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Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

MEMORANDUM

TO: ALL MEMBERS OF HSE MANAGEMENT TEAM; ALL REGIONAL DIRECTORS OF OPERATION; ALL ISA MANAGERS
FROM: TONY O'BRIEN, DIRECTOR GENERAL DESIGNATE
DATE: 14 MAY, 2013
RE: HOSPITAL GROUPS

Dear Colleagues,

As you are aware later today Minister Reilly will publish details concerning the arrangement of hospitals into Hospital Groups on an administrative basis. This is a precursor to the development of Hospital Trusts.

While today's announcement will simply begin the process of the development of Hospital Groups on an administrative basis, and nothing will change immediately, it nonetheless heralds the end of the structural basis for Integrated Service Areas.

In this context it is necessary and timely for us as an organisation to examine the best options for the future organisation and arrangement of our non-acute sector services. This will necessarily involve an examination of the appropriate successor structures to integrated service areas including taking a view on the appropriate number of such areas and the resource requirements in terms of management structures for such successor entities. It is important that I should tell you that there is a clear commitment to provide non-acute services with governance arrangements of equal weight and esteem to those that are now envisaged for acute hospital services. I believe that there is significant opportunity arising from this process. It is important that the HSE plays a full part in proposing options for the future and in this regard I have asked Pat Healy to lead a process of dialogue with you and to bring forward proposals in this regard.

Yours sincerely

A handwritten signature in black ink, appearing to be 'Tony O'Brien', written over a horizontal line.

Tony O'Brien
Deputy Chief Executive

Project Scope Statement – ISA REVIEW

Project Name:	Proposals for future organisation and arrangement of our non-acute sector services – Successor structures to ISAs
Project Lead:	Pat Healy, National Director Social Care Designate

Date: 18th June 2013

Project Justification:

Introduction:

In order to achieve the overarching objectives of the reform programme, real changes are required in the organisational arrangements, both from a governance and service delivery perspective. It is a key enabler that will facilitate the achievement of the vision for Primary Care & Community Services and inform our approach in developing a stable environment for delivering integrated care throughout the reform process and as we move towards the UHI environment.

The Reform Programme envisages a move from the current centralised management model for health services to a model that will see greater autonomy for front line services through the establishment of hospital groups and the organisation and management of primary care and community services within identified geographic areas. The changes to be introduced in 2013 will;

- Provide direct line accountability between the individual National Directors for services and the managers responsible for hospitals and primary care & community services as a precursor to moving to a purchaser provider split & commissioning model.
- Ensure the foundation for greater autonomy at service level is in place and provide the stepping stone to independent trusts
- Primary care, social care, mental health and health and wellbeing services will be delivered and managed through an integrated management structure within geographic areas, which will be identified in this review. This will include HSE funded agencies in these service areas.
- It is intended that the future governance of primary care & community services will be similar in approach to the development of hospital trusts, ensuring robust management structures and 'parity of esteem' with the acute hospital sector.

The following points are instructive in focussing the work of the review:

- Commitment in *Future Health* to reforming the way services are provided in the areas of Primary, Social and Mental Health care and review Integrated Service Area Structure
- The output and findings from the review will inform decisions in relation to establishing a stable environment for delivering integrated care during the course of and beyond the health reform process and into the UHI environment.
- Move from emphasis on acute care towards preventative, planned and well co-ordinated community based care
- Primary Care Teams and Social Care Networks provide the foundation for a new model of integrated care
- ISA review timely and necessary now with launch of new hospital Groups and governance arrangements.

Requirements:

It is necessary to delineate and map out appropriate successor structures and related catchment areas for Primary Care & Community Services and design appropriate governance models at Area and Sub Area levels that will:

- clarify the lines of governance and the operational management structure including frontline management arrangements to support effective service delivery and policy implementation
- drive and support safe, quality care for patients and clients
- bring decision making close to where services are delivered
- allow clinicians to shape and assure the services they work in
- get the best health outcomes for the money spent
- plan and organise around what we know people need and what we know works to give the best results.
- facilitate meeting increasingly complex patient and client needs
- remove any barriers to integrated care

Project Approach

There will be four elements to the project approach which will be run in parallel due to the limited timeframe available i.e.:

1. Extensive Consultation with stakeholders
2. Research & Evidential Base
3. Preparation of Report and Proposals for the successor structure
4. External Validation

1. Consultation

The project lead will be supported by a small project team to undertake a comprehensive process of consultation and dialogue with all stakeholders to identify options for the future and bring forward proposals in this regard.

- The consultation and engagement will be the most important element of the process providing direct engagement with stakeholders at all levels of the service and facilitating their input to shaping the future direction
- The process of consultation will involve a series of facilitated workshops and meetings guided by a structured framework around the following key stakeholder groups
 - 17 ISA Managers
 - Operational GMs/LHMs/SOMs
 - Workshop in each of the 17 ISAs with a multi-disciplinary group including the local acute hospital(s) / community services / General Practice representation together with Finance, HR, Estates and other functional supports, local care group Specialists / Managers etc.
 - Meetings with a wide range of stakeholders i.e. relevant national organisations and bodies (meetings will be arranged individually or collectively dependent on the nature of the group)
 - National Directors and members of the top team, National Leads and care group specialists etc.
- Consultation with Department of Health – a specific engagement will be required with DoH to ensure that the approach is in line with their current thinking and takes account of work already done
- A focussed consultation, in conjunction with the national Director of HR, with staff associations / unions to comply with the consultation element of public sector agreement.

2. Research & Evidential Base

The approach will also require the normal literature review and research to provide the evidential base to support the final proposals or recommendations of the report. The approach envisages:

- Secondary Research – A review of reports, documents, previous designs and reviews of Health Structures in the Irish context taking account of other relevant literature.
- Primary Research – An audit of existing structures and their stage of implementation of what was the intended ISA process.

The intention is to provide the learning from what has already been done to support any move to the future direction.

3. Preparation of Report and Proposals for Successor Structure

The intention is that the final report will succinctly identify the issues and recommend a way forward for the organisation based on the output from the consultation and research work.

- The intention is that a preliminary report will be produced which will enable focussed engagement and input from key stakeholders in advance of progressing to a final report.

4. External Validation

Consideration will need to be given to requirements around external validation of the proposals.

Project Description:

Develop a design blue print for the “best fit” for local organisational arrangements (both governance and service catchment perspectives) for Primary Care & Community Services that will:

- Deliver excellent health outcomes for the population by driving integration of services
- Ensure more efficient use of resources

- Have a clear spinal cord of accountability from top to bottom
- Support the strategy of shifting balance of activity towards prevention and community based care and away from hospital based care
- Ensure services are organised around the population based service deliver model
- Streamline and reduce the management layers and numbers bringing decision making as close as possible to service delivery
- Develop clinical leadership
- Support the implementation of the *Future Health* and *Healthy Ireland* strategies.

Influencing factors to apply to decisions around service catchments include:

- Catchment areas for new hospital groups.
- Community connectivity / affiliations and social and cultural links.
- Composition of current Primary Care Teams and Network spatial units.
- Service catchments of key services such as local authorities, education and social protection that influence the determinants of health.
- Spatial strategy and travel patterns of the public for general services.
- Existing ISA catchments.
- Supports the funding and commissioning model envisaged in *Future Health*

Principles to apply to the governance include:

- Operational responsibility and performance management must be vested at the lowest level of authority.
- Arrangements should support end to end service responses across patient care.
- Be consistent with the new organisational arrangements for the new HSE Directorate.
- Be applicable across all areas to drive consistency nationally.
- Business support services/ functions should be set at the appropriate levels to support service management and ensure economies of scale.

Project Deliverables

Task
<ul style="list-style-type: none"> ▪ Set up project team - underway
<ul style="list-style-type: none"> ▪ Review of existing governance arrangements in each of the 17 areas
<ul style="list-style-type: none"> ▪ Review of existing mapping of 17 Areas and previous HSE mapping options for local areas
<ul style="list-style-type: none"> ▪ Carry out comprehensive consultation process within each of the 17 ISAs <ul style="list-style-type: none"> - Design - Implementation
<ul style="list-style-type: none"> ▪ Literature review
<ul style="list-style-type: none"> ▪ Mapping of essential data
<ul style="list-style-type: none"> ▪ Analysis from consultation process ISA's - Phase 1 ▪ Analysis from other stakeholders - Phase 2
<ul style="list-style-type: none"> ▪ Design Workshop(s) to consider potential options for service catchments using GIS
<ul style="list-style-type: none"> ▪ Design workshop(s) to consider governance arrangements at Area and Sub Area level
<ul style="list-style-type: none"> ▪ Interim draft report for SMT
<ul style="list-style-type: none"> ▪ Validation engagement / workshop with key stakeholders
<ul style="list-style-type: none"> ▪ Final report and recommendation for decision

Assumptions	<ul style="list-style-type: none"> ▪ Sign off by Director General of decision criteria and scope of work. ▪ Release of core team members for project work as required. ▪ Availability of data from key stake holders. ▪ Stakeholder involvement in relevant workshops and meetings.
Project Quality:	<ul style="list-style-type: none"> ▪ Have “design” workshops with key stakeholders ▪ Internal and external literature reviews will be carried out ▪ Governance arrangements will meet organisational theory and design principles ▪ GIS Mapping will be used to support visualisation and integration of key data/information. ▪ Project Management methodology will meet key PMBOX standards
Outside of Scope of Project:	<ul style="list-style-type: none"> ▪ Implementation phase of Project. ▪ Resource allocation
Project Lead:	Pat Healy, National Director Social Care Designate
Project Team:	Bernard Gloster - ISA Manager West Michael Fitzgerald - ISA Manager South Public Health input Brian Murphy – Primary Care Lead Seamus Woods - Head of Change Management, C&FS Geraldine Crowley - Business Manager, South Imelda O'Regan – HSE South
Project Sponsor:	Tony O'Brien, Director General Designate



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17 July, 2013

Re: HSE Integrated Service Areas (ISAs) Review Project

Dear Minister & Secretary General

As you are aware the launch of the Hospital Groups (Higgins) Report effectively signalled the end of Integrated Service Areas (ISAs). In order to maintain operational stability I advise integrated service area management teams, on the morning prior to the launch of the Higgins Report that an operational review project would commence to examine the appropriate successor structures to ISAs for non-acute services. The commencement of this review was also mentioned at the formal launch of the Higgins Report and at the various regional roadshows which have taken place in the interim period.

