AIDA Project

Advancing Integration for a Dignified Ageing

MINISTERO DEL LAVORO
E DELLE POLITICHE SOCIALI

WP6 – THE EUROPEAN DIMENSION: TRANSFERABILITY OF THE GUIDELINES TO OTHER EUROPEAN CONTEXTS

Deliverable Nr. 1

TRANSFERABILITY REPORT

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DELIVERABLE NR. 1 – TRANSFERABILITY REPORT

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Report by

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Aim of the work-package

AIDA project has been carried out by a strongly Italian based partnership (being Italians all partners but one). Nevertheless, the project wished to have a broader impact at European level and dedicated one of the WPs to pursue this objective.

Indeed, aim of work-package number six was to disseminate AIDA Guidelines to a variety of European stakeholders and experts dealing with integration of social and health care services with the objective of collecting feedbacks and comments concerning a potential transferability of AIDA results to other European countries.

Activities and methodologies

As foreseen in the work-plan, the partner Eurocarers (European Network of Carers Organizations) in cooperation with all other partners, organized six events across Europe.

The first one was an European Seminar, organized in Brussels, where the draft guidelines were presented to experts and professionals from different European countries, to collect general feedbacks and impressions.

After that, five seminars had been organized in different European countries representing different care regimes:

- Finland[1], representing the Nordic model
- Estonia, representing the post-socialist model
- Slovenia, representing the Eastern European model
- Spain, representing the Southern European model
- The Netherlands, representing the Continental one

In each of these seminars, the guidelines were presented (see power point presentation in the appendix) and then a discussion was opened with participants, asking them to point out what

[1] The seminar in Finland was participated by representatives from Ireland (Anglo-saxon model) and Romania (Eastern European model) as well.

they considered suitable and transferable to their own countries and what was not relevant for them.

In appendix to this report, we will report details of each event, including photos and minutes of discussions.

In the next section of this document, instead, we will briefly point out issues raised by most of participants and that could be considered elements potentially transferable and useful at a wider European level.

Common European issues

- Social and health care integration is an **issue** now **faced all across Europe** and almost everywhere in the political agenda, although there are of course different ways and models to concretely implement integration.
- The **use of ICT** is widely considered a mean to support integration of social and health care services but: (1) we should be aware that an high use of ICT risk to discriminate older persons who might not be familiar with technology and (2) there is currently a problem linked with law regulating personal data protection which might hinder the exchange of information between different professionals.
- The **role of general practitioner and/or community nurses** is everywhere considered central for a successful integration between social and health care services. However, this is very differently implemented according to the service provision model (for instance, if the country foresee a free access to family doctors, if the doctor is employed by the health service or a free-lance etc.)
- The majority of participants pointed out that it's still difficult to have a fruitful dialogue and effective cooperation between social and health care professionals. The **development of new curricula and joint training** aiming to a better integration of skills and knowledge has been considered important in all countries and in some cases already in the political agenda.
- The focus that AIDA guidelines make on **carers** has been welcomed in all countries as an innovative aspect, especially for those countries who used to have a model strongly

based on the provision of formal care services and that are now shifting more to informal care because of budgetary restrictions.

- The political drive is very important and a **joint planning is needed**. Ideally, social and health care should be under the same political responsibility (for instance the same Ministry) in order to facilitate the process. On the other hand, in all countries involved there is still a **separation of financial resources** between social and health care (and in some cases also within the social care, where personal care and welfare / wellbeing are under different budgets and responsibilities) and this clearly creates barrier to integration.
- Across Europe and across each European country there is a variety of different contexts, from a geographical, organizational, cultural and demographic point of view. It is therefore essential to assure a certain degree of **flexibility** in the application of guidelines and models for social and health integration. Older persons living in **rural areas** seem to be everywhere a specific challenge to implement integration of services: it should be further developed how to respond to the needs of this peculiar target combining efficacy and economic sustainability.

Conclusions

People are ageing all over Europe in the same way: longevity, compression of morbidity... same problems everywhere but with different practices and regulation. Population ageing combined with cutbacks due to the economic downturn is raising everywhere the issue of how to combine care efficacy and sustainability and this is a challenge especially when shifting from formal to informal care provision. AIDA guidelines were welcomed in every country as relevant, useful and – at least to some extent – transferable to other European contexts.

APPENDIX

European seminar – Brussels (BE) – October the 15th 2013

As mentioned in the introduction, the meeting in Brussels was had the aim to introduce the draft guidelines to a group of 14 stakeholders belonging to the Eurocarers network and representing 8 different European countries.

