THINK TANK

SPACE FOR DELIBERATION ON THE FUTURES OF THE NEW WELFARE STATE

DOCUMENT No. 6

The territorial transition:

Territorial organisation, structure of powers and inter-institutional coordination

1. Characteristics of the care model

1.1. Digital Innovation Model

The care model structures the relationships between people and this is the fundamental element. In order for these relationships to be dynamic and interactive, it is essential to promote digitalisation of the model and of social services. This does not just involve digital technology but a system of innovation: vision, organizational culture, new approaches, new processes and personal skills.

1.2. Connected, Cross-cutting Model

The care model must overcome the existing silos that connect different institutional levels vertically (local, provincial and autonomous) and horizontally (health services, social services, community services, urban planning, economic promotion, mobility, etc.). Likewise, the element of transversality (cross-cutting) not only involves institutions and organizations but also different profiles of users (not only elderly people but all people of any age and condition included in the law).

1.3. Public-Private-Social Collaboration Model

The care model must be developed on the basis of collaborative governance. Collaborative governance must go beyond the public-private partnership model by extending and including the social sector in the process of co-creation, co-development and co-evaluation of social and health policies. Thus, public-social collaboration means strengthening community development and proximity care.

1.4. Person-Centred Care Model

The person-centred model of care structures the development of various interactions of people in need of care, attention and support with their physical, social and organisational environment in order to promote their quality of life. One central action within this model is to promote a training programme on person-centred planning, aimed at technicians and managers of

grassroots social services (at local and territorial level) in order to modify the management models of social policies.

1.5. Home Care Model

The Home Care model seeks to strengthen the quality of life of people and their families at home, for which it is necessary to promote and increase the portfolio of home-based social and health care services. This deinstitutionalization strategy promotes home care thanks to community and *comarca* coordination networks.

1.6. Relational Assessment Model

Development of an evaluation methodology based on objective and subjective Quality-of-Life indicators to strengthen Person-Centred Care. Promoting a relational model of evaluation is a strategic competence of public administration that must go beyond the model of supervision and administrative sanction. Promotion of the relational model of evaluation must be structured on a cross-cutting approach to social welfare and the actors involved.

2. Institutional powers to promote a new care model

2.1. Capacity for institutional innovation

One of the main institutional powers for promoting the transition to a new care model involves fostering the capacity for institutional innovation. Within the framework of these capabilities, it is important to encourage: a) design and management of the innovation portfolio; b) promotion of experimental projects (trial and error) and learning of innovative processes; c) development of new models for financing experimentation; d) flexible and agile management of the transfer of good practices and successful innovative initiatives; e) evaluation of the impact (internal and external) of innovative processes.

2.2. Institutional leadership capacity

The capacity of public leadership to promote a strategic vision in which Gipuzkoa becomes a reference point among provinces for a new care model. Institutional leadership means being able to offer a systemic vision of the care model, a transition strategy, a set of policies to promote ecosystems, an adapted regulatory model, an agile and effective financing system, and a provincial system of assessment and lesson-learning.

2.3. Capacity for anticipation and prevention

The capacity for anticipation and prevention of social and health policies at municipal, *comarcal* and territorial level are key capacities to promote the transition towards a new care model. Anticipation means exploring future scenarios while prevention means developing actions in the present to change consequences in the future.

2.4. Capacity for knowledge absorption

Knowledge absorption capacity refers to the institutional skills and competencies to integrate external knowledge thanks to the internal knowledge acquired. The development of new internal knowledge at both a political and technical level (internal to public institutions) is a prerequisite for driving the transition towards a new care model. The creation of innovation and training units for technical staff is a step in this direction.

2.5. Capacity for social dialogue

The aim of setting up the Gipuzkoa Civil Dialogue Panel is to guarantee effective participation by the third sector in the design, execution and evaluation of social policies and promotion of the transition towards an alternative care model in the territory. Structuring the participation of the third sector in this process guarantees the sustainability of social policies.

3. Inter-agency coordination mechanisms

3.1. Integrated digital platform

Design and implement an integrated digital platform capable of facilitating: a) Coordination of the relationship with the families attended; b) Effective and efficient management of the interrelation/interconnection between different territorial actors (social, health, public, private, etc.) linked to care; c) Integrating within the same support the portfolio of social and health services for potential users.

3.2. Implementation of case management methodologies (the Kaiser Pyramid)

Design and implementation of a case management model based on the Kaiser Pyramid, consisting of self-managed multidisciplinary teams operating in local proximity services. Case management allows different types of service (health, social and community) to be connected at the grassroots level on the basis of care pathways. Proximity with users is relevant for a change in model based on case management.

3.3. Local and *comarca* coordination bodies

Design and implement local coordinating bodies with decision-making capacity to coordinate pilot projects, case management and care pathways from the grassroots level. These bodies can become drivers and managers of local care ecosystems. Territorial bodies must be provided with agile and adaptable financing capacity, as well as technical evaluation capacities to generate learning.

3.4. Experimental working groups in PCC

Promotion of experimental PCC working groups to design, experiment with and assess (at a small scale) pilot projects to test the model and adapt it to the care environment of Gipuzkoa.

3.5. Inter-institutional (territorial) planning

In order to develop the transition towards a new care model, it is necessary to develop a strategy not only of coordination but also of inter-institutional planning that involves not only centres, care homes and financial benefits (social services) but also outpatient and day care services (health services), as well as other services and systems such as housing, employment, income, justice and territorial organisations. Including users in the planning process is an important condition for strengthening inter-agency planning processes.