Moving towards integrated health and wellbeing boards
Developing policy across sectors and with the community
Scotland

TransForm Integrated Community Care
Transnational Forum on Integrated Community Care

https://www2.gov.scot/Topics/Health/Policy/Health-Social-Care-Integration

Target population: Population Health

Mission: To improve the health and quality of life of people and communities across Scotland

Funding: Single health and social care budget of £9 billion managed by the new Integration Authorities. There are also annual allocation increases (between 2-5%).

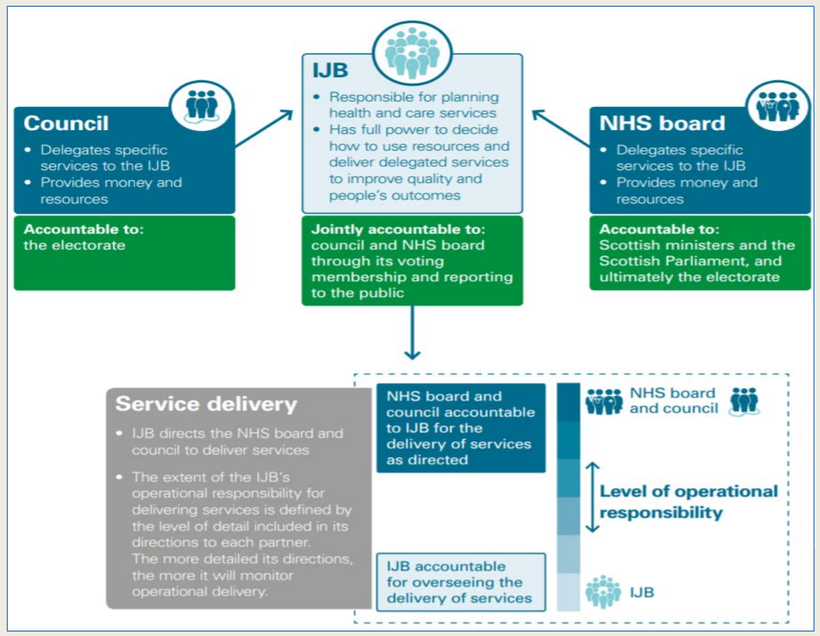
Context

The shape of Scottish society and the health and care needs of our communities are changing. People are living longer, healthier lives and in the next 10 years, the number of people in Scotland aged over 75 is likely to have increased by over 25%. In the same period, it's also estimated that nearly two-thirds of people will have developed a long-term condition by the age of 65.

In 2016 Scotland legislated to bring together health and social care in to a single, integrated system. Integrated Authorities are now responsible for funding local services. Previously this was managed separately by NHS Boards and Local Authorities. This is the biggest reform in health and care since the creation of NHS Scotland in 1948.

The reform places greater emphasis on anticipatory and preventative care and the 31 Integration Authorities across Scotland are now working with their local communities and care providers to ensure care is responsive to people's needs.

Governance and management



What this initiative is about

The key characteristics of the new approach are:

1. Adult health and social care services are firmly integrated around the needs of individuals, their carers and other family members;

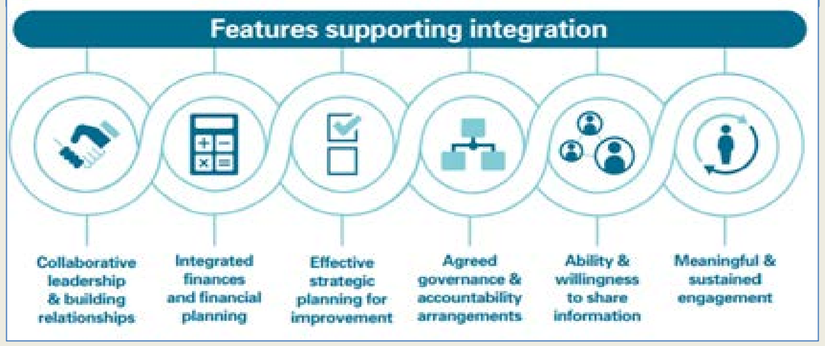
2. The providers of those services are held to account jointly and effectively for improved delivery;