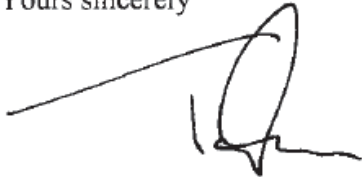
I indicated to ISA management teams at the time that it would be necessary to obtain their views on the appropriate configuration of non-acute service management/ leadership structures in the context of the Hospital Groups and the establishment of the Directorate, in the first instance, but also in the context of our direction of travel towards a UHI environment. I also indicated that the number of ISA successor bodies was likely to be considerably less than the seventeen ISAs that currently exist and that opportunities for the de-duplication of management structures would be taken. A key challenge is to identify the appropriate boundaries for successor service delivery entities in the non-acute sector in order to maximise integration with acute services. Given the footprint of some of the Hospital Groups there will be some challenges associated with this.

Tús Áite do
Shábháilteacht  Othar

I attach a copy of the up-to-date Terms of Reference for the Project. It is important to stress that the aim of the Project is to create an informed and considered operational context for the HSE to engage with the Department and Ministers around the necessary policy decisions that may need to follow. To date the announcement and subsequent initial commencement of the review Project has supported stability in our non-acute health service delivery structures and it has also been warmly welcomed by representatives of the workforce who value the opportunity for consultation and input.

As you will note the methodology of the Project is inclusive and well rounded. I look forward to our future discussion on the product of this work.

Yours sincerely

A handwritten signature in black ink, appearing to be 'Tony O'Brien', written over a horizontal line.

Tony O'Brien
Deputy Chief Executive &
Director General Designate

APPENDIX B STAKEHOLDER ENGAGEMENT

PHASE 1: *The following is a list of the consultation engagements undertaken in Phase 1 of the consultation process*

- Integrated Service Area Managers
- Primary, Community and Continuing Care (PCCC) Operational Managers
- Workshops in each of the current 17 Integrated Services Areas (ISAs):
 - Carlow/Kilkenny & South Tipperary ISA
 - Cavan/Monaghan ISA
 - Cork ISA
 - Donegal ISA
 - Dublin North City ISA
 - Dublin North ISA
 - Dublin South Central ISA
 - Dublin South East / Wicklow ISA
 - Dublin South West, Kildare/ West Wicklow ISA
 - Galway/Roscommon ISA
 - Kerry ISA
 - Louth/Meath ISA
 - Mayo ISA
 - Midlands ISA
 - Mid-West ISA
 - Sligo/Leitrim/West Cavan ISA
 - Waterford & Wexford ISA

PHASE 2: *This Phase of the consultation process involved a series of consultative engagements to which the following internal and external key stakeholders were invited:*

- HSE National Directorate & Leadership Team
 - National Director Mental Health & Senior Team
 - National Director Primary Care & Senior Team
 - National Director Social Care & Senior Team
 - National Director Health & Wellbeing & Senior Team
 - National Director Acute Services
 - National Director Children & Families
 - Chief Operating Officer
 - Chief Financial Officer
 - National Director Clinical Strategies & Programmes
 - National Director National Cancer Control Programme
 - National Director Quality & Patient Safety
 - National Director Shared Services
 - National Director HR
 - National Director Communications
 - National Lead Transformation and Change Systems Reform
-

- Services for Older People Organisations

- Age Action Ireland
- Ageing Well Network
- Alzheimer's Society of Ireland
- Carer's Association
- Caring for Carers Ireland
- Home & Community Care Ireland
- Irish Senior Citizen's Parliament
- Third Age

- Disability Services Organisations

- Disability Federation of Ireland
- Federation of Voluntary Bodies
- Not for Profit Business Association

- Professional Representative Bodies

- Association of Occupational Therapists of Ireland
- Association of Social Care Workers
- Head of Psychology Services Ireland
- Institute of Chiropodists & Podiatrists
- Institute of Community Health Nursing
- Irish Academy of Audiology;
- Irish Association of Directors of Nursing
- Irish Association of Social Workers
- Irish Association of Speech & Language Therapists
- Irish Chiropody & Podiatry Organisation
- Irish Dental Association
- Irish Nutrition & Dietetics Institute
- Irish Play Therapists Association
- Irish Society of Chartered Physiotherapists
- The Psychological Society of Ireland
- The Society of Chiropodists & Podiatrists in Ireland

- Irish College of General Practitioners (ICGP)

- Palliative Care Voluntary Organisations

- Association of Hospital Chief Executives (non acute hospitals)

- Unions:

- IMPACT
- IMO
- INMO
- IHCA
- PNA
- SIPTU
- IDA

- Focus Group Meetings:

- Dublin North City ISA
 - South East ISA
 - Mid-West ISA
 - Kerry ISA
 - Ayrfield Primary Care Centre
 - Belfast Trust, Northern Ireland
-

APPENDIX C ISA REVIEW – SURVEY QUESTIONNAIRE

ISA REVIEW SURVEY QUESTIONNAIRE

Guideline:

The purpose of this questionnaire is to assist a survey of existing ISA management and governance structures. The questionnaire should be completed and signed off by each Area Manager. The completed questionnaire should be returned to: isareview@hse.ie by **19th July 2013**.

Region	
ISA	

Section 1 – ISA Management and Governance:

1.1 Please provide details of current Title, Grade and reporting relationship of Area Management Team

Area Management Team (AMT) Members				
No.	Title of AMT Member	Grade of AMT Member	Responsible for	Reporting to
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				

Please provide a brief description of the management arrangements in your ISA i.e. managed on care group or geographic basis etc.

- 1.3 Please provide an organogram to describe current **management** structure
1.4 Please provide an organogram to describe current **governance** structure
1.5 Please list existing management and governance committees in your ISA (e.g. Clinical governance, Risk Management etc.) please specify reporting arrangements to AMT etc.

Committees				
No.	Title of Committee	Purpose of committee	Title of Committee Chairperson	Reporting to
1				
2				
3				
4				
5				
6				
7				
8				

Section 2 – Health & Social Care Networks (HSCNs)

Is there any Health & Social Care Network managed as a network in its totality?

Yes / No:	
-----------	--

Please list any services in your ISA which are **managed** at health & social care network level e.g. Specialist Disability Service, Home Care Services, Nursing etc.

No.	Service Type (e.g. Specialist Disability Service, Home Care, Nursing etc.)	Name of HSCN
1		
2		
3		
4		
5		
6		
7		
8		

2.3 If applicable, please provide an organogram to illustrate the management of the above services

Section 3 – Primary Care Teams (PCTs) Management & Governance

3.1 Please provide a brief description of how Primary Care Teams are managed in your ISA?

Section 4 – Mental Health Services Management & Governance

4.1 Please provide a brief description of how Mental Health services are managed in your ISA together with an organogram?

Section 5 – Older People Services Management & Governance

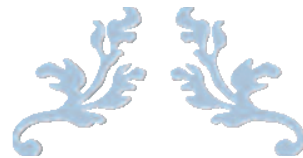
5.1 Please provide a brief description of how Older People services are managed in your ISA together with an organogram?

Section 6 – Disability Services Management & Governance

6.1 Please provide a brief description of how Disability services are managed in your ISA together with an organogram?

Signed by ISA Manager: _____

Date: _____



AN INTERNATIONAL REVIEW OF INTEGRATED HEALTH AND SOCIAL CARE



NOVEMBER, 2013
DR KATHERINE GAVIN

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1. Background to the report

This report is the result of a request by the HSE for an International Review of Integrated Health and Social Care. The review summarises the experience of a number of countries, with a variety of health and social care structures and systems, with the implementation of Integrated Health and Social Care.

The countries chosen were recognised as having made significant progress with Health and Social Care integration and were considered examples of Best Practice in integrated care.

The information for the report was obtained following an extensive literature review (see **References** section 5).

2. Individual Country Analyses

a. Northern Ireland 's (NI) Experience of Integrated Care

In the case of Northern Ireland, a King's fund review by Chris Ham, et al., (2013) was particularly helpful.

Northern Ireland is unique in the UK having a structurally integrated system of Health and Social Care since 1973. Hospitals (Acute care) and specialist services, local authority and health and welfare services are all integrated into one system.

Years of civil and political unrest have impeded progress with integrated care. Devolution has been in existence continuously since 2007 providing a more stable environment for advancing integration. .

Demography

Northern Ireland has a population of 1.8 million with 2/3 residing in the greater Belfast area. It is acknowledged to be one of the most deprived regions in the UK with relatively high unemployment, disability and poverty. The population is predicted to grow to 2 million by 2025 (increase by 8%). By 2025, those aged ≥65 years are predicted to increase by 42% (from 260,000 to 370,000). By 2025 those aged >85 years are predicted to increase by a factor of 2 compared with 2010 (from 30,000 to 55,000) (Department of Health and Social Services, DoHSS & Public Safety, 2013).

There is a documented increase in chronic condition amongst the population e.g. Diabetes mellitus, respiratory problems, stroke and obesity.

Health Service Funding

The health service is funded through general taxation across the UK using the Barnett Formula with funding allocated in blocks of 4 years with a fixed yearly budget*. Funding is calculated using a population based share approach. NI gets 3.8 billion sterling per year (equivalent of 4.5 billion euro) for a population of 1.8 million (compared with Ireland 13.81 billion euro -equivalent 11.65 billion sterling) for population 4.59 million (2013). NI receives circa 2.5 billion/million population versus 3 billion per million population in Ireland.