After presentation of project outcomes (downloadable from http://tinyurl.com/aidaEUseminar) the discussion is opened, with the question "You have heard about the key factors identified in Italy to support integration: do you think they fit to your country as well? Thinking about your country what would you add / change?"

Main issues raised:

- Social and health Integration is not a simple task, even when a "Minister for Social and health issues" exists, such as in Finland, in practice there are still big integration problems to solve. For example, it is a common experience in Finland that the two sectors keep **their budget separated**, making it complex to have an integrated strategy. (Marja Tuomi)
- As far as Ireland is concerned, it is confirmed the **importance on geographical areas matching**. It currently happens that, as a service user, you need to go to one area get one health service and somewhere different for another service. This is true for example as far as general health and mental health services are concerned as the organization was done in political grounds and decisions were made certainly were not in the consumer interest. Another example regarding Ireland: in order to rationalize the adaptations of houses to the needs of disabled persons, it was agreed between the social and health services that an occupational therapist would have the responsibility to make an assessment before the adaptation could be done. That seemed rational idea, except it wasn't very rational in practice, because what happened was, that there wasn't enough occupational therapist to do the job so it caused a big waiting list even for very simple interventions, and people even died before the occupational therapist assessment was done. This also has to do with giving authority to professionals vs. accepting that there are people having sufficient knowledge and expertise to take a decision themselves. The need is that of a system that is flexible and that keeps in mind the consumer needs. (Frank Goodwin)

- **Need of flexibility** was one of the points in which everybody agreed. Multidisciplinary teams are ok when is a complex case, but, in simple cases flexibility in taking decisions is important to avoid waiting lists and delays.
- In the Netherlands, social and health services are working separately, and there are no plans at the moment to integrate them. The Netherlands has a dual-level system. All primary and curative care (i.e. the family doctor service and hospitals and clinics) is financed from private obligatory insurance. Long term care for the elderly, the dying, the long term mentally ill etc. is covered by social insurance funded from earmarked taxation. Private insurance have not contact with social services and not even with local or national health and social professionals services. So responsibility relays on users, who have to find solutions by themselves to effectively integrate the two aspects. It is illustrated a Dutch good practice of social and health integration at a micro-level taking place in neighborhoods carried out by organizations of professional an informal carers who are working together with social workers. This can be considered as a good practice although it can be very confusing for users as it leads to different service depending in which community you live. [More information on this practice can be found in the minutes of the Dutch seminar – see further].

Seminar in Finland – Helsinki – 27th of January 2014

The Finnish seminar was held in coincidence with an European seminar on elder abuse – scheduled for the following day – taking advantage of the presence in Helsinki of NGOs active in the field of ageing coming from Ireland and Romania, thus broadening the European dimension of the event. Finnish participants were mainly representatives of NGOs dealing with older persons as well as of Social and Health care services departments of Municipalities.

After presentation of project outcomes the discussion is open, with the question "You have heard about the key factors identified in Italy to support integration: do you think they fit to your country as well? Thinking about your country what would you add / change?"

Main issues raised:

The first round of comments comes from **Finnish** participants:

- The relation between **social and healthcare professionals** is a common problem in Finland. The number of doctors, and especially of geriatricians, is considered insufficient and it's very difficult to have the chance to talk with them. The need of a **common training**, between social and health care professionals, is felt. Nevertheless, it is an opinion of our speaker that health centers in Finland are now more aware of the challenge of persons with dementia and they now have a specific training for nurses taking care of this kind of patients, including social aspects.
- In Finland, **elderly care is very medicalised**: very often it is forgotten that older persons are part of the family and they have also social problem. The support is provided mainly to help them with disease, sicknesses. There are few gerontological social workers and not enough skills. The shift from socially-centred to medically-centred home care is mainly due to lack of funding. One of the participants tells that in the 1980s there was a home-help service available, where they provided supports such as cleaning, do the shopping together… A nurse would have stayed with the client for an hour and he/she had time to focus on life-quality. Now it's mostly basic nursing: each nurse sees 5 to 8 clients in one day – in the evening shift even 15. During weekends, when they do the most important things only, they would see up to 20 users. Nowadays most of the persons would only receive homecare in order to get medications.

- In Finland they have integrated home care and home nursing services / hospitals many year ago and at **political level the council is one** (health and social services together) and this is considered to be very helpful. Doctors were very much against that because they wanted to belong to the health service but it was a very good solution.
- Concerning the **governance** issue, Finnish municipalities also purchase services from private companies but the assessment of needs is always made by the municipalities – they try to listen to family and client and they have a certain amount of choices among available services.

