DESCRIPTION OF THE PRACTICE	
1. Title of the practice	
- 'LOCAL HEALTH CARE IN WESTERN SKARABORG: AN EXAMPLE OF LIDKÖPING' -	
2. Organisation responsible for the practice	
The initiative is run by 6 municipalities and 12 primary health care centres, and Lidköping hospital. This practice focuses on the case of Lidköping municipality, where Primary Health Care Centres and Lidköping Hospital are implementing the initiative.	
3. Contact person(s)	
E-mail	policy@esn-eu.org
4. National/regional/local context of practice	
The legal foundation for health care in Sweden is the 'Health and Medical Services Act' 1983, which aims to provide equal, needs-based access to health services. The 'Social Services Act of 1982 regulates that municipalities have the responsibility to ensure help and support for citizens and emphasises the right of the individual to receive public services and help at all stages of life. National policy has put an emphasis on the cooperation between health and social care, especially in the care of older people with complex health problems and severe needs. The 'Ädel reform' of 1992 was set out to address regional differences and the health and social divide. Municipalities became responsible for patients ready to leave the hospital and were obliged to pay fees if a patient stayed longer than needed in the hospital. These laws have created 'frames' that leave flexibility for local authorities. The national policy has tried to enforce cooperation between health and social care, especially in the care of older people with complex health problems and severe needs. In recent years, this has resulted in several different financial incentives by the government to stimulate cooperation. Sweden's counties are responsible for health and medical care, which includes hospital care and primary health care. Municipalities are responsible for social care for older people. Support at home includes: help with activities of daily living, personal care, nursing (medical) care, assistive devices, daycare, and short-term institutional care. Additional services include transportation, foot care, meals on wheels, security alarms and housing adaptations.	

In recent years, there have been several different financial incentives by the government to stimulate cooperation. Developmental projects have been implemented with earmarked resources to develop models of integrated care for older people. In addition, health and social care authorities are paid when they include a patient in a relevant register; e.g., the authorities are remunerated for every person diagnosed with dementia who is registered in the Swedish Dementia Register, for people included in the Senior Alert Register, where data on the prevalence of pressure sores, falls and malnutrition are registered, and finally for people included in the Swedish Register of Palliative Care (payment for registration).

Recently, a performance-related payment system was introduced in the Swedish health and social care system to reduce hospital admissions and readmissions among older people. It provided financial rewards to county councils, regions, and municipalities for reducing such admissions. Another type of performance-related payment is tied to the reduction of inappropriate drug use among older people.

5. Summary of the practice

This initiative is located in the western part of Sweden (Skaraborg county), in six municipalities with together around 100,000 inhabitants. This initiative will focus on one of the six municipalities: Lidköping, with around 38,000 inhabitants (almost 22 per cent 65 and over and 6 per cent of 80 years and older).

These municipalities in western Skaraborg have a history and tradition of collaboration between health care and social services, starting at the beginning of the 2000ties. The collaboration has involved many stakeholders: politicians, professionals, older people, their carers, and service providers.

The aim of this initiative was to develop person-centred integrated care for very frail older people, which could not be achieved without a close collaboration between health care and social services. Two 2pecialized teams have been established: the mobile palliative care team and the integrated home care team. These two teams serve patients in all six municipalities and are financed by the county (i.e., the health care authorities). The palliative team serves primarily younger people with cancer (and will not be discussed further in this presentation). The integrated home care team is responsible for serving older people with extended needs who cannot visit the outpatient clinic. The teams serve, on average, 24 patients at the same time and can be seen as “a hospital ward at home”.

Further, in Lidköping, there is a “mobile doctor” who primarily makes home visits to older people in need.

In Lidköping, home help services and home nursing care are organised by in-home care teams (home helpers, occupational therapists, physiotherapists, and nurses) to offer older people proactive rehabilitation services at home. Since 2009, the home care teams have closely cooperated with the integrated home care team and the “mobile doctor” services. The municipal home care nurse is the main contact person

who coordinates the collaboration and acts as a contact person for the integrated home care team and the mobile doctor, as well as a partner in the municipal home care team.

Lessons learnt:

- Local sustainability: very well received among all: the service user, their carers, care personnel/professionals and responsible authorities,
- Staff structure: specialist workers that are difficult to replace, it is important to plan to ensure adequate cover,
- Impact: difficulty in evaluating outcomes

6. Staff involved

Politicians, health and social care managers and professionals, integrated home care teams, mobile doctors, home help services

7. Target group

Very frail older people with complex needs and frequent hospital admissions

8. Aims of the initiative

- Address the need to improve care coordination: From an organisational perspective, the initiative addresses the lack of cooperation between health and social care for service users with complex problems.
- Improve the quality of care: From a service user perspective, the example identified the need to improve person-centred care. It also aims to use resources/cost reduction better and to improve health for service users and informal carers by a proactive home-based care system that leads to fewer use of hospital care, fewer queues at the hospital and improved routines for safe hospital discharges.