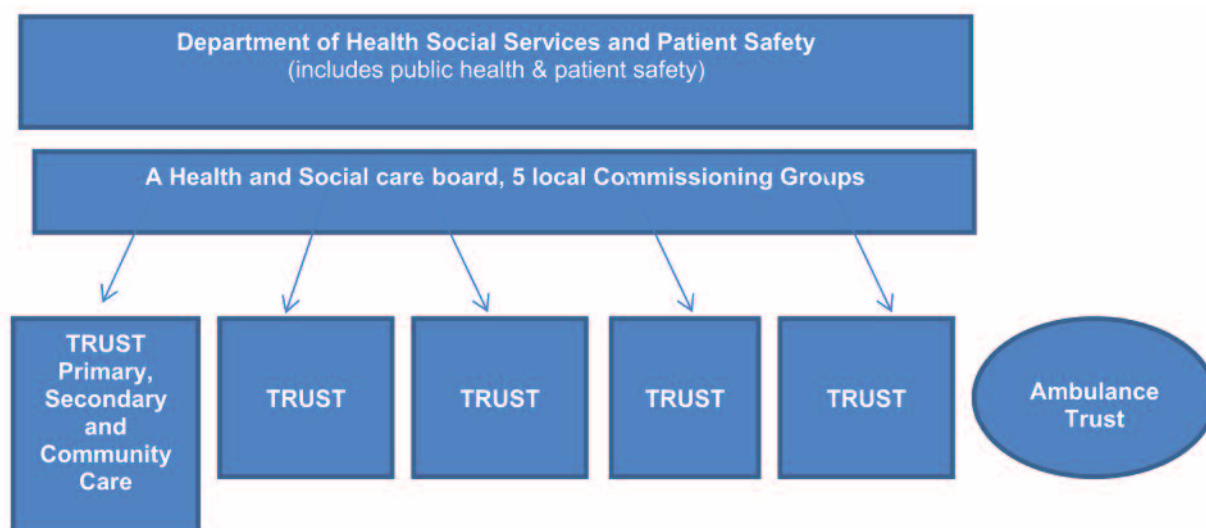
Evolving Structure of Health and Social Care

- In 2009 Health and Personal Social Services were restructured as follows (Figure 1):

Department of Health Social Services and Patient Safety (includes public health & patient safety, DoHSS & PS).

A Health and Social care board, 5 large health and Social Care Trusts and 5 corresponding local commissioning Groups. The Trusts deliver the care. There is a separate Ambulance Trust.

Figure 1. Structure of Health and Social Care Northern Ireland



The DHSS & PS is responsible for Acute care, General Practice (GP), Community, PSS, Public Health and Public Safety. The department answers to the Minister for health. The Board commissions care from the trusts and also from General Practitioners (GPs), dentists, opticians and community pharmacists. The trusts provide the services; Each trust controls their own budgets, staff and services. The average population per trust is 359, 878 versus a figure of 307,753 in the UK.

➤ General Practice (GP) and Health Service Structure

GPs are generally in group practices and care is delivered by multidisciplinary teams including nurses and others. The service is generally provided by public hospitals and there are only 2 small private hospitals in NI. The majority of residential home places are private. The GPs are accountable to the HSC board directly and not the trusts and are funded through the HSC board.

➤ Integrated Care Partnerships (2011)

Following the Compton review (2011), a new proposed system was put forward for NI, "Integrated Care Partnerships" (ICPs). These were proposed to join a full range of H & SCC in each of 17 areas. Each ICP would perform a needs assessment of its local population and then plan and integrate the delivery of Services. GPs were to take a leadership role. ICPs are described as a co-operative network between service providers for the design and delivery of services and are clinically led. The focus initially was on certain aspects of care e.g. "frail elderly and chronic disease conditions e.g. DM. It was aimed to be proactive by identifying people at risk in the community and putting care in place to keep them in the community for care as much as possible. Questions were asked regarding the need for 17 bodies and the resourcing of such a system with increasing health care costs amid funding pressures. In addition it was feared that Social care would get lost within the priorities of Health.

Evidence for progress with Integrated Care in Northern Ireland

There is an absence of an explicit performance management system in order to make meaningful comparisons with other countries E.g. England, Wales and Scotland.

Lack of rigorous evaluation of the system is evident in NI however there are reports of some pockets of progress reported (Heenan & Birrell in 2006, 2009 and 2012).

Integrated management is having a positive impact in addressing the gap between health and social care and decreased delay in discharging patients from hospital has been noted.

Challenges remaining include the dominance of Health over Social care on the agenda and a lack of inter-professional training.

➤ Programmes of Care

Nine Programmes of Care have been introduced in NI in the following areas; acute service, maternity and child health, family & child care, elderly, mental health, learning disability, physical and sensory disability, health promotion and disease prevention, primary health/adult community care.

These programmes are made up of interdisciplinary teams. Professional support is reportedly high for this scheme

Patients have a named key worker and care is co-ordinated. Having one agency and one budget in NI is seen as a positive as in the UK interagency tensions in their Care Programme have been difficult to overcome. The UK have reported increased MDT working in the area of elderly care and Mental health but have not yet achieved full integration of services (Snappe 2003).

Other suggested positives in the NI system are the management structure of the Programme of Care teams where any profession can be the team leader, leading to greater respect and parity of esteem amongst the different disciplines. In addition, patient discharge is the responsibility of a single body which leads to a more streamlined process. One area where improvement could be made is in the area of core professional training which is separate, whereas in the trust training is multi-professional.

It is suggested that the existence of a single unified Health & Social Community Care system in NI might help alleviate many of the issues impeding successful integration of care and service delivery.

Difficulties with Integration in NI

- Unequal partner Health versus Social Care;
 - Most of funding goes towards health and not social care especially Acute care
 - Nearly all targets set are regarding health-need other targets of wellbeing
 - The medical model of need identification is dominated by health agenda and priorities.
 - The composition of the Team on HSC trusts has heavy health bias and this needs changing
 - Pay and status of social care should be addressed

Although robust evidence is lacking as to improved healthcare outcomes as a result of integration, there is some evidence that integration of health with social care in certain areas, namely domiciliary care for elderly, community mental health and learning disability and physical disability is progressing. A good example of integration is the “rapid access for GP referral and community stroke rehab” initiative. Less integration is evident in other areas such as individual budgeting and children’s services.

Recommendations to achieve full Integration of Services (Heenan and Burrell, 2006)

- Raise the profile of Social Care
- Joint training for Health and Social Care professionals
- Focus on outcomes
- Debate social models of care
- Have a balanced composition of Bodies (Health and Social Care)
- Robust research and evaluation to provide evidence for the impact of integrated care on outcomes
- Good leadership

Overall Conclusions from the NI experience of Integrated Care

- System is evolving in NI
- Need robust evidence to assess and evaluate outcomes and for international comparison. Small studies suggest advantages to integrated care. Need evidence of improved patient care to support integration.

Key advantages of the set up in NI

- Single employing body
- Single budget
- Agreed strategies and plans

Disadvantages

- Health care dominates social care
- Cultural differences between health and social care
- Separate training of the professions-lack of awareness of other's roles, lack of parity of esteem
- GPs not yet fully integrated
- Need strong leadership and buy –in for success

b. Scottish Experience of Integrated Care

In the case of Scotland, a King's fund review by Chris Ham et al., (2013) and a Government report on the integration of Adult Health and Social Care in Scotland (2012) were particularly helpful.

Demography

Scotland has a population of 5.2 million. Population density is low compared to rest of the UK. Similar demographic trends exist to those reported in the rest of the UK; the proportion of people aged 65 and older has grown significantly and is projected to increase by over 2/3 over the next 20 years (www.scotland.gov.uk/Topics/Statistics).

Health Service Funding

Funding of Health and Social Care is devolved. Funding is through general taxation across the UK using the Barnett Formula (see Northern Ireland). In addition, funds may be realised by local authorities through council tax and non-domestic rates. There is also the capacity to borrow funds. There is a small independent health sector with which the NHS contracts to very limited extent-independent and 3rd sectors are important providers of care & support for elderly (88 % of care home places and 51% of home care hours are provided in this way). These services are often delivered in partnership with statutory sectors funded by the NHS and local authority users.

Funding for 2011/12 for Health was 11.68 billion sterling. Spending per capita is higher than in other UK countries (2,072 in 2010/11 for Scotland versus 1,900 for England). Spending for local authorities in 2010/11 was 18.5 billion. Spending was 3 billion on social care services in 2010/11 – (thought to be an underestimate as does not take account of personal contributions and other sources). Free personal care for the elderly was introduced in 2002.

Evolving Structure of Health and Social Care

Between 1974 and the early 1990's there were 15 **health boards** with responsibility for hospital and community services including primary care.

In the early **1990's** this structure was replaced by a model based on **market principles**. Health boards were purchasers of care for their populations and hospitals and community services were

separate NHS trusts supplying services to the boards. GPs purchased a limited range of services from NHS trusts for their patients.

In 1996, **29 unitary authorities** were added to the 3 pre-existing island authorities making a total of 32 local authorities to replace regions and districts. The local authorities have populations ranging from 600,000 to less than 51,000. The local government system mainly operates through committees with delegated accountability. In each local authority area, a **Community Planning Partnership (CPP)** has been established to oversee public services.

Creating Conditions for Integration in Scotland

There has been a focus on integrated care in Scotland for over two decades. The system structure of unified boards is designed to promote integration. There is evidence of steady progress in establishing formal health and social care partnerships between NHS boards and local authorities. The Community Care and Health Scotland Act (2002) was designed to break down perceived barriers to collaboration giving power to transfer functions without removing statutory responsibilities and giving powers to create pooled budgets between health and social care partners.

Performance Management

A National Performance Framework aligns performance management. Progress towards these outcomes is measured through 50 National Indicators and targets—a significant number of these relate to health and social care. There is a **Single Outcome Agreement (SOA) between government and each Community Planning Partnership (CPP)**. SOAs are the means by which CPPs agree strategic priorities for their area and express these as outcomes to be delivered by the partners (individually and jointly)

A Quality Measurement Framework provides a structure for understanding and aligning the wide range of measurement occurring across the NHS showing how it all leads towards the various Quality Ambitions (including long and short term targets and local and national targets).

Responsibility for **External Regulation of Health & Social Care** in Scotland is divided between Healthcare Improvement Scotland (HIS) and the Care Inspectorate. Audit Scotland oversees both health and social services.

Scotland reports progressive integration of hospital, primary and community services alongside mental health and learning disability. Through **Community Health Partnerships (CHPs)** links are strengthened between GPs and local authorities.

There are 2 types of CHP; health only (29 in 2010) and integrated health and social care structures, CHCP, of which there are 7 (community Health and Care Partnerships). Glasgow has a single CHP. All are statutory committees or sub-committees of NHS boards and are accountable to their respective boards. The integrated CHPs have dual accountability to the relevant local authority.

