5. Integrated Care – Research and Learning

5.1 Introduction

In outlining the overall policy underpinning the reform programme, *Future Health* emphasises important research and learning from the international literature. *Future Health* goes on to say:

> "*while the reform of individual elements of the service will be informed by the experience of other countries and best practice, the system as a whole will be uniquely Irish. Our goal is not simply to copy other health systems but instead to learn from what works best elsewhere. This will help us to design a truly Irish model of healthcare which meets the needs and requirements of the Irish people."*

In this context, the project team was conscious in undertaking this review, not only to take on board the learning and experiences from other countries, but also to listen to the inputs and experiences of those who took part in the consultation process. Those involved provided important insights and relayed their experience of how services and structures operated as they were delivered on the ground and what is required to improve how people experience them.

Future Health emphasises the emerging importance in the international literature of integrated care and it is useful to reiterate some of the key points identified in Future Health as follows:

5.2 What is Integrated Care

It is clear from international literature as well as from policy discussion in Ireland that integrated care means different things to different people. Integrated care, as set out in *Future Health*, can be defined as care that

- *improves the quality and outcome of care for patients and their immediate families and carers by*
  - *ensuring that needs are measured and understood and that*
  - *services are well co-ordinated around these assessed needs.*
- *It is preventative, enabling, anticipatory, planned, well-coordinated and evaluated.*
- *It is a system of care that critically looks at the impact on health and wellbeing of the patients concerned.*

Understanding integrated care means looking at processes and outcomes of care rather than at structural and organisation issues. Achieving integrated care means that services must be planned and delivered with the patient's needs and wishes as the organising principle.

It is preferable that the term "integrated care" rather than "integration" be used so that it is clear that the focus is where it should be i.e. on people and families and the services they need rather than on funding systems, organisation or professionals. Each of these will be important levers in enabling and facilitating integrated care – but they in themselves are not the objectives.

International research on integrated care shows three things very clearly:

- *It can make a real difference to the quality of care received by patients: The danger of a fragmented delivery system is that individuals' needs will not be fully met, substantially reducing patient outcomes.*
- *It is very difficult to turn the concept of integrated care into a cost effective operational reality. One of the main challenges is to target the right individuals and conditions. For instance, it is clear that case management must be a crucial part of integrated care. However, because case management is a labour intensive activity it is unlikely to be cost effective unless it is targeted effectively.*
- *There are many ways to implement integrated care: Crucially organisational integration is not necessarily required. The key requirement is clinical and service level integration, supported by an appropriate incentives system.*

5.3 Enabling Integrated Care – Irish Context

The Kings Fund and the Nuffield Trust identified ten key elements to enabling integrated care as follows:

- *Provide a compelling and supporting narrative for integrated care;*
- *Allow innovations in integrated care to embed;*
- *Align financial incentives by allowing commissioners flexibility in the use of tariffs and other contract currencies;*
- *Support commissioners in the development of new types of contracts with providers;*
- *Allow providers to take on financial risks and innovate;*
- *Develop system governance and accountability arrangements that support integrated care, based on a single outcomes framework;*
- *Ensure clarity on the interpretation of competition and integration rules;*
- *Set out a more nuanced interpretation of patient choice;*
- *Support programmes for leadership and organisational development;*
- *Evaluate the impact of integrated care.*

The final conclusions from Kings Fund and Nuffield Trust can be translated to an Irish context as follows:

- *Government policy should be founded on a clear, ambitious and measurable goal to improve the experience of patients and service users and to be delivered by a defined date.*
- *Setting an ambitious goal to improve patient experience should be reinforced by enhanced guarantees to patients with complex needs. These guarantees would include an entitlement to an agreed care plan, a named case manager responsible for co-ordinating care, and access to telehealth and telecare and a personal health budget where appropriate.*
- *Change must be implemented at scale and pace. This will require work across large populations at a city and county-wide level. There should be flexibility to take forward different approaches in different areas and to evaluate the impact, with the emphasis being on people with complex needs.*

The project team, in developing proposals for Community Healthcare Organisations which will have relied significantly on this overall policy direction outlined in *Future Health*.

The project team has also been cognisant of the importance of community within the Irish context, particularly the importance in Ireland of enabling local communities to support their own people through the life cycle. Community in this sense involves a significant network of voluntary organisations and supports. It is in the engagement between these informal networks and the more formal state-provided services that real partnership is developed and sustained and through which people come together in a way that supports and enables communities to meet local needs.