3. Services are underpinned by flexible, sustainable financial mechanisms that give priority to the needs of the people they serve rather than the needs of the organisations through which they are delivered; and

4. Those arrangements are characterised by strong and consistent clinical and professional leadership

Important ingredients:

- National performance framework, including agreed outcomes, supported by indicators: 1) acute unplanned bed days 2) emergency admissions 3) A&E performance 4) delayed discharge bed days 5) end of life spent at home or in the community 6) proportion of over 75s who are living in a community setting
- Primary, community and social are linked to unplanned admissions
- New accountable boards that plan and commission services, with a focus on localities
- Single budget for health and care
- Operational integration of services – Chief Officers have full operational responsibility for all community, primary and social care services, i.e. single manager working across teams. Note this is optional.



How are citizens engaged and empowered?

The population health approach in Scotland is about matching up the national strategy with local delivery systems, recognizing that services need to be developed within localities and that the ability to customize care for individuals is crucial. Data is what enables the services to trigger those conversations around need and how to best address them. Adult community and unscheduled services is required to be delegated, while community justice social work, children's health and care services and other NHS services can also be delegated allowing a fair degree of local customisation.

Impact

The recent report by audit Scotland* shows Integration Authorities (IAs) have introduced more collaborative ways of delivering services and have made improvements, such as:

- A Rapid Response Service establishing a different referral route for patients between A&E and the Community Rehabilitation Team to provide next-day response. The service prevented approximately 33 per cent of people referred being admitted to hospital (2017/18).
- An Intermediate Care Team providing rapid multidisciplinary team support to help people return home from acute hospital and to remain at home through GP referral. Resulting in an estimated 3,370 bed days saved due to avoided admissions and 903 bed days saved due to early supported discharges (2017/18).
- A Reablement Project Team (occupational therapists and social care officers) offering care packages adjusted as the person becomes more independent. As a result, fewer people required intensive packages, freeing up staff and leading to an estimated £200,000 reduction in purchasing care from external homecare providers.

Areas to be improved:

- Financial planning is not yet integrated, long term or focused on providing the best outcomes for people who need support.
- Strategic planning: lack of collaborative leadership and strategic capacity; a high turnover in IA leadership teams; disagreement over governance arrangements; and an inability or unwillingness to safely share data with staff and the public.
- Appropriate leadership capacity: all partners need to be signed up to, and engaged with, the reforms and they need to be more honest about the changes required.

Insights

- Data as a tool to inform change – e.g. use variation for quality improvement purposes
- Not looking to fix a universal, general challenge but rather to address the needs of a relatively small number of people within the population through customization of services – (move away from the traditional 'one-time solution, and roll it out 100,000 times' to a new 'find 100,000 solutions')
- Good clinical care does not always on its own lead to good outcomes
- Iterative process
- Behaviours – need for more collaborative leadership
- Workforce pressures are a clear barrier to implementation. Contribution of the third and independent sectors should be part of workforce planning.
- Housing needs to have more central role in integration.

* http://www.audit-scotland.gov.uk/uploads/docs/report/2018/nr_181115_health_socialcare_update.pdf

The CoFoR Project (Recovery Training Centre)

Marseille, France

www.coforetablissement.fr/

TransForm Integrated Community Care
Transnational Forum on Integrated Community Care

Target population: People in Marseille who have or have had mental health problems.

Mission: enable people who have had mental health issues to become experts in their own self-care and develop the skills and confidence to manage their own recovery journey.