Structure of Community Health Partnership teams

The make-up of the CHP teams are well defined and consist of a general manager, GP, nurse, doctor (not providing primary medical services), councillor/officer of local authority, staff member of public partnership forum, community pharmacist, allied health professional (AHP), dentist, optometrist, and a member of a health related voluntary sector organisation.

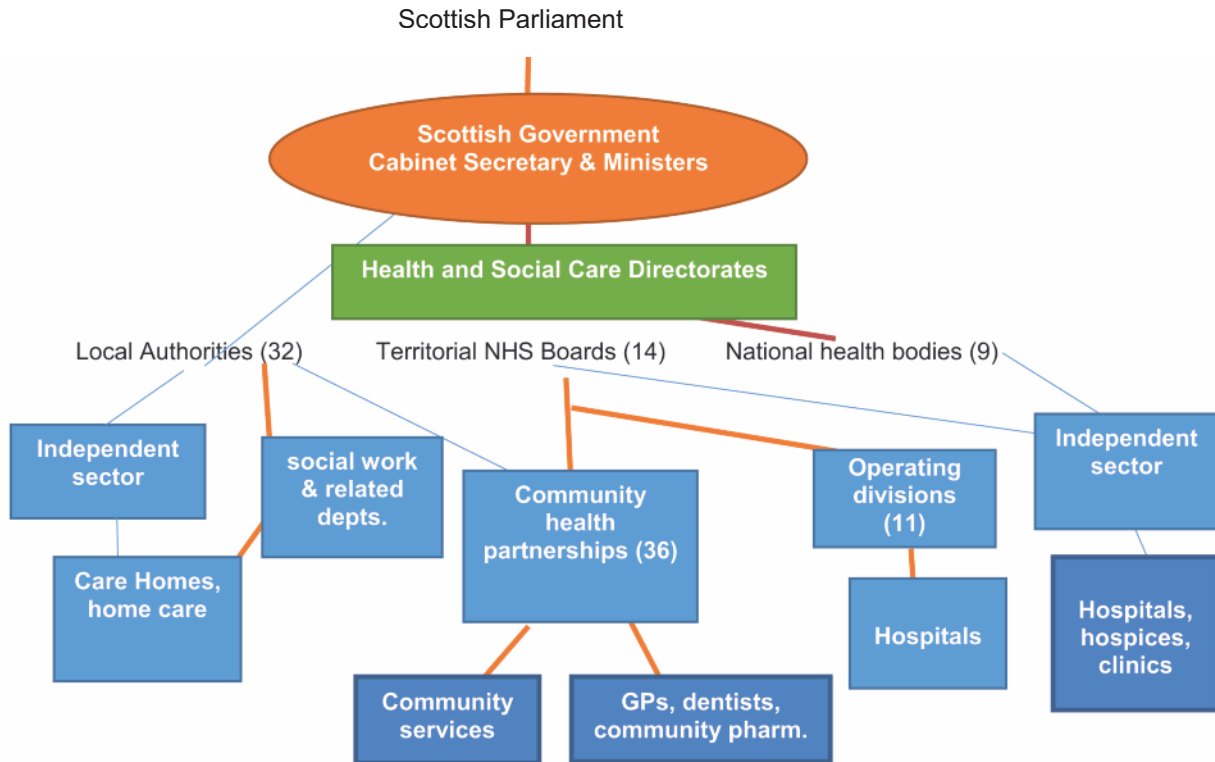
Two reviews of CHPs in Scotland provide evidence of some shift in the balance of care yet few examples of joint planning and suggest that a comprehensive understanding of shared resources is needed. The cultural differences within organisations are recognised. Clarity around the roles and authority of the CHPs are needed.

Evolving Structure of Health & Social Care Partnerships

In **2000, responsibility for health and adult social care was combined in Scotland**. There are Health and Social Care Directorates, 32 local authorities, 14 NHS Boards and 9 National health bodies. The 14 health boards are responsible for the planning and delivery of services for their populations (Figure 2). The sizes of these populations range from 113,000 to 1.2 million. The boards focus on strategic leadership and performance measurement. Responsibility for service delivery is delegated to 11 operating divisions for acute services and to one of 36 Community Health

Partnerships for community and primary care services. Some of the boards have unified this function and have a model of a single operating system combining both acute and community health functions. The 9 national bodies work in partnership with the 14 boards for services such as ambulance, education & training, quality improvement-issues best provided on an all Scotland basis. GPs and general dental practitioners are independent contractors providing services to the NHS.

Figure 2. The Structure of Health & Social Care Partnerships Scotland



Accountability relationships —————

Other relationships (e.g. funding, contracting, regulating) —————

Since 2012, the Government decided to **replace CHP with Health and Social Care Partnerships** to secure greater integration between health and social care for all adults. The arrangement provided freedom to extend to other areas of service by local agreement & and allowed for mandatory extension in the future

Functionally, the NHS boards work closely with the local authorities to deliver a range of community health and social services. Each local authority has representation on the relevant NHS board, and through local authority membership of all CHPs and some joint appointments & joint accountability.

Key principles of integration;

- o Services should be integrated around needs
- o Strong leadership
- o Joint accountability from providers of services for outcomes
- o Flexible sustainable financial mechanisms-around needs of people not the delivering organisation

In the Scottish system, Managed Clinical Networks (MCNs) are linked groups of health professionals and organisations from primary, secondary and tertiary care working in a co-ordinated way, unconstrained by existing professional or health board boundaries. There are currently 130

MCNs. Coverage varies - 29 are countrywide, 22 are regional and the remainder are local. The MCNs also vary in their scope, some cover conditions e.g. diabetes, epilepsy and others cover specialities e.g. neurology, palliative care. There are 5 areas where coverage is universal, that is there are MCNs in each Board Area for cancer, respiratory, stroke, diabetes, and coronary heart disease. There are 3 regional cancer networks.

In the area of mental health and learning disability MCN have full local authority involvement.

Evidence of impact of MCN

There is limited evaluation of the impact of MCN but there are some positive findings. Analyses of a local cardiac MCN and 2 cardiac and 2 diabetes MCNs, a positive impact on inter-professional and inter organisational activity reported along with some changes in professional practice and service improvement (Hamilton et al. in 2005, Guthrie et al 2010) It was felt that the MCNs had facilitated the implementation of national initiatives such as clinical guidelines. There was however limited evidence of decreasing emergency hospital admissions.

The fact that MCN are in existence in Scotland for 15 years indicates support from Government, clinicians and management for the concept.

Role of Information Technology (IT)

The importance of IT in promoting service integration in Scotland is stressed. Since 2005, there has been a drive in Scotland for the development of a comprehensive health information system based on an electronic health record (Scottish executive 2005). Two major advances are already reported; universal use of unique patient identifier and national emergency care summary, accessible to NHS staff in out of hours centres (*NHS24 and A & E departments). The NHS works in partnership with local authorities to develop health and social care IT strategy for information sharing towards an appropriate community based service. Scotland is seen to be a leader in the area of Telehealth and telecare. It is believed that such advances could be useful in monitoring long term conditions e.g. Chronic Obstructive Pulmonary Disease, (COPD), Coronary Heart Disease (CHD), Mental Health with results being sent to a Hub call centre daily and raising an alert if results are abnormal.

Key principles of Managed Clinical Networks in Scotland

- o Lead clinicians
- o Structure
- o Annual plan with roles and responsibility to deliver, specified standards
- o Evidence base, Continuous Quality Improvement (CQI)
- o MDT with role clarity
- o User involvement & voluntary sector input
- o Education and training, Continuous Professional Development (CPD)
- o Opportunity for Value for Money (VFM), value added regarding patient care

The Government is setting up an **Integrated Resource Framework** to facilitate budgetary integration in the future. The framework increases clarity around cost and quality implications of local decision making around health and social care. It is recognised that the financial relationship should be around populations served and not organisations-the framework aims to show this. **Integrated Resource Maps provide** cost and activity information in health and adult social care. Boards have begun mapping in this way, some with local authority partners. A report on the experience of 4 sites and their 12 partners in local authority indicated it was easier to capture data on cost and activity in the hospital setting compared with social and community care (Ferguson et al 2012).

Successful Integration needs

- Clarity of purpose and outcomes
- Strong leadership
- Staff empowerment and carer empowerment
- Agreement on appropriate scale and scope
- Alignment of all available drivers; policy, legislation, structures, information, incentives, outcomes.

There are examples of successful integration including:

- **Risk Prediction of patients with long term conditions** 2008-2011 (which showed a 13.5% reduction in rate of emergency bed days for long term conditions from 2006/7 to 2010/11),
- **The hospital in the Home initiative**,
- **Anticipatory Care Planning** for at risk groups for hospital admission.
- Provision of intermediate care by **community** hospitals providing extended primary care facilities with 24 hour cover.

CHPs were encouraged to use community hospitals as a platform to bridge the gap between home and specialist hospital care. Community hospitals could extend their role to provide Outpatients and or inpatient services e.g. Invergodon.

The National Framework has seen development of 32 local partnerships with joint strategic plans and with the **Change Fund** acting as a catalyst for the health and social community to work together. A **Multiagency Improvement Network** acts as a support for these partnerships. The change fund is seen as a stepping stone towards longer term commissioning strategies

Lessons for Scotland

Performance Management has been a focus for some time. In 2008, A National Outcomes Framework for Community Care has been provided with National Outcomes identified and 16 performance measures. Some official targets include;

- Decrease rate of bed days as a result of emergency admission of elderly
- Speed up discharge from hospital to an appropriate setting

Challenges remain

- The trend in the numbers of A&E admissions of people ≥65 years continues to rise
- Delayed patient discharge requiring new targets are evident e.g. get to zero the numbers in hospital more than 4 weeks by 2013 and to 2 weeks by 2015.
- Curb numbers of elderly in care homes and increase numbers receiving intensive care in home
- For Integrated care to be sustainable need transfer of resources from hospital to community setting and from the NHS to local authorities. The CHP were to have a key role in initiating this process but in reality not much has changed.