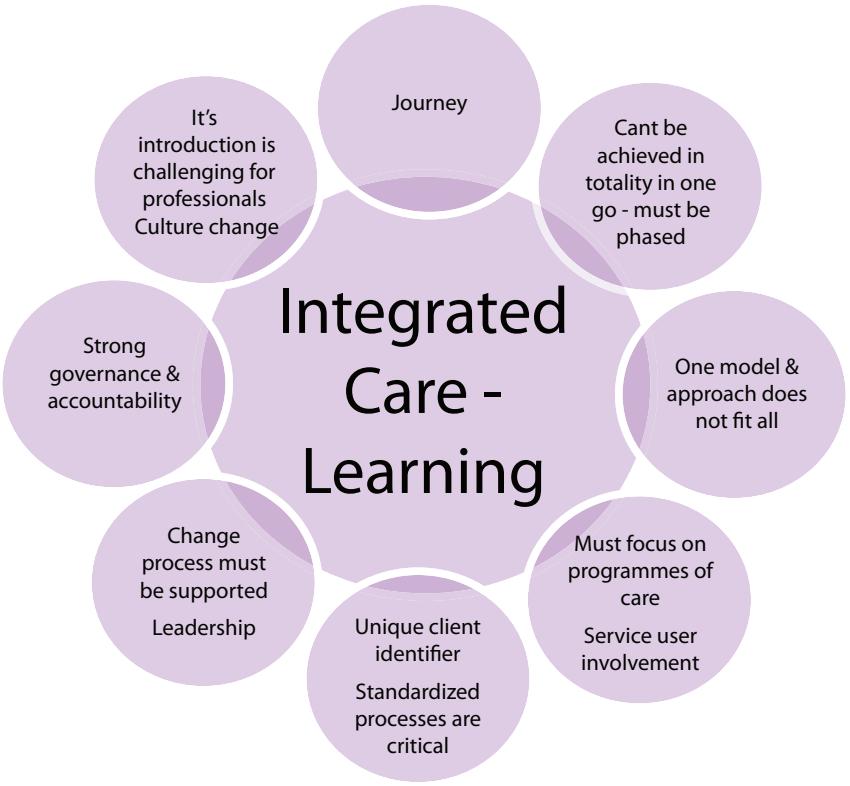
The project team recognises the challenges involved in integrating care within the community i.e. primary care and the specialised services in social care and mental health, and also between hospital and community services, while at the same time supporting productive relationships with other key sectors such as local authorities, education etc.

However, it was felt that given the importance identified by *Future Health* around this whole issue of integrated care (as summarised above), that further analysis of this issue was important in finalising the project team's consideration of Community Healthcare Organisations and associated governance and management arrangements.

To complement this process, a *Review of International Experience from the Literature* was carried out under the auspices of the Institute of Public Administration on behalf of the project team. The work was undertaken by Dr Katherine Gavin, Healthcare Management Consultant and IPA Associate. With the assistance and support of the Department of Health the project team also had insight into the research undertaken by the Health Research Board on integrated care and related issues and advice on emerging thinking with regard to the implementation of an UHI model in Ireland.

5.4 Summary of Key Themes and Learning from International Experience of Integrated Care

The output from the international review undertaken by Dr Gavin is attached (Appendix D) and outlined below is a summary of the key themes and learning from the review of international experience from the literature:



- Integrated Care is a **journey**; even countries recognised as having made significant advances in the area of Integrated Care have been working on the concept for two decades or longer.
- **One size and approach to Integrated Healthcare does not fit all** circumstances
  - Successful integration has followed different paths and approaches in different healthcare systems
  - It is important to be cognisant of the **local context**, and inherent challenges
- It is neither possible **nor advisable to attempt to introduce Integrated Care across all areas in one step.** A number of countries have adopted a pilot type approach introducing integrated care in pockets of service with a view to expansion e.g.
  - Health pathways in Canterbury DHB integrating care around disease states/conditions
  - Care Programmes in elderly care and mental health in Northern Ireland
  - Persuing Perfection in Jönköping Sweden for childhood asthma
- **Focus on the patient need** and journey through the healthcare continuum rather than focusing on the service providers perspective e.g. Mrs Smith (Torbay) and Esther (Jönköping Sweden)
  - A named person to co-ordinate patient care
  - Single point of patient contact, co-ordinating care across the continuum
  - Focus on collaboration between health and social services and acute and community sectors rather than competition- CQI in patient care
  - Care in Community wherever possible- shift focus from acute sector