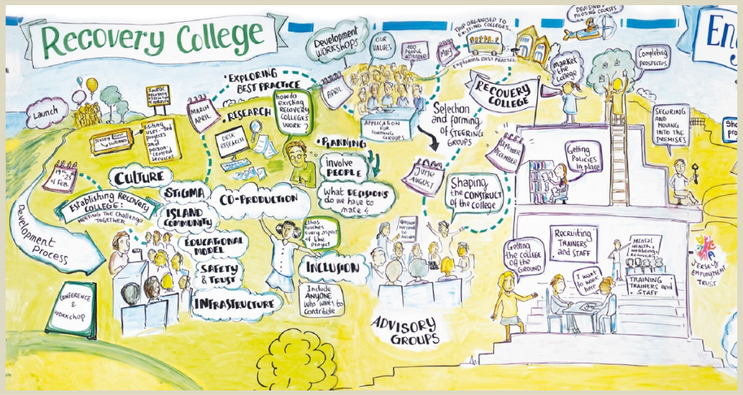
Funding: DGS (Directorate General of Health) and France Fundation.

Context

CoFoR is anchored on the Recovery College model. Recovery Colleges offer educational courses about mental health and recovery, designed to help students feel more confident in self-management of their own mental health and well-being. For persons with lived experience of mental ill health, taking control and become an expert in their own health and recovery is important to move on with their life.

People may use the college as an alternative to mental health services, alongside mental health services or to help them move out of mainstream mental health services.

Since 2009, the Recovery College has continued to expand around the world, with currently forty colleges including in England, Australia, Canada, Japan and the United States. CoFoR opened its doors in Marseille in September 2017. At the same time, an action research project was initiated with "first-time" people, experience experts , peer workers, families and relatives, medico-social, social and psychiatric professionals, researchers, artists, etc.



Governance & management

Partners are:

- a local NGO of users and family of users (Solidarité Rehabilitation)
- a school of social work: (IRTS)
- a research center: (EA3279 in Aix-Marseille University)
- a public hospital: (AP-HM)

The governance is transparent and democratic, with strong involvement of students in weekly Management Committee where everything is decided.

What this initiative is about

CoFoR is a RecoveryTraining Center for people who have or have had mental health problems as well as those who care for them. Seeking to move away from a clinical, hospital centric or even rehabilitation approach, the Recovery College focuses on using learning activity to complement traditional treatment approaches. The approach:

- Helps people recognise and make use of their talents and resources;
- Assists people in exploring their possibilities and developing their skills; and
- Supports people to achieve their goals and ambitions

The working principles of the model are founded on co-production and shared decision-making:

- Non-therapeutic but educational approach
- Partnership with different organizations
- Co-construction of the project at all stages
- Co-construction of training modules
- Animation, facilitation of sessions by users or ex-users of mental health, experience experts, peer workers.
- Training location outside mental health organizations
- Student status rather than user or patient
- Free training & financial reward of 250€ for attendance

CoFoR currently comprises 4 modules:

1. Recovery plan: Implementation of an Individualized Recovery Action Plan and Psychiatric Advance Directives. One afternoon a week for 11 weeks.

2. Wellness: Practice sport and techniques in the management of stress and anxiety: breathing, mindfulness, gentle fitness, “get back in touch with your body”, self-defense.

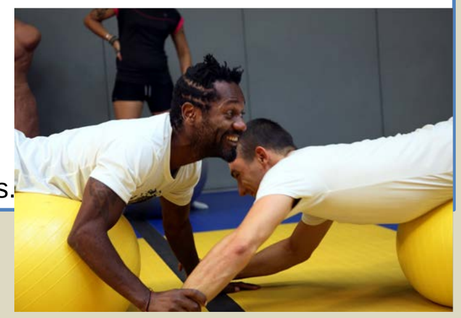
3. Rights: Know your rights vis-à-vis institutions. Learn to speak up.

4. Living with: Management of medication and substances, sexuality, living with your voice, living at home.

The training is organized by coordinators and facilitators. Each module has 2 facilitators, one of whom is also coordinator of the module (responsible for content and planning). The general coordination is ensured by the project coordinator with all decisions are taken in weekly Management Committee.