Then, participants from Ireland and Romania are also asked to comment on the guidelines. As far as **Ireland** is concerned:

- **Social care is under health department** but it's not very developed. You have a right to health care but not to social care. Because of recent cut-backs, unless you are already in the system, it is very difficult to have home-help – basically, now they only give it in case of discharge from hospital. It is free and not mean-tested but in average each client would receive a couple of hours of care a week . Each Local Health Office area now has 4 approved providers available to provide service to clients locally. Clients can view the list of providers in their area and can express a preference for one of the providers, if they are available. It is important to mention that there are normally no doctors in the staff of nursing homes.

- An important role in the provision of services is played by NGOs with financial support from the state. Indeed, **municipalities do not provide any service directly**, so they have no control over that as they don't monitor the services.
- Most **GPs in Ireland are private practitioners** so they do not generally provide their services for free, but the majority of GPs provide services on behalf of the National Health Service to people with Medical Cards (low income or over 70s). Since you can't get in touch with family doctors after 5pm, in case of need persons would go to emergency services but not precautions are given to older persons accessing these services.

Finally, the floor is given to the **Romanian** guests:

- Elderly care in Romania is traditionally attended by the family.
- City councils are in charge of social services and it can vary a lot from area to area but the homecare and day care services are very, very limited and available almost exclusively in the big cities, therefore there is an **issue concerning older persons living in rural areas**.
- There is state health-care provided to everybody on a minimum level. For uninsured persons this would mean getting only emergency care and three days of hospital care. Additionally, there are some subsidies for medications for special groups (for example, dementia medications are 100% subsidized but only the cheapest one). On the other hand, there are a lot of private providers providing a limited number of medical and care services.
- Concerning **professionals**, they have few gerontologist and few hospitals and clinics specialized for older persons. On the other hand, there is a lack of social workers in hospitals and **there is no close cooperation between social and health care services**. Basically, if the patient or the household takes the initiative and calls the social services to ask for help, they would intervene but it's very limited. For example doctors in hospitals would not inform patients about their rights and entitlements and it is not their responsibility to activate the social services. Many people don't even ask for these services because they don't know they can have it.
- **No social professionals are involved in need assessment**.

Seminar in Estonia – Tallin – 31th of January 2014

The seminar in Tallin was attended by **23 participants** representing Carers organizations, NGOs , local governments, academic institutions and colleges , service providers.

After presentation of project outcomes the discussion is open, with the question "You have heard about the key factors identified in Italy to support integration: do you think they fit to your country as well? Thinking about your country what would you add / change?"

Main issues raised:

- Concerning the financing issue, it is a common problem in Estonia that **social services and health care services are financed differently**. Social services are a responsibility of municipalities that in most cases do not have funding to provide adequate number and quality.
- When a person is discharged from the hospital, the responsibility shifts from the health sector to the municipalities that not only don't have enough funding, but also in most cases lack of the necessary skills. **There is no dialogue between health and social services and information do not circulate.**
- In Estonia there is also a lack of GPs and the tendency to gather them in the same facilities, which implies large differences in the availability of doctors across different areas of the country. In **rural areas** patients might have to travel 80km to get a medical advice.
- In Estonia, **GPs can rarely be considered a pillar of social and health integration** as in Italy since they are mostly private practitioners, therefore the access is not free and the approach is „entrepreneurial" and money-oriented. Also, the lack of public commitment makes it difficult to involve GPs in integrated processes.
- On top of the agenda in Estonia now is the issue of **e-health** which is now largely used also as a system to monitor doctors and patients (for example, a prescription made by a doctor can be followed in order

to check if the patient did buy the medicine). On the other hand, it might be seen as a form of discrimination for all those persons that for age, education or other reasons are victims of digital-divide.

- Concerning **training of social and health professionals**, Estonia 5 years ago integrated the social helper and help assistant profiles, thus creating a vocational profile that integrates basic health skills with social care competences. At the moment this profile is not specialised on elderly care but they are planning to introduce this specialisation in the future. On the other hand, as far as higher profiles are involved a training aiming to integrate social and health skills is not available, but would be considered very useful.

Seminar in Barcelona – Spain – 20th of February 2014

The seminar in Barcelona was held at the Auditorium of the Health Services of the Catalan Government in Barcelona and together with the contribution of the Heath Department of the Catalan Government. The introduction was made by Dr.Toni Dedeu, Senior International Officer of the same Department and chaired by Dr.Albert Ledesma, Director of the Prevention and Care for chronic services.