- **Leadership**
  - Strong leadership from the top and at various levels in the process-consider leadership development
  - Buy in from clinicians is essential-clinicians to act as leaders
  - Political commitment
- **A firm foundation**
  - A robust primary care system acts as a firm foundation for integrated Care
  - A history of successful collaboration between health and social care may facilitate further integration
  - Structural and organisational stability facilitates the change
- **Synergy regarding drivers** for integration is advisable e.g. National Policies support local initiatives, legislation, policy and structures facilitate the process
- **Staff**
  - Must be included in the decision making process
  - Must be enabled and supported throughout the process
  - Must be trained in the knowledge and skills required to make integration a success. Systems thinking approach may be beneficial
  - Commitment of staff necessary for success
  - Multidisciplinary/Interdisciplinary staff training and development-can help break down barriers and smooth cultural differences and facilitate a unified approach to patient care
- **Governance**
  - Representatives from community health and patient on the governing bodies
- A clear vision regarding the purpose and outcome of integrated care is essential and this needs to be **communicated** to all stakeholders
- Capturing robust **evidence** of improved healthcare outcomes as a result of integration is important
  - Recognise difficulties around definition of Integrated Care. Is it primary and secondary, primary, secondary and community any or all of these with social care? Important to define what to measure.
  - Performance Management Systems are important to capture meaningful data on improvements in patient care and efficiency/cost savings.
- **Information Technology** plays a key role in communicating and sharing information regarding patients within the system, avoiding duplication, etc. and in evaluating the impact of any changes in outcomes by capturing data.
- **Funding**
  - A unified health and social care system with a unified budget
  - Flexible sustainable financial mechanisms - enable funding to follow the patient
  - Provide a system of shared resources and mutual accountability for Service delivery and patient outcome
- **Introduce incentives and remove disincentives** where possible
- **Accountability**
  - Be clear on roles and responsibility of all team members. Have a clear line of accountability
  - All providers need to understand what aspect of care they are responsible for and develop and agree protocols for how care is to be delivered. Regular communication between team members is essential. Different systems appear to have different systems of Accountability

- In Canterbury New Zealand, responsibility for operational and management duties are delegated to the CEO of the Health Board. The CEO has an executive team. A clinical board provides clinical leadership and clinical governance.
- Joint accountability from providers of services for outcomes is proposed to be a factor in enabling integrated care in Scotland (Ham et al 2013).
- A named Non-healthcare) person co-ordinates a patient's care in Torbay trust. It is not clear if the co-ordinator is accountable for patient care

5.5 Guiding Principles for Delivery of Integrated Care

International research identifies that the delivery of integrated care has been achieved through a focus on a combination of many, if not all, of the ten guiding principles outlined below. The delivery of integrated care has been more successful where, not only have the ten principles been adopted, but resources have also been allocated to the development of processes and strategies that support implementation of these guiding principles.

- **Comprehensive services across the care continuum**
  - Cooperation between health and social care organisations;
  - Access to care continuum with multiple points of access;
  - Emphasis on wellness, health promotion and primary care.
- **Patient or population focus**
  - Patient-centred philosophy focusing on patients' needs;
  - Patient engagement and participation;
  - Population-based needs assessment focusing on defined population.
- **Geographic coverage and rostering**
  - Maximise patient accessibility and minimise duplication of services;
  - Roster: responsibility for identified population and recognising the right of patient to choose and exit.
- **Standardised care delivery through inter-professional teams**
  - Inter-professional teams across the continuum of care;
  - Provider-developed evidence-based care guidelines and protocols to enforce one standard of care regardless of where patients are treated or who is treating them.
- **Performance management**
  - Demonstrates commitment to quality of services, evaluation and continuous care improvement;
  - Clinical diagnosis, treatment and care interventions linked to evidence-based outcomes.
- **Comprehensive Information systems**
  - Modern information systems to collect, track and report activities;
  - Efficient information systems that enhance communication and information flow across the continuum of care.
- **Organisational culture and leadership value collaboration**
  - Organisational support with demonstration of commitment;
  - Leaders with vision who are able to instil a strong, cohesive culture.
- **Physician integration**
  - Recognised that physicians are the gateway to integrated healthcare delivery systems;
  - Are the single-point-of-entry and using a universal electronic patient record;
  - Engaged in leading role through participation on Board and to promote buy-in.

