADES) – which are integrated with social care services – Telecare, cleaning services, meals at home, home care services, GPS localizer and home rehabilitation. The uniqueness of the programme lies in the integration of healthcare and social support, which has proved cost-effective and allows the provision of innovative services that promote independent living and proactive care.

Leadership & governance

BSA is a non-profit integrated care organization under the umbrella of the Badalona City Council. It is made up of five different entities: (i) the Hospital Municipal de Badalona, (ii) Homecare Integrated Services, (iii) the Socio Health Centre El Carme, (iv) Seven Primary Care Centres, and (v) the Centre for Sexual and Reproductive Health. Both governance and organizational change are facilitated due to the fact that BSA is an integrated organization.

Workforce

The strong leadership of the BSA professionals has fostered the preparation of the workforce for adoption of the care model. In the course of the programme, the new professional roles of domiciliary attention physician and case management nurse have been introduced.

Technologies & medical products

Information and Communication Technologies (ICT) have played a key role in supporting the novel services. The BSA programme has generated synergies between existing ICT infrastructures at regional and healthcare sector levels with innovative on-site developments supported by different programmes. Tele-monitoring services have been only carried out at pilot level.

Information & research

The evaluation of key performance indicators, namely: length of stay, bed occupancy days, emergency visits, hospitalization rates, process outcomes (including adherence) have been positive. Moreover, the programme has generated a clear reduction in the operational costs of clinical services, thereby demonstrating its sustainability. A formal assessment of the BSA programme is planned within the project's lifespan.

Financing

The BSA programme has generated significant efficiencies at healthcare sector level, providing it with sustainability despite a poor level of budget coverage through external funding. The programme is suffering from poor alignment between its successful evolution and a lack of adaptation of the reimbursement model. The current financial gap may compromise both the sustainability and further development of the programme.

Area Integral de Salut, Barcelona-Esquerra (Ais-Be)

[Claudia Vallve, Jordi Piera, Joan Carles Contel, Isaac Cano, Erik Baltaxe, Carme Hernandez, Josep Roca]

The Ais-Be model was launched in 2006 to improve the coordination of care between different providers and care levels in one of the four healthcare sectors of the city of Barcelona, an area with some 524,000 inhabitants. From then on, work towards the functional integration of services in a complex system that includes heterogeneous independent providers has been ongoing. There are three distinctive elements to the Ais-Be model:

Firstly, the change is driven by Hospital Clinic, a highly specialized academic institution. The hypothesis is that an appropriate transfer of selected care complexities from hospital-based to community-based care within an integrated care scenario can increase healthcare value generation both at provider and at health system levels.

Secondly, the programme has, as one of its core goals, to foster appropriate cross-fertilization among i) healthcare; ii) innovation & research in the biomedical sciences with a systems approach; and iii) innovation in education with a focus on new professional roles.

Thirdly, significant organizational changes in the healthcare sector have been implemented as a key element for adoption. The work done has had a real impact on the territory and on the attention given to patients, who are positioned at the centre of the organizational system created by Ais-Be. This model of attention has performed well from a cost-efficiency perspective and has also shown very positive results in terms of both patient and health professional satisfaction.

Service delivery

SELFIE will evaluate an evolving mainstream programme addressing the management of Chronic Complex Patients (CCP) requiring specialized care among all ICT-supported integrated care services active in Ais-Be.

Leadership & governance

Ais-Be is currently in the process of consolidating a multi-strata governance that fosters convergence between the large-scale deployment of integrated care and the implementation of the systems medicine approach to multi-morbidity.

Workforce

A culture of organizational change already successfully implemented in Ais-Be facilitates the adaptation of the workforce to well-identified evolving needs. Several new professional roles have been introduced in the course of the programme, namely an advanced practice nurse, a case management nurse, a liaison nurse and a homecare attention physician.

Technologies & medical products

Two priorities are: (i) evolution of the current personal health folder (PHF) toward a self-management tool; and (ii) consolidation of a collaborative adaptive case management platform on top of the existing ICT systems.

Information & research

The functional alignment of different European research and innovation initiatives undertaken in Ais-Be under the umbrella of EIT-Health, EIP-AHA and RIS3CAT, as well as specific R&D projects, should contribute to cross-fertilization among healthcare, research and innovation.

Financing

The limitations of current reimbursement modalities are acknowledged. SELFIE should pave the way towards implementation of the conceptual business model that was formulated in a previous project and allows sustainability and scalability of the services.