The programme included the following speakers: Alessandro Pigatto Head of the Representative Body of Directors of Local Health Authorities. (Italy), Anna Banchero**.** Responsible of technical coordination of Social Policies in Liguria Region (Italy), Albert Ledesma. Director of the Prevention and Care for chronic Program, Catalonian Government; Frank Goodwin – President of Eurocarers; Sara Santini from Italian National Research Centre on Ageing; Loredana Ligabue from ANS - Anziani e Non Solo società Cooperativa and Mrs Ester Sarquella Director of Social Service and Citizenship - La Plana Area.

The seminar was attended by 84 participants, mainly representing Social and Health Care Centers. social workers and primary care health agents

Note: During the Seminar a visual Summary was done by the company Connecting Brains (www.connectingbrains.es) in which at the end of the seminar everyone could visualize a single sheet (drawing) the topics discussed during the seminar. This had a very good acceptance.

The meeting was also filmed – the footage is visible from:
https://www.youtube.com/watch?v=8Pho2dSnUBY&feature=youtu.be

1- Visual summary done by Connecting Brains

After presentation of project outcomes and a Catalonian example on social and health services Integration at local level, from the Municipality of Tona (downloadable from http://tinyurl.com/sarquella) the discussion is open.

First of all, answering to a question from Joan Carles Contel (Chronicity Prevention and Care Program at the General Directorate of Planning and Health Research of the Catalonian Government) asking for more details on how this process of integration has been implemented between the different regions of Italy, Dr. Pigatto from Veneto Region provided more information. He explained that across Italy there are different model, and also across Veneto Region there are different levels of implementation of integration (at least 4/5 different models over 21 Districts in the Region). For example, as far as the "individual electronic portfolio" is concerned, there is a Regional law stating that each district has to develop one, but then it's left up to each District to decide how much money to invest in it, therefore there are many different levels of implementation. The same as far as tele-medicine is concerned. One of the uses foreseen for the "individual electronic portfolio" is that of gathering information useful for monitoring the efficacy of services provided, and this should include users satisfaction but also the political and institutional consent.

There are models highly integrated and others who aren't. The main obstacles to implementation identified so far are (1) the law on protection of personal data, which is very strict, and (2) the need to negotiate every further tasks requested to family doctors because they are freelances and not employed by the public administration.

Dr. Albert Alonso, MD, PhD, IFIC Vice-chair, Innovation Directorate of Hospital Clinic, Barcelona, Spain, commented and agreed that social and health integration is a complex issue. He appreciated the EU Best Practices from the qualitative analysis point of view which do really provide transferable elements although he thought that there is always a certain degree of weakness in the evidence on qualitative and quantitative approach which entails moving more towards results from process activities.

In general, and also mentioned by Dr. Albert Alonso the people attending the seminar thought that the project and its outcome (Guidelines) could have been more ambitious; for example considering the **desirable level of integration**. Also, it is stressed the fact that **social and**

health integration should be implemented always taking in account a certain degree of flexibility, as we can't find solutions fitting all different contexts and situations.

Dr Toni Dedeu, Senior International Officer at the International Relations and Cooperation, Department of Health in Catalonia commented **that social and health integration services** (synergy within those two cultures) **is an issue raised in many EU countries but still few solutions.**

On the importance of **technology**, the sharing of information is considered the easiest aspect to implement and it is actually already a reality in many contexts. It is true that there is the problem of data confidentiality but the EU is already dealing with it. Indeed, he informed participants that there is an EU directive being prepared (expected to be ready in two years) that will regulate this topic. It will be compulsory and homogeneous across Europe. That will for sure contribute to enable us to do more rigorous validation and homogeneous studies.

Dr. Albert Ledesma from the Prevention and Care for chronic, Program Director explained that Catalonia is now working on a new program in which "**culture change" between the two pillars** (social & health) **is one of the main issues together with how financing flows from one pillar to the other.** They started working from bottom up, learning how to share knowledge and experiences together with the participation of the people.

Seminar in Ljubjana – Slovenia – 27th of February 2014

The Slovenian seminar saw a qualified participation of representatives from the Ministries of Health and Welfare, as well as from the Municipality of Ljubjana, NGOs and service providers.

The programme included, after the presentation of AIDA guidelines, two statements from the Ministries, who were asked to comment from their respective point of views the challenges for integrating social and health care. Finally, a round table discussion with participants was held.