Enablers for Integration in Scotland

- Structural/organisational stability in NHS and local government facilitates the change coupled with on-going Political commitment to the Integrated care and Partnership approach
- The fact that the NHS boards unify acute primary and secondary care is a strong enabler and that local authority representation is evident at Board level and in CHP. This brings an emphasis on collaboration and not competition
- The strong Performance Management Culture in the NHS as evident by the National Performance Framework which also encompasses local government and public service
- A small size allows brokerage amongst a small number of senior leaders to happen more easily

Barriers for Integration in Scotland

- In health care there is a history of dominance by the Acute speciality sector which is hard to shift towards the community
- There are barriers between health and social care in structure, responsibilities, roles, culture, educational background and professional differences
- Tensions exist around joint working, information sharing and respective roles
- Separate training for the key professions is not conducive to increased understanding of each other's roles
- The new system challenges conventional hierarchical arrangements and reporting structures
- Terms of employment and efforts to harmonise the conditions of employment are needed
- 2 distinct disconnects have been reported between primary and secondary care in the NHS and between health and social care.

c. Torbay's Experience of Integrated Care (UK NHS Trust)

Much of the information and analysis on Torbay is from the official Torbay government website. (www.torbay.gov.uk/index/council/factsfigures/torbay201213jsna.pdf) and a policy paper by Ham (2010).

Demography and Background

Torbay is a small unitary council area that includes the 3 towns of Torquay, Paignton and Brixham. It is a generally impoverished area. It is predominantly urban and has a higher than average elderly population (23% over 65 years) versus the national average of 16% in the UK).

South Devon Healthcare NHS Foundation Trust (Torbay Hospital) is described as a medium-sized District General Hospital, situated on the SW coast of England. It serves a population of approximately 280,000, rising to >350,000 in the summer months. The hospital works very closely with its Primary Care system and is striving towards fully integrated healthcare. It is acknowledged nationally as a progressive and innovative organisation with good patient outcomes (Health Partnerships-THET).

There is a history of whole-systems thinking in Torbay and a strong foundation of primary care services for some time with the council and primary care team having a shared territory. For over 20 years the PCT and the Council are reported to have had good relations.

Torbay Primary Care Trust came into existence in 2000 and became Torbay Care Trust in 2005 (taking on responsibility for social care in a partnership agreement with Torbay Borough Council) and Torbay and Southern Devon Health and Care NHS Trust in 2012. There are **19 GP practices in Torbay with a registered population of 145,000 and an average practice size of 7,600** (slightly higher than the UK average of 6,900). The 19 GP practices are encouraged to work together in **5 small clusters**.

The Care trust provides community health services in Torbay and Southern Devon and in Torbay provides and commissions adult social care services

The Chief Executive of the Care Trust is accountable for the delivery of the aims and objectives of the organisation and the Partnership Agreement with Torbay Council. As an NHS body, the Trust is formally accountable in accordance with the relevant NHS legislation.

Trust staff operates from a range of different premises across Torbay and South Devon such as community hospitals and clinics.

Since 2012 healthcare commissioning became the responsibility of the Commissioning Cluster for Devon, Plymouth and Torbay.

Funding of the Care Trust

Torbay and Southern Devon Health and Care NHS Trust receive funding directly from the Department of Health. The trust works with other organisations across the South West in the provision of directly managed health services, primary care and prescribing, community health services and commissioning, public health and other locally delivered services.

In addition the Trust receives funding for adult social care expenditure delegated from Torbay Council under a Section 75 Agreement. The Partnership Agreement details the financial contribution from Torbay Council to Torbay and Southern Devon Health and Care NHS Trust and the accountability arrangements.

Budgets and Expenditure Reports

Torbay and Southern Devon Health and Care NHS Trust reviews its funding arrangements annually and agreement on the application of these funds is made by the Board.

A key target set by the Department of Health, is for the Trust to deliver a financial surplus by the end of each financial year. A Director of Finance & Corporate Services has responsibility for the oversight of the Trust's finances and provides a monthly finance report to the Board. The Board monitors spending against this budget through this report. At the end of the financial year, a set of Annual Accounts are produced.

As of 2013, Torbay and Southern Devon Health and Care NHS Trust will sit at the heart of the health and social care system. As a result, the commissioning of care for Torbay residents now happens as part of what is called a commissioning cluster – a group of NHS organisations consisting of Torbay, NHS Devon and NHS Plymouth. This cluster has its own Board and its own decision making processes, designed to ensure the residents of Torbay, Devon and Plymouth have access to the best care possible.

Governance of the Care Trust

The Care Trust has representation from the council at a number of levels. The **Trust Board** has 2 councillors nominated by the local authority, a cabinet member for adult social care attends board meetings and a number of the Council's executive directors attend the board. There are 5 executive and non-executive members of the Board. Torbay council has a CEO and a nominated officer. There is a chief executive director of adult social services, a company secretary and a professional executive committee chaired by the medical director. There are 5 acting directors reporting to the CEO; directors of public health, operations, finance and corporate services, Human Resources (HR) and commissioning. 5 general managers representing Brixham, Peigton (2), and Torquay (2) report to the director of operations. Support services provide assistance to the General Managers.

Evolution and functioning of the Care Trust

Torbay is one of three areas in England who have tried to adapt the experience of Kaiser Permanente (one of the longest established and best known Health Maintenance Organisations or HMOs in the USA). At Kaiser there is a drive toward integrated Health and Social care, a focus on improving care for people with long term conditions and strengthening the role of clinical leaders.

The vision for the Care Trust was centred on a fictional character "Mrs Smith" and how the health and social care services should operate to deliver seamless integrated care. Torbay established **5 integrated health and social care teams organised in zones or localities aligned with general practices**. This would equate to a catchment population for each team ranging from 29,000 based on a registered GP population of 145,000.

A pilot project in the Brixham area discovered a number of users who needed intense support from the community and integrated care teams. The teams are co-located, have a single manager, single point of contact and use a single assessment process for patients. The team meet very regularly to review these complex cases and decide on a course of action. The format facilitates understanding of each other's roles and facilitates co-ordination of care. As with other successful care programmes, Torquay teams focus on the needs of the populations they serve. **The teams work with GPs acting in partnership** across all areas including long term care, palliative care and disabilities.

Health and Social Care Coordinators work within each team to accept referrals and are the single point of contact for patients. They are not professionally qualified-this aspect of the Torbay experience is being regarded as particularly innovative. Budgets are pooled and can be accessed by any member of the team to commission whatever care is needed by each patient. Since 2009, a fully integrated electronic health and social care record has been created to facilitate this process.

Another development in Torbay is investment in **intermediate care services** to treat patients in the home whenever possible and facilitate discharge in a timely fashion with adequate home support. The review of the role of community hospitals towards an active intermediate care role is supporting this endeavour.

A collaborative project by the Care Trust sees a team review patients in hospital, when beds are under pressure, to work with hospital staff to discharge patients. Torbay is involved with a national integrated care organisation pilot focusing on elderly patient discharge.

Enablers

- Solid foundation of Health and social care working together for 20 years
- Commitment of the staff to integrated working
- The evidence of benefits to the new approach

Evidence for Progress with Integrated care in Torbay

There is considerable objective evidence for progress towards integrated care in Torbay. Torbay has the lowest use of hospital beds in the region and has the shortest length of stay. Favourable performance in the areas of emergency admissions for the elderly, use of emergency beds for the elderly, day surgery rates and low rates of discharge to residential homes has been recorded. The Care Trust has received external validation from the Healthcare Commission, in the form of the Health Service Journal (HSJ) award for innovation and achievement in the UK in long term care management and good financial performance (2008). Reports of staff and user satisfaction have also been high.

Future challenges

Budget constraints -tighter funding from the NHS will challenge providers trying to advance the integration process

A potential conflict may result for PCTs and Care Trusts from the Transforming Community Services Programme in the NHS which will require a clear separation between provider and commissioner functions. This will challenge integrated team function by introducing competition and choice into the mix.

There is a need to;

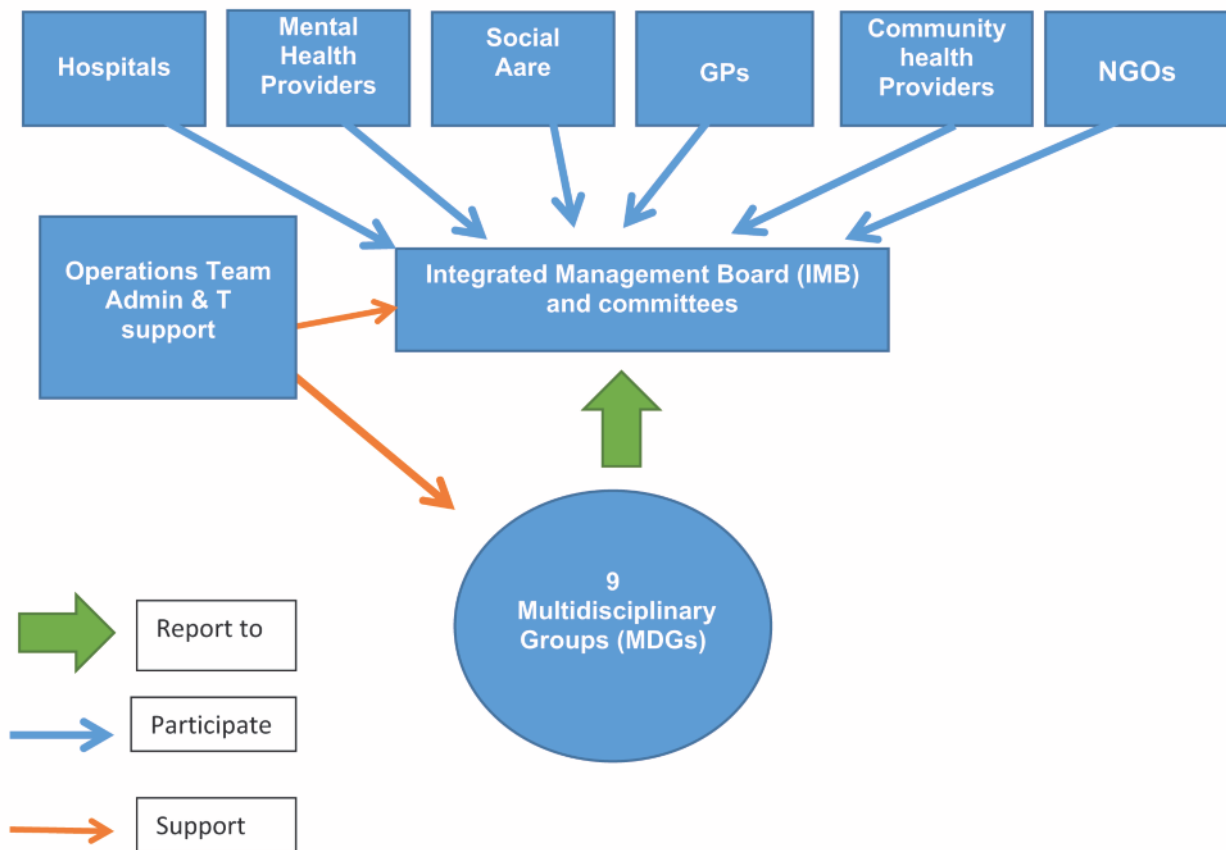
- build stronger links with mental health services and health care elements of learning disability provided by Devon partnership NHS trust for the past 10 years,
- build stronger links with secondary care and specialist care,
- operate a new approach to commissioning. Clinical Commissioning Groups (CCGs) replaced primary care trusts (PCT) from April 2013 as part of the Government's Health and Social Care Act (2012). This sees the responsibility for buying services for patients shifting to the clinicians (doctors, nurses and other healthcare professionals) who provide the care.