How are citizens engaged and empowered?

- In the very beginning, we started from scratch. Everything had to be done outside of the mental health system. It was the occasion of being creative and of doing a real co-construction involving a majority of users. Absolutely everything was discussed and voted.
- The 11 week courses take place in a school. Here people are students.
- More than 90% of people working and teaching in the CoFoR have personal experience of mental health problems.
- Students register themselves to the courses of their choice. Facilitators and volunteers support involvement and co-construction of the courses.
- Every student is invited to participate in governance and decision making processes, or in communication or events.



Impact

- CoFoR is the first full user-led program in France.
- Quantitatively, we have shown significant decrease in levels of auto-stigmatization (ISMI10 scale), and an increase in recovery scores (RAS scale) between the beginning and the end of the courses.
- Qualitatively, the journeys of students are impressive, with lots of energy regaining hope and empowering themselves.
- It is perhaps too early to say, but we think we are witnessing the structuring of a user-led recovery movement in France, with CoFoR as masterpiece.

Insights

Co-construction is longer and more demanding than other ways to perform a project, - it is both a mean and a goal.

Anger can arise in empowerment processes.

The future

We will start a new module at the request of students: it will be a professionalizing one about peer-work and professions in the self-help area.

Mental health activists in France are working to implement the CoFoR in other cities, like in Lille or in Paris.

Programme HM (Habitat Microaree) – A Caring City

Friuli Venezia Giulia Region, Trieste, Italy

https://vimeo.com/219664857?fbclid=IwAR2SxEcGFsQ7uQkPeuzPmqpBB9wkNA__xl9ok0_F0wZU4aKc0Mx9743Lvtw

TransForm Integrated Community Care
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Target population: population health (deprived community)

Mission: to improve the quality of life of inhabitants of 13 pre-defined, targeted urban areas through promoting social cohesion.

Funding: Trieste Local Health Department, Trieste City Council and the regional Public Housing organization. The total cost is estimated between €100-200.000 per year per site, incl. the professionals dedicated to the programme, the facilities and other resources.

Context

The programme is a result of a memorandum of understanding (2006) which was signed by three public entities: the Trieste Local Health Department, the Trieste City Council and the regional Public Housing organization. The city of Trieste has a population of 204,234 inhabitants characterized by a substantial ageing, significant family fragmentation and moderate levels of incoming migrants creating a more diverse population. There is also a high proportion of one-person households, often elderly women.

The HM is a social, health and housing joint program with the intent to create effective and concrete integration between policies and sectors and to positively influence life contexts, actively involving the local community to reinforce social cohesion. The programme targets the local community living in a “Microarea” a small municipality or housing cluster (500 to 2,500 residents), characterized by a high proportion of public housing, socio-economic vulnerability and a high proportion of over-75 inhabitants.

The programme approach promotes community development through matching at a ‘micro’ level the demand for services with the available public and/or private resources, thus reinforcing the active participation and resilience of citizens in addressing social and health needs.

Governance & management

Territorial Technical Group: one for each area of intervention, composed of employees/contractors of the services of the three public entities. It is open to the participation of representatives of civil society and of the third sector with the aim of collecting the proposals presented by the territorial area targeted by the Project, in order to design, organize, record and verify the interventions domain of each body and stakeholder involved.

Inter-bodies coordination committee: composed of one representative for each of the three Bodies, who identifies the general guidelines and the goals to pursue annually. They meet once every 6 months

What this initiative is about

The programme’s key ingredients for success are that it is:

- **local:** limited to a specific community context where joint actions take place
- **pluralistic:** with multiple actors working together in order to achieve agreed goals
- **comprehensive:** as it implements innovation which deal with the whole range of community welfare issues.