Mojca Gobec, MD, Director of the Directorate of the Public Health at the Ministry of Health explains that in Slovenia Health and Welfare are currently two separate ministries with separate policies. Nevertheless, they have some common recommendation and documents because there is a clear need to be addressed and also from the EU, there is a clear guide that Slovenia should address these issues in a more integrated way. Indeed, for some years now Slovenia is **discussing about a law on integrated care at home,** but so far the law was not approved by the parliament because of lack of funding. On the other hand, in recent year they opened some spaces for piloting innovative way of integration as a priority of use for **EU structural funds** and in this case the planning was joined with the Ministry of Social Affairs.

The main challenge that is foreseen at the moment is due to the fact that traditionally in Slovenia health and social care are very centralised system, although formally municipalities would be responsible for that. So, although there is a need to merge these two services at local level and although there are now examples of good practices they are unfortunately not coherent and systematic and not a standard. The government is concerned that **smaller municipalities might not have yet the capacities to implement this process** even if – in fact – there is the clear feeling that those professional working in front-line services (such as community nurses) clearly realise that an integrated work with social services is needed and at individual level find ways to implement it.

Concerning the issue of **continuity of care** they believe it is good organised as far as hospital discharges are concerned. Indeed, social services are part of the hospital services so when a person is discharged they intervene promptly. Also, Slovenia – compared with other EU

countries - have a strong institutionalisation (at the moment there are over 60.000 persons in facilities, 18.000 in community services and 20.000 in different forms of informal help. They have different facilities such as long-term care wards, nursing hospitals and nursing homes who are receiving the patients after discharge and where **integration of social and health care services is well implemented** . Patients also have the possibility to receive community care but in that case the integration is more problematic, as they would receive health treatments from a nurse (paid by the health insurance) and personal care provided by municipalities, therefore meeting two different professionals depending from different organizations.

Concerning the professional **curricula,** they **are also very oriented health / social –** in practical professionals do work in an integrated way but they are not trained to do so. Also, a need is felt to develop **new curricula,** both from the social and medical side, including skills for long-term care (for example combining nursing, communication and social skills). Speaking about staff, compared with other EU countries, it is underline that they don't face yet the problem of shortages in educated staff in the care sector, although they expect that they will also have this problem in the future.

Then the second speaker was **Davor Dominkuš**, Director of the Directorate of the Social affairs at the MLFSAEO, who at first underlined that the current political organization of services in Slovenia foreseen a **state level and a local level, there is nothing in between**. Local

communities are very small in Slovenia, with few hundreds inhabitants, and they don't have the capacity to exercise the duty they should have. Therefore, he also stressed the concept that at local level it is very difficult because they don't have proper and enough staff to organise this collaboration. So from the Ministry perspective at state level a lot of things have been agreed but at practical level they don't have formal possibility to exercise it. There are big differences across the country. Politically, they have for a long time been thinking about the possibility to integrate an intermediate level, the regional one, but there is a big discussion about responsibilities, funding etc… Mr Dominkuš connects the current situation with the history of the country. Indeed, he explains that when Slovenia gained the independence there was a big discussion about to organize the social protection system. They wanted to give more responsibilities at local level but they were afraid that local communities where not able to deal

with it. So the idea was to have centralised responsibilities and then progressively shifting to a de-centralised level but that hadn't happened yet.

It is then stressed again the challenge created by the financing system. Services within the health care system are paid by the national health care institute and people pay contribution within the obligatory insurance. On the other hand, social services are financed by taxes at state or local level. **It is very hard to combine the financing of these two systems**, especially in case of LTC. Because of this financial diversity is difficult to integrate the delivery of services, because it's hard to plan and combine.

They are aware of the importance of collaboration and that they should not work divided but they are lacking the system which will enable this collaboration. They also need formal structures to coordinate the system for a proper collaboration. But the awareness on the importance of working together is very present and they are trying to achieve this collaboration within very concrete projects.

Finally, he also agrees with the idea that to integrate the services we have to **change the educational system** and to **provide informal carers with knowledge from both sides**

Then the floor is given to participants to the seminar, who mainly stressed the following points: 1) the need to **empower informal carers**, that should be considered an investment that will return in terms of capacities and contribution to effective care; 2) the important role that **ICT** can play to support long term care.