It is suggested that the planned integration of the Care Trust and Foundation Trusts into one new Trust from 2014 may facilitate further progress with integrated care in Torbay. The Foundation Trust will take on responsibility for running all services, in one new integrated trust providing services to over **375,000** people across the entire hospital community spectrum. GP services, NHS dentists, pharmacies and opticians will remain separate.

d. North West London's Experience of Integrated Care

Curry et al. (2013), reports on a large scale integrated care initiative in North West London. The population of the North West region is 550,000. Primary, secondary, community, mental health and social care is provided by the pilot (Figure 3). For the purpose of the pilot, the aim was to reduce emergency admissions in residents aged 75+ and/or living with diabetes over a one year period. The project involves 2 hospitals, 2 mental health providers, 3 community health care service providers, 5 municipal providers of social care, 2 Non-Government Organisations, (NGOs) and 103 GPs. The aim was to proactively manage the target group of patients and prevent unnecessary hospital admissions. The pilot operates as a Network – virtual integration type model as care is provided by a number of professionals working across many organisations. Separate providers work together towards common goals according to contractual agreements which are signed on joining the pilot. Agreements state that providers must operate within a governance structure based on weighted voting rights if consensus not reached and financial savings must be shared according to pre-agreed proportions. The pilot was expected to target an estimated population of circa 30,000 patients fulfilling the criteria (>75 and or diabetes).

Figure 3. Structure North West London Primary Care Pilot (Adapted from Curry et al., 2013)



Organisations participation is voluntary. Representatives from all organisations participating are invited to attend monthly Integrated Management Board meetings.

Locally, representatives from all provider organisations belong to Multi- Disciplinary Groups (MDGs) set up to improve care across different services especially those at high risk of hospitalisation.

Representatives work collaboratively to improve care. GPs create care plans for all patients intended to bring standardisation to care and best practice. The care plans are shared amongst service providers via IT. An innovation fund allows MDGs to commission community services to support out-of- hospital care. The MDT decides how to use the allowance from the innovation fund and submits proposals to the Integrated Management Board for approval. Curry et al., (2013) refer to the literature for suggestions of key elements crucial for successful and effective integrated care. They indicate that the pilot was built around these key elements; governance structures, financial arrangements, care process common, information sharing enabling collaboration, shared vision and culture.

The pilot set out to run on a voluntary basis as a “club” to encourage engagement from participating organisations. Agreement to share savings/surplus was seen as a key factor in overcoming mistrust.

Curry et al (2013) suggest the governance arrangement was complex and that this gave rise to concerns regarding accountability and clarity of decision making. In addition, close to 1/3 of survey respondents were unclear about their roles and responsibilities. Active engagement amongst clinicians was variable and 64% felt they were not involved in the planning and development of the project pilot. The design & roll out of the IT platform was suboptimal leading to frustrations. MDGs were set up to improve care & planning for the target population. Some evidence of inter-professional working and learning emerged during this process although sessions were reported to be dominated by the presenting GP/consultant with little input from other GPs and healthcare professionals in attendance. Discussions did not tend to extend to systems of care and rather focused on individual cases. Care planning was hampered by the poorly functioning IT system. Quality of the care plans was an area where no clear mechanisms for assessing quality were apparent.-pressure to complete a

care plan but what about quality. The Integrated Management Board was charged with scrutinising the performance of MDGs in terms of care plan completion. Patients were supportive of the pilot. However, real evidence of improved outcomes e.g. decreased hospital admissions was not evident. More time for the system to embed is requested before real outcome measures can be realistically captured. Key lessons learnt from the pilot are reported to aid those embarking on similar journeys

Enablers

- Up- front funding
- Strong support from London strategic health authority
- Leadership across all participating organisations
- Common goal and vision which organisations are committed to
- Vision needs to be extended to middle management and clinicians delivering the care
- Streamlining of the decision making process is required and
- Stronger accountability mechanisms are needed. E.g. Mechanisms for holding MDGs to account for quality are weak and need strengthening
- Vision needs to be embedded.
- MDTs need tools and skills to establish new models of community based –care-training and education MDT.
- Advise organisations not to be too impatient for outcome change as complex change processes have proved to be a marathon not a sprint. Chose appropriate short term targets and give sufficient time for more ambitious outcomes targets to be realised.
- A functioning IT system is important for collaboration e.g. EPR etc. and sharing information.

e. Australian experience of integrated care

Demography

The population of Australia is around 23 million (Australian Bureau of Statistics, 2013). There is significant urbanisation with 32% of the population living in New South Wales and a further 25% in Victoria (2012 statistics). 15 million people live in a capital city (2/3 of the population). The population density ranges from 160/sqkm in Australian Capital territories down to 9 /sqkm in New South Wales and 3 per sq/km in the extreme rural areas. The bulk of the population is aged between 15-64 years (15.2 million, 67%). There is a sizable and growing elderly population with 3.22 million (14%, aged ≥65 years (Australian Bureau of Statistics, 2012). In addition there are 4.29 million children <15 years old, (19% of the total population).

Political Context & Health Service Funding

The Australian health System has a mix of Federal (Commonwealth) and State funding and control. Service is provided through public and private sectors. A National Universal Health Insurance System, Medicare, was introduced in 1984. There is subsidised access to primary care, private specialist care and pharmaceuticals. GPs act as gatekeepers to specialist care as Medicare will only reimburse for referred consultations. The States provide drug and alcohol addiction and infectious disease care.

The Australian Federal Government consists of 3 political and administrative Tiers; The Commonwealth, States and Territories and local government. In 2007, a new Framework for Health Care - the National Health and Hospital's Network Agreement proposed changes to the governance and funding of public hospitals and performance measures against national standards of care. Based on the recommendation of the Australian Government's National Health and Hospital Reform Commission (2009), the Commonwealth government assumed full responsibility for the policy and public funding of Primary Health Care Services and the dominant funding role for the entire public hospital system. Previously, the States, Territories and local government had a greater role in funding and administering health services.

For the public hospital system, the Commonwealth and State Governments now share funding in a 60%/40% split. The States & territories are enabled to negotiate for additional funding from the Commonwealth due to an agreement reached in 2010 between the Council of Australian Governments (COAG) and the Commonwealth Government. Western Australia has not yet signed the Agreement arguing against the Government withholding of 1/3 of Government State Tax, (GST) to fund the arrangement.

Hospital Networks and Primary Health Care Organisations

Hospital Networks have grouped hospitals generally geographically around a principal referral hospital serving populations from 400,000-500,000. (For a population of circa 20 million this would amount to around 50 Local Hospital Networks, (LHNs). Hospitals will be operated by the Networks under service agreements on volume, mix, and quality of services negotiated with the States. Each Network will have a governing Council with expertise from business, management and accounting. Although, there is no community representative, the Governing Council of each Network is required to incorporate the views of the community and local clinicians. The emphasis is on decision making close to the site of service delivery and clinical leadership. There are **50 new Primary Health Care Organisations (PHCO)/Medicare Locals** servicing the same population and regions as the Local Hospital Networks with some overlapping Board membership. This would result in a **Primary Health Care Organisation, (PHCO) per 8,000- 10,000 of the population**. The PHCOs were predated by Local GP Practice Networks (data from 2010 indicated that > 90% of GPs and an increasing number of practice nurses and allied health professions were members of a local practice network).

➤ Role of the PHCOs/Medicare Locals

Since 2009 there has been increasing regional integration within the PHC teams and with other sectors. In 2010, the first Australian National PHC Strategy identified priorities including regional integration, IT development, improved access to services, chronic disease management, and disease prevention. **The Medicare Local** is the structure proposed to act as a framework for integrating primary and community care and to work closely with the Local Hospital Networks to identify and address the population needs of their regions. Details on how the Primary sector and Acute hospital sector will be integrated are scant. However, it is clear that integrated governance is key to successful health care integration. A single regional health entity has been proposed.

PHCOs/ Medicare Locals include representation from the community, other professional groups, business and management. There are reports that the new structure has encouraged local networking between GP practices and the wider health system.

Although evidence suggests that Australia rates highly in recognised primary health care outcomes (Davis K, et al. 2010). The COAG reform Council (2010) reported that 2 million Australians attended A & E in 2007-8 (accounting for >40% of all A & E activity) and that these cases could have been treated by a GP.

It is proposed that the new structures encourage a population focus providing targets and defined outcome measures and funding based on performance. There is an emphasis on the provision of health care in the community setting whenever possible.

Incentives/Enablers towards integration

- Incentives identified include the Practice Incentive Programme and the Service Incentive Payment which funds practices for quality services such as immunisation targets, quality prescribing and the management of diabetes mellitus.
- Multi-disciplinary Team training is provided locally for the PHCO to equip staff with the necessary skills and knowledge to best meet the needs of the populations they serve.
- The Australian Primary Care Collaboratives Program, plan-do-study-act methodology developed at the institute for Health Care Improvement (Boston MA) has seen 1000 GP practices (12% of all) get involved in the improvement of diabetic and cardio vascular disease care and access initiatives. Results show substantial improvements in practices participating (Nicholson et al., 2012).