- **Adequate governance structure**
  - Strong, focused, diverse governance representing comprehensive membership from all stakeholder groups;
  - Organisational structure that promotes coordination across settings and levels of care.
- **Financial management**
  - Alignment of service funding ensuring equitable funding distribution for different services or levels of services;
  - Funding mechanisms promotes interprofessional teamwork and health promotion;
  - Sufficient funding ensuring adequate resources for sustainable change.

5.6 Guiding Principles of Good Governance

As set out in Appendix E international research identifies a number of core principles of good governance which should be considered in the development of organisational and structural arrangements. It is necessary for organisations to;

- have clear purpose and outcomes
- have appropriate capacity and capability to govern effectively
- engage effectively with stakeholder and be accountable to them
- perform effectively in relation to defined functions and roles
- promote values for the whole organisation
- ensure that decisions are informed, transparent and that risks are managed appropriately.

In the public sector, to assist in ensuring that good governance is in place, organisations must clearly define their outcomes in terms of sustainable economic, social and environmental benefits and determine the interventions necessary to optimise the achievement of those outcomes. To deliver on these outcomes and implement the interventions, the necessary leadership capacity must be developed. In order, to appropriately manage risks and performance a robust internal control and financial management environment must be established, with transparent reporting to deliver effective accountability

In the context of health and social care systems, the importance of appropriate clinical governance, involving continuously monitoring and improvement of the quality of services, is acknowledged as a fundamental requirement. The benefits of clinical governance rest in improving patient experiences and better health outcomes in terms of quality and safety and has been widely adopted internationally. A particularly important component of clinical governance is clinical supervision, which can be defined as “the formal process of professional support and learning that addresses practitioner’s development needs in a non – judgemental way”. This enables practitioners to deliver an appropriate standard of care and to keep abreast of developments in care.

5.7 Linking Learning from Research, Consultation and Experience of Change to Date

It is the considered view of the project team that it is not possible to deliver integrated care in the way intended, across an individual care group or between care groups, given the current service delivery structures and absence of standardised processes or agreed outcomes of care. International evidence advises that it is neither possible nor advisable to attempt to introduce integrated care across all area in one step. A number of counties have adopted a pilot type approach, introducing integrated care in pockets of service with a view to expansion. The learning and experience of other countries advises us that the introduction of sustainable integrated care is successful when its introduction is on a phased and planned basis, and when it is targeted on pathways and models of care.

The commitment and supports required, as well as the timelines involved in successful implementation of a sustainable model of integrated care is illustrated in the work undertaken in Scotland around *Managed Clinical Networks* (App G). This illustrates the scale of what was involved

in the Scottish context in establishing a project and commencing implementation (see Appendix G). From this we can see that within the framework in Scotland it takes a full 12 months to simply put the project plan in place to establish a *Managed Clinical Network*, and perhaps 18 – 24 months to begin to successfully implement and gain traction from the initiative. This illustrates the scale of work involved in implementing this type of change programme and also the level of support that will be required at all levels to enable the clinical and professional capacity as well as management capacity for successful implementation.

While emphasising this point of step by step progress in a managed way towards a fully integrated model of care, it is important to emphasise also the benefit that will accrue from taking the time and effort to standardise the models of care, business and clinical process and care pathways associated with each individual care group such as primary care, social care, mental health and the health and wellbeing approach. By undertaking this work as an important first step in the journey towards integrated care, it will be possible to deliver significant benefits to local communities, patients and service users over an 18-24 month period, in parallel to the work being undertaken on the development of the integrated care approach.

Equally, it is emphasised that having in place a robust primary care system acts as a firm foundation in implementing integrated care. The fact that in Ireland there is a history of successful collaboration between health and social care will support and facilitate further integration. The work that has been undertaken to date in developing primary care in line with the national strategy will also support this objective. What has not been sufficiently progressed however in the Irish context is the development of the necessary framework for standardised models of care and supporting processes or key measures of performance or outcomes. These would enable a progressive step by step achievement of integrated models of care within specialised services, or between the specialised services and primary care over a reasonable period of time.