Seminar in Den Bosch – Holland – 6th of March 2014

The seminar in Holland was slightly different from the previous one, as it was focused on a specific experience – that of the District team in the municipality of Den Bosch (Wijkteam Helftheuvel). The meeting participants were the team of professionals working for this team, together with three experts from the Knowledge Center Movisie.

After the presentation of the AIDA guidelines, it was first briefly mentioned by Movisie that the issue of **social and health care integration is now in the political agenda in Holland** as well. For instance, there is currently a commission re-discussing all the training curricula in the social and health care field with the aim to provide more background on integration and also a discussion on social and health care integration for family carers, where it is challenged the dominance of the medical aspect in care.

Then it was introduced the District Team programme. Started in May 2013, it is a team of

professionals from different backgrounds (in social care, health care, community development…) paid by the municipality and working in the neighborhood with two main aims: a) help vulnerable people with different issues (social, health, finances…) and b) involve and connect the local community. The team of 10 intervene on an area of approximately 20.000 inhabitants and while they all closely cooperate, each of them is responsible for a defined area of the neighborhood covering approximately 1.000 households, thus that each worker can be clearly recognized and create relations of trust with inhabitants. The intervention approach is mainly that of coaching and empowerment of users, together with the research of the most affordable and "near" solution. Specialist care is activate only if really needed, but basically they try to "normalize" the situations as much as possible.

The District Team was considered interesting for AIDA as it can be considered in many ways a concrete example of implementation of social and health care integration at community level.

First of all, the team **integrates professionals from different disciplines** (a community nurse, social workers, professionals with expertise in mental illnesses and disabilities…) who work

together sharing and integrating skills. Each week there is a team meeting where new cases are presented and discussed but each worker – while being responsible for a specific area – can turn to others when he/she realizes that a further specialization is needed. The team describes this joint work as a real added value and points out that it has never created critical situations. It is interesting to mention that they have never participated to a joint training before starting with the programme and that their approach was basically a "learning-by-doing together" since at the beginning they followed each case in a sub-team of a social and a health care professional, in order to "learn to see with the eyes of the other".

The service also makes use of a **multidimensional tool**, which is a self-sustainability matrix of 11 fields of life. It is important to mention though that this is a **self-assessment tool** that is filled by the client with the support of the professional, so it is not a professional assessment. This because – as said – they intend to empower the client who will make its own individual care plan. The plan is therefore drafted by the client (or sometimes by family members) and shared with the professional (and not the other way round) who then plays a **case management role,** supporting the client in implementing the plan.

In order to do so, they would first try to find a solution in the family network and in the community. They incentive informal support, under the principle that it is not proper volunteering but "everybody taking care of everybody in the neighborhood". Volunteers in this way can solve basic needs such as providing respite care, assisting in household management, grocery shopping, do the gardening – but also translate for fellow migrants with less linguistic capacities.

If the solution can't be find in the community they will activate professionals but a member of the team will remain in contact with the family playing a case-management and mediation role. On the other hand, they do **receive referrals from the health care sectors, for example from GPs in case of hospital discharges** and they activate the services needed. In the case when other professionals are involved, they also make sure there is a **sharing of information**, so that the client must not be re-assessed again (although this is a challenge with some professionals). They are allowed to do it because when they take in charge a case, they ask for the user permission to share information about him/her with other professionals.

Concerning the use of **ICT**, they work with clients using tablets, for example the self-assessment is filled online through this tool, which is considered much more user-friendly and personal then

a PC as the worker doesn't sit behind a screen and it can be used also by persons with lower ICT skills.

It is planned to make use of ICT also to collect and share of information as well as to create a "needs / resources" database, but this process is still on-going.

Teams like this exists all across the country, although it is not an obligation for Municipality to activate them, the central Government "strongly advice" them to do so. The innovation and strong point of the Den Bosch's one is the division of responsibility of professionals according to geographical areas. According to them, this makes the difference as they are on the street, recognized by inhabitants (they also wear a labeled jacket) and this makes it easier for them to collect information, referrals and to monitor the conditions of their clients. In 8 months, the Den Bosch's team has worked on approximately 300 cases and although the service is too new to be able to measure an impact, results are considered very promising.

Finally, the group discusses about the issue of **integrated funding** for social and health care mentioned in the guidelines as a key systemic point for a successful integration. Holland is actually going in the opposite direction, as from January 2015 competences and funding for care will be distributed under three main players: the health care insurance, an insurance that will cover personal care and municipalities having the responsibilities for welfare. The idea behind the decision to separate welfare and care is that it is considered that care is a complex issue and municipalities wouldn't have the necessary expertise to implement it.

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