- The option for capitated payments for the management of Diabetes could encourage care in the community setting and could be expanded for other chronic diseases, should outcomes prove favourable.
- The extension of Medicare cover to include additional health professionals for community care such as community allied health cover for chronic disease and elderly care and practice nurses is seen as a positive move towards integrated community care. Similarly, the funding of access to the Allied Psychological Services programme delivers packages of co-ordinated care for people with severe mental illness being managed in the community setting/primary care.
- IT development is making it possible for a person to more easily access their health information and for appropriate access by other Health Care providers across the Primary and Secondary care interface.
- Appropriate IT systems allow for the collection of accurate demographic and performance data to aid decision making and funding allocation to meet identified population priorities.

Challenges to integration identified were;

- The exact governance structure to integrate primary and secondary health care is unclear
- How best to ensure all stakeholders understand the vision and priorities.
- Ensure stakeholders are supported in the process.
- There is recognition that the PHCO need the HR capacity (skills and expertise) to deliver the service in the community setting.
- IT development is required to facilitate data collection on Performance and to facilitate communication across the health system and enable the tracking of patients through the care continuum.
- Quality improvement strategies and Continuous Quality Improvement (CQI) need to be prioritised.
- A system of shared resources & mutual accountability for service delivery and patient outcome is proposed.
- Providing incentives and financial resources to encourage co-ordinate care (move from fee per item) and align incentives across care (Ham & Smith J. 2010 and Zwar 2010).
- High quality communication.

f. New Zealand (Canterbury experience of integrated care)

(the bulk of the analysis refers to the experience of Canterbury District Health Board)

For New Zealand, the critique of Canterbury District Health Board relied on a King's Fund review by Timmins and Ham (2013), a research report by Thorlby et al. of the Nuffield trust (2012) and Canterbury district health board's official website.

Demography

The population in New Zealand is circa 4.5 million (www.stats.govt.nz). In the 1990's and early 2000s, a purchaser provider split approach to health care was explored. This was deemed unsuccessful. During this time, GPs began to organise themselves into collectives resulting in a well-organised GP healthcare system which is seen as one of the key enablers of establishing integrated health care (Timmins and Ham, King's Fund 2013).

Structure of Health Service

District health Boards

In 2000, twenty District Health Boards were established in New Zealand with populations ranging from 32,600 in the West Coast district health Board <http://westcoastdhb.org.nz> to 528,500 in Waitemata District health Board <http://www.waitematadhb.org.nz>

DHBs are responsible for ensuring the provision of health and disability services (hospital and primary health services) to the populations within defined geographic areas, either directly or through contracts. They are funded from central government by the Ministry of Health based on population based funding with adjustments for variables including higher proportions of elderly or deprived persons in the area.

Independent Practitioner Associations (IPAs) and Primary Health Organisations (PHOs)

The Independent Practitioner Associations (IPAs)/ autonomous networks of GP practices formed in the early 1990s, have evolved over 2 decades with many forming larger organisations and providing primary care and management support services with an increasingly multidisciplinary work force. They are privately owned, non-statutory and have a mixture of for profit and not-for-profit status. Primary Health Organisations were introduced by the Government as part of the Primary Health Care Strategy in 2002 as the new non-governmental bodies with a variety of community focused governance forms. Primary Health Organisations contract with their DHB for funds to support the provision of essential primary health care and preventative services through general practices to those people enrolled with the PHO. There are **31 PHOs of varying size and structure** in New Zealand. All are not for profit.

Canterbury District Health Board

The remainder of the analysis in New Zealand is on the **Canterbury District Health Board's (CDHB)** and the CDHB's experience with integrated care. CDHB is recognised as an area of best practice in the area of Health Services Integration.

Background

Since the late 1990s, Canterbury has been engaged in a number of nationally funded projects aimed at bridging the divide between primary and secondary healthcare e.g. in the area of elderly care and under Pegasus PHO programme tried to limit acute demand on hospital services by diverting patients to GP and community settings. This pioneering approach has continued and gained momentum over the years.

Demography

Canterbury is the south islands largest and most populated region with a population 510,000 (circa 400,000 live in Christchurch the main city). Canterbury covers circa 42,000km². It is the second largest DHB in New Zealand (by both **geographic area** covered and population size). Canterbury is experiencing similar demographic changes to Ireland and many other countries with an increasing

elderly population; it is estimated that by 2025, 20% of its population will be over 65. There are around 130 General practices in the Canterbury area and more than 50 mental health providers (Timmins and Ham, 2013). This would equate to each GP practice serving a population of circa 4,000. Almost all general practices in Canterbury are aligned with one of 3 Primary Health Organisations; Christchurch PHO, Pegasus Health and Rural Canterbury PHO. (www.cdhb.govt.nz).

As well as providing services for its own region, the Canterbury DHB also provides services to people referred from other DHB for services on a regional basis or National/Semi-National Basis for services not available in other Districts (e.g. neurology, cardiothoracic neurosurgery, paediatric oncology). One of these collaborations, with the population of the West coast DHB, has been formalised into a clinical partnership arrangement.

Governance

Canterbury District Health Board is the hospital and healthcare provider for the Canterbury region and uses the funding received from government to purchase and provide health and disability services for its population. Like all DHBs in New Zealand, the CDHB is governed by a **Board** of up to 11 members, 4 appointed by the Minister for Health and 7 elected members*** (see below for composition of the board). There is a chair and co-chair (both from non-healthcare backgrounds). DHB members meet monthly and are accountable to the Minister (through the Chairperson of the Board) for the performance of the DHB. Public hospitals are owned and funded by DHBs. The Board is responsible for the overall performance and management of the DHB. Operational and Management matters are delegated to the **Chief Executive (CEO)** of the Board who is supported by an **Executive team**.

*****The Executive Management Team** consists of the CEO, the General Manager for population and Public Health, Executive Director of Nursing, General Manager Planning & Funding, Maori representative, General Manager in HR, Chief Medical Officer, Director of strategic management and business development, Strategic Communications Manager, Executive Director of Allied Health, General Manager-Finance. The Executive Management Team reports directly to the CEO who reports directly to the chair of the DHB. **There is a General Management Team** with 5 members representing different specialities (rural health, medicine/surgery & women's & child care, elderly & orthopaedics/rehabilitation, hospital support and laboratory and mental health).

There is a **Planning and Funding division of the CDHB** which is accountable to the CEO and the Board for determining how best to invest the funds. The Planning and Funding Division's Core Responsibilities are (www.cdhb.govt.nz):

- Assessing the population's current and future health needs;
- Determining the best mix and range of services to be purchased;
- Building partnerships with service providers, government agencies and other DHBs;
- Engaging with stakeholders and community through two-way consultation;
- Leading the development of new service plans and strategies in health priority areas;
- Prioritising and implementing national health and disability policies and strategies in relation to local need;
- Undertaking and managing contractual agreements with service providers;
- Monitoring, auditing and evaluating service delivery.

In addition, there are a number of **committees/advisory bodies** established by the DHB (Advisory Committee, Consumer Council, Clinical Board, Hospital Advisory Committee, Quality Finance Audit and Risk committee).

There is some overlap in appointments when deemed appropriate. E.g. The CEO of the CDHB is also the CEO of the West coast DHB and there are number of joint clinical leadership and management positions supporting both DHBs at executive level. The General Manager of the Planning & Funding division is a member of the Executive Management Team.

The **Clinical Board** is a multidisciplinary clinical forum with membership from primary, secondary and community sectors. There are 26 members (17 elected). The clinical board is chaired by the DHB's Chief Medical Officer. The members play an important clinical leadership role and are responsible for the clinical governance of the DHB and are accountable to the Minister for the performance of the DHB. The board advises the CEO of the DHB on clinical issues.

Accountability for Canterbury's DHB. www.cdhb.govt.nz/About-CDHB/Planning-Funding

On behalf of the DHB, the **Planning and Funding Team** holds and monitors alliance contracts and service agreements with the organisations and individuals who provide the health services required to meet the needs of the population. This includes an Internal Service Agreement with the Hospital and Specialist Services Division and over 1,000 service contracts and alliance agreements with external providers including the three Primary Health Organisations (PHOs) in Canterbury.

Planning and Funding Team members maintain on-going relationships with these providers and ensure the efficient management of these service contracts and agreements. The monitoring of service contracts occurs through a number of mechanisms, including relationship development, reporting mechanisms and audit.

The Planning and Funding Division is also responsible for producing key accountability documents on behalf of the Canterbury DHB and monitoring performance against national health targets, expectations and the Funding Agreement between the Crown and the DHB.

Together with national policy, the DHB's accountability documents help to maintain transparency and enable robust review of the intentions of both the Ministry and of DHBs. The documents provide a long-term planning element to demonstrate capacity, sustainability of services and best use of resources. The use of short-, medium- and long-term performance targets in these documents also assists in evaluating DHB progress and effectiveness (www.cdhb.govt.nz/About-CDHB/Planning-Funding).

Enablers for change in Canterbury (Timmins and Ham, King's fund 2013)

There is evidence that Canterbury has made considerable progress towards health service integration. Factors proposed to have contributed to this process include;

- **Vision** for change (one system , one budget –even though funding was separate for hospital and PHOs-it was clear to staff that they needed to work together to integrate services). Staff were involved in developing the vision.
- **Investment in providing staff** (board employees and contractors) with skills needed to innovate and providing them with **support** during the process.
- Staff training and development - **Programme for leadership development**, an **innovative-different approach** to healthcare delivery was fostered. Business development units in CDH since 2000. Business process engineering type focus,
- **Canterbury Initiative** is the operational arm of funding and planning and through Clinical Networks, key leaders and organisations are brought together
- **IT** –an electronic request management system allows for appropriate access to the health service for referrals and sharing of patient records.
- Well organised GP service through PHOs is a big plus
- Stability and continuity of leadership.
- Organisational structure stable
- A shared funding system covering health and social care
- National targets and local definitions and drivers for success.
- Empowering and enabling clinics to make changes.
- Recognising that integrated care is not a quick fix. CDHB is still on a journey 5 years into the process

Lessons learnt from the Canterbury experience

- Need robust performance measurement systems to capture improved outcomes
- Must take account of the local context and challenges
- Integrated care cannot be judged solely on current performance-improved patient outcomes often only become evident after an initiative has had a chance to bed down.
- There are many different paths to sustained successful integrated care. Pilot projects can be useful to assess new initiatives before roll out on a larger scale.