The development of these standardised models of care and related processes are a critical foundation phase in the journey if services are to be successfully integrated;

- within community health services i.e. primary care, social care, mental health and health and wellbeing
- between community services and hospital services
- between the health and social care system and other public authorities
- in a way that is sustainable and serves local communities.

It will be necessary firstly for each care group (considering acute hospitals a care group in this context) to develop standardised models of care. These will need to incorporate clear business and clinical processes, care pathways and internal and external outcome measures. The learning from abroad is that this work will need to be phased in over a period of time with clear targets and milestones being set, progressively improving the quality and responsiveness of services in each care group, while also moving in a phased way to the implementation of a sustainable and integrated model of care.

We are fortunate in Ireland at this time, that much of the ground work is already underway to deliver such an ambitious reform programme, building on progress through the National Clinical Programmes. We have also established a System Reform Unit which will be an important enabler in supporting the implementation of the change programmes in a coordinated and prioritised way.

Only when the milestones are successfully achieved, will it be possible to move to the next phase of comprehensive integration, across all service delivery settings. Each individual milestone and goal which is achieved will represent a significant improvement in service delivery to local communities and to the experience of people and service users in terms of quality and access to services.

As outlined above, a first key step will be for each care group to undertake a programme of work to standardise the models of care and service delivery, linking resources provided to outcomes delivered and with an appropriate suite of key performance indicators and other measures.

While these programmes are being developed from a care group perspective, they will also need to build in appropriate mechanisms to incentivise integration and set out measures against which successful implementation can be assessed.

Health Service Directorate - The recent establishment of the new Health Service Directorate brings a specific focus to each of the care programmes. This, together with the establishment of the System Reform Unit will support the:

- effective programme management of a project of this scale,
- development of management and clinical leadership and capacity
- ongoing education, training and development to support the workforce and teams at all levels
- translation of the learning on an ongoing basis to inform effective implementation.

National Clinical Programmes - The programmes of care (clinical programmes) will be a key component in providing the overall guidance and framework in supporting this approach.

The establishment of these National Clinical Programmes in 2010, involving collaboration between the health service, the Royal Colleges and with the support of HIQA and the Department of Health, provides a strong platform to develop the standardised models of care and processes referred to above. Its role is to develop a national, strategic and co-ordinated approach for the design of clinical service improvement to deliver improved patient care, improved access and better use of resources.

A revised governance and organisation model has been put in place for the programmes, whose objectives include;

- the enablement of an integrated approach to the design of care models particularly as they cross acute services, mental health, primary care, social care and health and wellbeing
- maintain and enhance clinical leadership as a fundamental building block of reform of patient care
- align the programmes with other strategically important areas including national performance metrics, patient safety, workforce planning, and ICT and Informatics strategy.

National Clinical Group Lead - A National Clinical Group Lead is being appointed for each of the Divisions, which will embed clinical and professional leadership within the management structures of the new Divisions, providing the necessary support and advice at national, regional and local level.

System Reform Group – The System Reform Unit, established by the Health Service Directorate, will provide an important support to the system in the implementation, project management and assurance of the reform programme of work. It will also provide programme planning and monitoring of the implementation, together with the education and training supports necessary to deliver sustainable change over time.

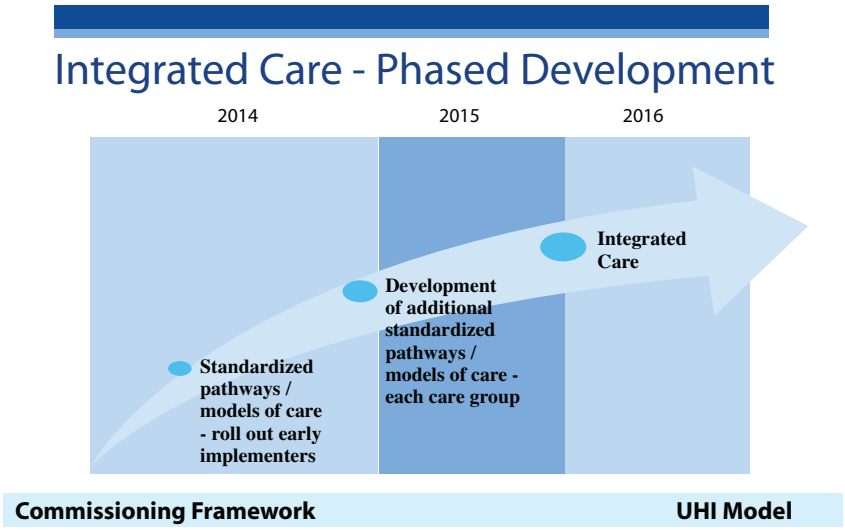
During each phase of the reconfiguration of specialist community based services and acute hospital led programmes, all changes will need to be proofed against the ultimate goal of delivering an integrated responsive service to people in the most appropriate possible setting which will be within their communities, serviced by their primary care networks.