The main activities can be divided into:

1. **Knowledge Area** – a) "Door to door" home visits to meet the resident population, b) joint home visits recommended by socio-sanitary services and c) proactive visits to specific population groups

2. Community Development Area- a. socialization activities (informal thematic groups), b. valuing individual inhabitants' skills useful to the community (eg. time bank)

3. Health intervention areas- a. Monitoring the health of those most vulnerable (health centre), b. Health education and promotion, c. integration with socio-sanitary services on individual cases.

Every micro-area has a professional team responsible for contact and activation, as well as for the coordination of activities (both at individual and community level) and the local management of resources. The team includes:

- a **full time coordinator** (a nurse or other professional) acting as a “community health manager”. They are the active guardian of all the inhabitants. Their role includes: health proactivity, improvement of social-sanitary integration in care pathways, coordination between different services and other professionals, reducing avoidable hospital admissions
- two **“social concierges”:** one social worker from the City Council and one from the Public Housing company, in charge of coordinating community engagement and socialization activities. They are the first to notice residents’ needs and agree on the most appropriate solutions

Every Microarea has a **multi-functional centre** with a dual function: contributing to the decentralization of socio-sanitary services and to the promotion of social cohesion. They are “local laboratories" where the needs expressed by the citizen are combined with the integrated intervention. Volunteers and resident citizens are also involved in various activities.

How are citizens engaged and empowered?

Needs are addressed through citizens’ involvement, by the on-going collaboration between different entities and by support from the third sector.

Users of social meals (provided by the municipality) were first experimentally invited to eat together in the common facilities. Under the right conditions, after a "start up" phase, users also become producers (of services). Today many self-organized and self-funded social lunches are held, giving the opportunity to meet, share information, maintain community links or guarantee access to healthy food to specific target groups (e.g. people with chronic diseases).

Impact

Over 10 years, the comparison of HM and non HM population (using regional data warehouse) showed a decreasing ratio of incidence for first hospitalisation, especially when urgent. The decrease of urgent hospitalisation is significant for a number of pathologies: Psychosis –85% for women, –28% for men; Respiratory acute infections –56% for women; Cardiovascolar pathology –28% for men.
The programme has created “useful social capital” (relations and interdependencies) by: mobilizing support mechanisms for the most vulnerable; involving people in supporting each other; recognizing points of references and increasing the trust in “close actors” that are working in the community.

Insights

- Continuous presence of the professionals in the care receivers' daily lives has a positive effect by not being limited only to physical health but considering income, social network, practical needs, daily life and life goals.
- The small-scale approach facilitates real integration, creates conditions for activating citizens and communities
- It also allow the development of services and allocation of resources to counteract the institutionalisation of care (i.e. more personalised and home care)
- The involvement of local communities in innovative solutions to daily problems helps foster more resilient communities

Remaining challenges:

- Keeping the public mandate and direction
- Role and responsibility of professionals (to be activators/not replace missing services)
- Micro-dimensions vs. generalization of practices and learnings
- Learn to work with local resources. Often "scarcity of formal resources" obliges (and allows) you to work with what is already there
- Flexibility to define new standards and models

Community Health Center Botermarkt in Ghent (BE): Patients, the community together with the interprofessional team, that makes the difference!

http://www.wgcbotermarkt.be/eng/

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CHCs in Belgium provide integrated primary care

Target population: All inhabitants in a specific geographical area, that subscribe to the patient-list of the CHC

Mission: To ensure high quality, accessible and comprehensive primary care for all. To contribute to intersectional actions aimed at tackling health inequity

Funding: 67.86 % needs-based capitation system, 10.14 % fee-for-service and 22 % of subsidies (<>leading primary care model ± 100 % fee-for-service)

Context

Federal level (Belgium)

- ±175 not-for-profit CHCs provide integrated primary care to 3% of the Belgian population
  - min. 3 disciplines
  - No co-payment for patient
- 2016: Liberal government questions the model: development of new centres halted, audit of sector and budget cuts

Association of Community Health Centres

Association of 32 CHCs (including CHC Botermarkt) in Flanders and Brussels, with shared concept of care

CHC Botermarkt in Ledeberg

+- 6500 patients, relatively big share of chronic disease.