4.8. United Kingdom

Salford Integrated Care Programme (SICP) / Salford Together

[Jonathan Stokes, Sudeh Cheraghi-Sohi, Søren Rud Kristensen, Matthew Sutton]

Salford's programme is aimed at the elderly (over 65s) and consists of three broad interventions: 1. Multidisciplinary groups (MDGs) – case management of the highest-risk patients by neighbourhood groups; 2. Community assets – investment in community assets to promote social interaction and active lifestyle; 3. Centre of contact (/health coaching) – a centralised telephone hub to help with navigating services and self-management.

Service delivery

Stakeholders described a dilemma, namely that those with multi-morbidity (particularly the elderly and frail) may be those who struggle the most to self-manage, despite being those who potentially have most to gain from it. Professionals in the Salford programme appear to agree that organisational and structural integration (rather than service delivery changes) are the most important aspect of delivering efficiency savings, and, thus, sustainability. However, the protection of market regulation at the macro-level was felt to sometimes act as a barrier to integration (particularly organisational integration).

Leadership & governance

The usual time pressures faced by professionals outside their programme commitments have made MDG attendance and shared decision-making difficult. There have also been continued issues in coordinating with those not directly involved in the integrated care programme. Supportive leadership, historical relationships and the direction of wider national policy are seen as key enablers of integrated care in the area.

Workforce

The programme has found that MDG team management alone is not sufficient for integration to occur. Co-location is, however, seen as particularly beneficial for relationship building between professionals.

Technologies & medical products

The introduction of shared records was seen as particularly important, but has been difficult to implement due to the macro context.

Information & research

The value of healthcare data used for risk prediction has been questioned by professionals (by definition, patients selected by these tools are already well known to healthcare services). There is some evidence of evaluation fatigue, but the CLASSIC study allows us to ease this workload on the programme.

Financing

Other work pressures beyond those additionally incentivised have remained in place for the professionals. The programme has found non-financial incentives (e.g. access to other benefits conditional on participation) beneficial for ensuring provider participation. The programme envisions moving towards a single provider of services model, but this is potentially in conflict with the national choice and competition agenda.

South Somerset Symphony Programme

[Jonathan Stokes, Sudeh Cheraghi-Sohi, Søren Rud Kristensen, Matthew Sutton]

South Somerset's programme is aimed at multi-morbidity (i.e. patients with multiple chronic conditions) more generally, and consists of two broad interventions (with a commonality of 'health coaching'): 1. Complex care hubs – an 'extensivist' GP model with GPs located in a hospital hub and individually managing the most complex patients; 2. Enhanced primary care – co-location of health coaches in GP practices to assist with disease self-management and prevention.

Service delivery

Self-management through health coaching is a major focus of the programme (in both delivery models), but realisation has occurred that changing a complex patient's ability to self-manage is difficult, and there is also the danger of creating a dependency on the additional services offered. Shared decision-making and life goal setting are seen as important first steps to self-management, but this approach is not for everyone (some patients still prefer a traditional paternal doctor-patient relationship). There is plenty of room for informal caregiver involvement in the programme, but some safeguarding issues have arisen with this.

Leadership & governance

Supportive leadership and historical relationships are again seen as key enablers. There have, however, been issues with connecting with those outside the immediate professional boundary of the integrated care programme.

Workforce

Co-location has been seen as particularly beneficial for relationship and trust building. New less-professionalised roles have been seen as positive for addressing patients' needs and in allowing professionals to work to the top of their license. However, some patients might see their interaction with new roles as a 'downgrading' of their own importance.

Technologies & medical products

A single shared electronic record has been exceptionally difficult to implement given the macro environment, but is nonetheless seen as an essential enabler of integrated care by the professionals. Patient interaction with technology has been available, but uptake has so far been poor (there have been some teething problems + the elderly and IT-illiterate are perhaps those least likely to use it). Use of tele-health is developing through the programme and is seen as positive for keeping patients at home, but requires active participation, so the ability of neediest complex patients is again questionable.

Information & research

The data-driven risk tool used has been seen as a potentially useful starting point for identifying patients, but not entirely adequate for the selection of the 'right' patients. Instead, GP knowledge is seen as the ultimate deciding factor. There has been a gradual move away from a focus on the highest-risk patients to attempt to prevent escalation in the first instance rather than 'fire-fighting'.

Financing

Pump-prime funding has been available and seen as necessary, but the amount given was not as requested, so the programme has not been implemented entirely as planned. National competitive tendering and governance policies have again found a tension with the envisioned formation of an Integrated Accountable Care Organisation (IACO). Independent GP practices have been particularly difficult to contract and to integrate into the hospital's vision (as GP contract is not directly held by the programme).