The project team, in addressing this issue, have considered “what successful implementation of integrated care might look like in an Irish context” - the type of practical benefits that could be delivered from this approach to the development of a standardised care model in Ireland are:

- Home Care and Community Support Services – Re- alignment of the model of care to enable older persons to live independently, in their own homes for as long as possible, with a service improvement programme to ensure standardised delivery of home help and home care packages.
- Disability Services for Children and Young People (0 -18s) – A national unified approach to delivering a clear pathway to services regardless of where a child lives, the school attended or the nature of the disability or delay.
- Diabetes – Integrated management of diabetes, alignment of existing primary diabetes care initiatives to nationally agreed model of care.
- Chronic Obstructive Pulmonary Disease (COPD) - A model of care including guidelines for the management of COPD including spirometry in the primary care setting
- An over-arching model of care in Mental Health Services, to provide a relatively standard level of basic services regardless of location, focused on recovery and enhancing clinical excellence.

The list above is illustrative of the type of programmes that can be successfully rolled out as "early implementers" in this approach to the development of an integrated care model. Such programmes can be the first phase of work as we move towards the development of a comprehensive, fully integrated model over a period of years. This more comprehensive model will require a body of work by each care group to bring their services to a level where integrated care is delivered in a consistent and sustained way.

The following diagram illustrates the phased approach to the development of integrated care models as we progress the implementation of a commissioning framework and create the environment to support a UHI model.



5.8 Summary

The consultation output, the findings from the literature and research review, the input from the project team and wider HSE Leadership Team emphasises the following:

- One size does not fit all and it is not advisable to attempt to undertake a comprehensive integrated care programme across all areas in one step.
- Our experience to date in seeking to develop ISAs and PCTs / HSCNs and the evidence from the research indicates that in seeking to integrate all aspects of the service in a comprehensive fashion at the one time within the community services, and between the community services and acute hospitals, may have been too large a task. A more simplified, step by step approach needs to be taken to successfully deliver sustainable change in a systematic way across the system. With hindsight, the tendency has been to speak in terms of integrating "community services" with acute hospital services, as if it can be assumed that community services themselves are sufficiently developed and integrated to effectively integrate with the hospital system.
- From the analysis of the project team and the feedback from the consultation and research, it is clear that significant work remains to be done within each of the individual care groups that make up "community services" i.e. primary care, mental health and social care to develop standardised models and pathways of care. These models and pathways must encompass the necessary clinical procedures and protocols, business processes and performance measures necessary to deliver comprehensive and effective outcomes to their service users and patients.
- It is only when this work has been sufficiently developed can the services encompassed by each of these "care groups" effectively integrate with each other in a way which maximises the experience and outcomes for service users. Similarly, the development of such standardised processes will support effective integration between all aspects of community services with the hospital system and external partners e.g. local authority, education, etc.

- The development of standardised models of care and care pathways, etc. are essential to support the UHI environment, including the development of commissioning and the purchaser / provider split.
- The National Clinical Programmes and the System Reform Unit position the organisation well as it progresses on this journey of change and will provide the necessary leadership, challenge, evaluation and performance assurance to ensure that the milestones along the journey are reached and deliver integrated care.

The diagram below illustrates the central role of primary care, supported by the specialised services of mental health and social care, within a health and wellbeing framework. The interaction between acute hospital services and community services is also depicted. The significance of Primary Care Teams, Network Managers and GP Lead is emphasised, together with the supporting architecture / enablers required to deliver integrated care e.g. clinical programmes, leadership development, System Reform Unit, etc.