9. Issues for social services

Service Integration/ Cooperation across services	X	Service Planning		Contracting	
Technology		Skills development (of the workforce)		Quality of services	

ANALYSIS OF THE PRACTICE

10. Status

Pilot project (ongoing)	
Pilot project (terminated)	
Project (ongoing)	

Project (terminated)	
Implemented practice (restricted areas)	X
Widely spread practice/rolled out	

11. Scope of the initiative

Describe the setting of the practice, considering the following criteria:

- *Micro-level initiatives:* initiatives involving individuals at the local level
- *Meso-level initiatives:* initiatives involving organisations or communities
- *Macro level initiatives:* initiatives involving large population groups

Meso level initiative

12. Leadership and management of the initiative

Describe the leadership of the practice, considering the following criteria:

- *Collaborative management*: shared between large partnerships, often of central, regional and local representation
- *Organisational management*: by one organisation
- *Professional management*: managed by a single person
- *Shared management*: shared with no defined leadership

Collaborative management: A steering group was convened through network discussions based on a political agreement to cooperate, with senior managers representing the municipalities, the hospital and regional primary health care, meeting four times annually to discuss and plan future work.

Coordinated by professional management: The municipal home care nurse is the main contact person who coordinates the collaboration and acts as a contact person for the integrated home care team, the mobile doctor, and a partner in the municipal home care team.

13. Engaging stakeholders in the project

Describe the engagement of stakeholders, considering the following criteria:

- *Individual initiative*: Individuals have sought practice change

- *Network approach*: one or more organisation(s) develop a network
- *Collaborative approach*: large collaboration with relevant stakeholders

Network approach: A steering group was convened through network discussions based on a political agreement to cooperate, with senior managers representing the municipalities, the hospital and regional primary health care, meeting four times annually to discuss and plan future work. This initiative describes how new roles for new integrated care pathways had been established. This includes the creation of specialised integrated home care teams including a mobile doctor for service users with extended needs. The teams create a care pathway for older people with complex needs.

14. Involvement of service users and their families

Describe the involvement of service users, considering the following criteria:

- *Team involvement: service users and carers were part of the project team*
- *Consultative: A consultative body of users was set up for an ongoing dialogue and feedback*
- *Involvement in care: person-centred approaches to care/support*

n.a.

15. Costs and resources needed for implementation

Describe how the practice is financed, considering the following criteria:

- *Within existing resources:* staff time and other resources are provided 'in-house'.
- *Staffing costs:* costs for staff investment
- *Joint/Pooled budgets:* two or more agencies pool budgets to fund services
- *Funded project:* external investment

Service delivery costs/resources: the health care authorities funded the two specialised teams.

16. Evaluation approaches

Describe the evaluation method of the practice, considering the following criteria:

- *Multi-method:* use of both a qualitative and quantitative approach,
- *Single method: a* qualitative or quantitative approach
- *Audit:* looks at data sources such as existing medical records and other routinely collected service data.
- *Informal:* refers to in-house service evaluation using locally designed tools and/or collecting opportunistic feedback
- *No evaluation*

☐ *An evaluation is planned*

Multi-method: a consultant company conducted an evaluation based on an analysis of documents, registered data of service use, interviews, and an economic assessment. The evaluation compared costs between health and social care expenses in terms of fewer costs for the county (financing hospital care and outpatient health care) and no cost development for the municipality (financing home help, home nursing and instructional care).

17. Measurable effects of the initiative and what it has achieved	
Service users	For older people with complex health problems, usually with big problems accessing health care, the Lidköping model has increased security and, thereby, quality of life.
Formal caregivers	Increased effectiveness and targeting of the health and social care system implies greater professional satisfaction at work.
Informal carers	
Organisations	A local evaluation in Lidköping municipality (in 2009 – 2010) showed an impressive reduction in the number of visits to the emergency ward (80%), hospital visits (89 %) and the number of care days at the hospital (92%), among patients served by the integrated home care team. Municipal costs for home-based care increased, at the same time, this was counterbalanced by less use (and costs) of municipal, institutional care.

18. Anticipated or 'aspirational 'effects of the initiative and what it has achieved *This category can include outcomes which are not documented, quantified, or properly evaluated. They can include such elements as improved knowledge, quality, workforce, etc.*	
Service users	
Formal caregivers	
Informal carers	
Organisations	

19. How has the initiative changed the way care/support is provided
Care pathway changes: eight examples at the micro and meso levels of integration explained how, particularly for frail older people or those with complex needs, care is now routinely proactive and person-centred

20. Sustainability of the practice *Describe if the practice is sustainable, considering the following criteria:* • *Potential for sustainability:* practices were newly started or are ongoing/not yet mainstreamed. How could the initiatives be sustained (in terms of resources)? • *Organic sustainability:* service users have been empowered to take the initiative forward • *Established:* the project has been operational for several years
Established: The project has been implemented in all six municipalities and is a part of mainstream services.

21. Transferability of the initiative

Describe if the practice has been transferred, considering the following criteria:

- *Transferred:* transfer to other regions, countries, service user groups, etc.
- *Potential for transferability:* there is interest from the outside; elements of the initiative have been taken up and used elsewhere; material for transferability (for ex. training material) has been developed

Potential for transferability: Elements of the initiative had been taken up and used in other Swedish regions, such as a mobile doctor.

22. Further information

Lifvengren, S., Andin, U., Huzzard, T., Hellström, A. (2012). The Path To Sustainability In Health Care: Exploring The Role Of Learning Microsystems. In, S Mohrman, S.A. & Shani, A.B. (Eds)-Organizing for Sustainable Health Care, Emerald Bookstore. HCM Health Care Management (2013). Närvård i Skaraborg.Utvärdering och ekonomisk analys av Närsjukvårdsteamet, Mobila palliativa teamet och Mobil Hemsjukvårdsläkare (in Swedish).

Developing a Person-centred network in Argyll. “Caring Connections”. Report from March 5th, 2014.