Ledeberg = deprived neighbourhood within Ghent (Belgium).

Interdisciplinary team includes GPs, nurses, social workers, dieticians, dentists, receptionists, health promoter, etc.

Interdisciplinary subteam around the topic of health promotion, managed by 1 FTE 'manager Health Promotion'

How are patients involved/empowered?

Within the CHC:

- Patients included in organizational board
- Use of goal-oriented care

Within the health promotion projects

- Patients take up the role of experiental experts
- Personal goals are starting point (cfr. Rest Rusts)
- Enabling patients & informal caregivers to have their voice heard (towards team, social partners, city services, …)

What this initiative is about?

This contribution describes two health promotion activities as best practices of integrated community oriented care.

The starting point of community-oriented care * is defining health needs in the community. This follows a stepwise process in the centre.

1) Identification of care needs in individual care provider-patient contacts
2) Interdisciplinary patient meetings: which care needs seem relevant for a larger part of the population?
3) Prioritization and validation of care needs in the population using data and experiences of relevant stakeholders at regional and city level.

Activity 1 : "Rest Rusts"

- Outreaching prevention of falling for elderly at home
- Individual goals of patients (motivational interviewing) => development of tailored physical exercises
- Students 'nursing assistant' of local school visit patients to help with exercises. The exercises serve as a point of reference for all involved (in)formal caregivers

Activity 2: Multiloog

- Part of project exploring methods to minimize the divide between society & individuals with psychological vulnerability
- Roundtable of professionals, informal caregivers and experiential experts (all work and/or live in Ledeberg). External psychologist facilitates
- Goal = setting up co-creative process to improve accessibility of services for individuals with psychological vulnerability & creating new accessible meeting places
- Conversation enables the validation of health needs assumed by care providers with end users
- Health promotor joins & supports patients & informal caregivers

The future

- Co-creative trajectory to follow up on themes identified through Multiloog
- Creating hospital places for individuals with a psychological vulnerability : summarizing best practices
- Using Multiloog-method for other care needs
- Augmenting patient participation within the own organisation & in local government

Impact

Capitation financing (CHCs) compared to fee-for-service funding**

- Quality of care equally good & better for rational prescribing, preventive care & follow-up of diabetes patients
- Comparable societal costs, cheaper

Health promotion projects

- No formal evaluation
- Two price nomination showing the acknowledgement for the projects in 2018
- Informal evaluation: perceived benefits for end users & involved partners

Need for complex & contextualized evidence in line with flexibility of projects.

Insights (enablers and barriers)

Enablers

1. Capitation funding stimulates focus on health promotion & is an incentive for interdisciplinary cooperation & task shifting.
2. Shared location & vision on goal-oriented care for interdisciplinary team CHC
3. Supportive local social policy
   - Funds 0,5 FTE manager health promotion in CHC
   - 'Social director' payed by city services coordinates regular interprofessional meetings of welfare & health organisations in Ledeberg. These meetings gathers signals as input for the local health policy
4. 10 CHCs in Ghent: monthly local meeting to share evidence & experience on health promotion
5. Neutral position of 'Manager Health Promotion' to connect & coach partners. Time for her to be present in the community (also informally)
6. Collaboration with local partners with complementary expertise, based on win-win situations

Barriers

1. Insecure financial and legal framework of CHCs
   - balancing focus on prevention & curation, ….
2. Pressure on patient population due to rising individual responsibility
3. Process is slow and requires flexibility
4. No formal centralized responsibility to coordinate local activities
5. No formalized agreements on collaboration between social partners

*Rhyne R, Bogue R, Kukulka G, Fulmer H. (Eds.). Community-oriented primary care: health care for the 21st century. Washington, DC, American Public Health Association, 1998
** Boutsen, M. et al (2017). Vergelijking van kost en kwaliteit van twee fianncieringssystemen vooor de eerstelijnszorg in België : een update. IMA, Brussel.