Evidence for Integration of Health care

- **HealthPathways** across the Primary Secondary divide were devised by clinicians from each sector working together. HealthPathways are essentially care pathways based on local agreements on best practice. Hospital doctors and GPs work out together the best way to manage conditions between them and agree a pathway. Initially doctors but later other MDT members were included to determine the services need around the agreed pathway.
- Three initiatives promote care in the community by either preventing acute admission and or facilitating early discharge.
 - The Acute Demand Management System which is aimed at preventing hospital admission provides GPs with a means (board funding) to treat patients in the community whenever possible.
 - 24 hour GP services are provided by GPs in centres with 5 bed observation units, and a range of diagnostic tests capabilities.
 - Intermediate care type programmes were introduced to reduce length of hospital stay.

g. Sweden- Jönköping County Council's experience of Integrated Healthcare *(the bulk of the analysis refers to the experience of Jönköping County Council)*

Demography

Sweden is the third-largest country in the European Union, with a population of 9.5 million in 2013 (Statistics Sweden). Population density is recorded as 20.6 people per square kilometre, (53.3 per square mile), with a higher population density in the South than in the North.

Life expectancy at birth is 83.5 years for women and 79.5 years for men. The bulk of the population lives in the urban areas (approximately 85%). A significant portion of the population is 65 years and above (19.7%). Most of the population are middle-aged: 15-64 years (64.8%), (2011), (Statistics Sweden).

Healthcare

Everyone in Sweden has equal access to health care services under a largely decentralized, taxpayer-funded system. Costs for health and medical care represent about 10 per cent of Sweden's gross domestic product (GDP), which is on par with most other European countries. The bulk of health and medical costs in Sweden are paid for by county council and municipal taxes. Contributions from the national government are another source of funding, while patient fees cover only a small percentage of costs. Chronic diseases that require monitoring and treatment, and often lifelong medication, place significant demands on the system.

Structure of the Swedish Healthcare System

Sweden is divided into 290 municipalities, 20 county councils and four regions – Gotland, Halland, Skåne and Western Götaland. Sweden's regions are based on county councils or municipalities that have assumed responsibility for regional development from the state.

County councils are political bodies whose representatives are elected by county residents every four years on the same day as national general elections. County councils are also responsible for dental care for local residents up to the age of 20.

There is no hierarchical relation between municipalities, county councils and regions. Around 90 per cent of the work of Swedish county councils concerns health care, but they also deal with other areas such as culture and infrastructure.

Sweden's municipalities are responsible for care for the elderly in the home or in special accommodation. Their duties also include care for people with physical disabilities or psychological disorders and providing support and services for people released from hospital care as well as for school health care.

County council costs for health and medical care, excluding dental, were €21 billion in 2010. It is now more common for county councils to buy services from private health care providers — 12 per cent of

health care is financed by county councils but carried out by private care providers. An agreement guarantees that patients are covered by the same regulations and fees that apply to municipal care facilities.

Governance

The responsibility for health and medical care in Sweden is shared by the central government, county councils and municipalities. The Health and Medical Service Act regulates the responsibilities of county councils and municipalities, and gives local governments more freedom in this area. The role of the central government is to establish principles and guidelines, and to set the political agenda for health and medical care. It does this through laws and ordinances or by reaching agreements with the Swedish Association of Local Authorities and Regions (SALAR), which represents the county councils and municipalities. Responsibility for providing health care is devolved to the county councils and, in some cases, municipal governments.

History of innovation and strong performance

Sweden's healthcare system has an international reputation for strong performance, equity and innovation and was among the first countries to recognize the limits of hospital care and to make a national commitment to primary care and preventive services (Glenngård et al. 2005). Sweden compares very favourably internationally with regard to access and medical outcomes with moderate resource and cost levels (Organisation for Economic Co-operation and Development 2005). Rooted in a social ethic of participation and partnership, the Swedish system is highly decentralized and aims to achieve its objectives through public ownership as well as local and regional democracy, operation and accountability.

The county councils have been in existence since 1982. Members are elected to the council every 4 years at the time of general elections. County councils, which typically include several municipalities, fund, plan and deliver healthcare services. There are **20 county councils in Sweden for a population of 9.5 million**. Healthcare is a dominant focus for county councils, comprising over 70% of their resources (other responsibilities include cultural activities, public transportation and regional development). County councils finance their healthcare expenditures by income taxes (in addition to taxation revenue, healthcare financing is supplemented by state grants and user charges). They plan and allocate resources to healthcare, dental care, education and research for their jurisdictions, own and operate all their healthcare facilities and contract with healthcare providers. The councils employ salaried, community-based primary care physicians. Hospitals, which are owned and operated by the county councils, employ salaried, hospital-based physicians (Glenngård et al. 2005).

Other national organizations that influence healthcare in Sweden include the National Board of Health and Welfare, which sets standards for patient safety, performance assessment and practitioner licensing. The Swedish Association for Local Authorities and Regions (SALAR), a result of a recent merger of the Federations of County Councils and Local Authorities, is the county council's membership organization. The SALAR advocates for county councils and regions in government and reports publicly on their performance, supports quality improvement and oversees relations with labour unions.

Jönköping County Council

The remainder of the analysis focus on the experience of Health Service integration at Jönköping County Council (Baker et al 2008).

Healthcare System Jönköping

Jönköping County is located 330 km southwest of Stockholm in the southern province of Småland. It has three hospitals and **34 care centres** (including primary care clinics, specialized medical services, rehabilitation facilities and pharmacies), with a combined workforce of over 9,900 across 13 municipalities (Bojestig, Henriks and Karlsson 2006). It serves a **population of around 340,000**. Jönköping has gained a reputation as a centre of excellence for healthcare improvement and a model of health care system transformation.

Two initiatives stand out among Jönköping County Council's achievements in health and social care integration:

1) Esther

Care for the elderly is a critical issue in Sweden, a country that has the world's oldest population (19% ≥65). **Esther is an 88 year old fictional patient invented by clinicians in Jönköping to help them improve patient flow and coordination for seniors in six of the county's 13 municipalities. Esther lives alone in the community but has a chronic condition and occasional acute health care need. In the late 1990's Jönköping clinicians and leaders came together to map Esther's movements through the complex network of care settings and providers. In addition, interviews were conducted with patients like Esther and clinicians who provide care across the system. The collaboration tried to simplify the journey for the patient through the complex health care system and improve health service integration.

Changes included a redesigned intake and transfer process across the continuum of care, open access scheduling, team-based telephone consultation, integrated documentation and communication processes and an explicit strategy to educate patients in self-management skills. The "Esther project" yielded impressive improvements over a three- to five-year period, including an overall reduction in hospital admissions by over 20% (9,300 to 7,300) and a redeployment of resources to the community, a reduction in hospital days for heart failure by 30% (from 3,500 days per year to 2,500) and a reduction by more than 30 days of wait times for referral appointments with specialists such as neurologists (Institute for Healthcare Improvement 2006).

** (Similar to Mrs Smith in Torbay)

2) Pursuing Perfection

Jönköping participated with other international health systems in an Initiative called "Pursuing Perfection" aimed at system transformation across all major healthcare processes. The project was directed by the Institute for Healthcare Improvement (IHI) in the United States (US). Involvement in this project led to a **systems thinking approach** to healthcare and new ways of working and resulted in substantial streamlining of processes and cost savings across the system.

As part of this initiative all providers and resources for children with asthma in the county were brought together resulting in care mapping and process improvement. Jönköping reduced the number of hospitalizations for paediatric asthma to 7 per 10,000 (Jönköping formerly had 22 hospitalizations per 10,000; (the US national average is 30 hospitalizations per 10,000). Another outcome was the increase in Jönköping's rate of influenza vaccination by 30% (over four years), translating into substantial reductions in acute care hospital admission as well as in morbidity and mortality among the elderly population.

If the example in Jönköping could be spread to other county councils this would obviously result in considerable national health cost savings.

Further **projects to improve integration and continuity of care** were undertaken as a consequence of the success of these projects. This is reported to have led to a longer term focus on data to inform strategic and budget planning within the Council.

Governance of the Council at Jönköping

County Council CEO

Board of directors-Assembly with a chair and 81 elected members (4 yearly)

Enablers of success for Jönköping

- **Vision**
- **Continuous and effective leadership and governance**
 - Period of stability with sustained leadership from the same CEO of the county council for 18 years, & the same elected chair
 - Long standing key senior team members - physician leader and learning & innovation leader
 - Stability regarding the majority of the council's assembly of 81 politicians
- Board interference in day-to-day operations is virtually non-existent in Jönköping.
- Culture of financial discipline coupled with CQI approach

- Education of all staff in frameworks and tools for audit measurement and Total Quality Management (TQM) & CQI **Establishing Qulturum - a centralized "quality" house for training and education & open dialogue.** Supported by Qulturum, Jönköping County Council reports having made over 800 measurable improvements
- **Government initiatives** complimented local Jönköping projects e.g. CQI initiatives
- **Performance measurement and communicating objective information** on performance to board members for comparison
- **Including clinicians and staff in the process**
- Strategic guidance, support and coordination of initiatives.
- Management and front-line staff - oriented toward process and systems thinking in their everyday work
- Small scale changes then spread to other areas-“pilot projects”
“Results across the small parts of the system create big results for the system ... and lots of winners. ... Big, high-risk projects and changing structures in a traditional way, buying and selling and depending on the market, creates losers”. Karlsson County council CEO.
- **Use of tools for change** e.g. Action-Oriented learning / the Model for Improvement. Plan-Do-Study-Act (PDSA) type cycle that guides the testing and implementation of changes in a real work setting and accelerates improvement (Langley et al. 1996).
- **Facilitating and enabling change-**
Collaborative team projects towards common goal of improvement –facilitated/supported by Swedish Association for Local Authorities and Regions annual Quality Conference, the QUL award and Breakthrough Series modelled after the IHI's approach. Funding projects
Management restructuring to align with this learning. Managers and clinicians who were working on improving common or linked processes across the council came together regularly
- **Leadership Development**
Network for CEOs and other decision-makers, & investment locally in leadership development and education across various council levels.
Strategic appointments to the leadership team of chief of learning and innovation & a chief medical officer and planning director.
Widespread learning about how to change and improve processes for patients
- **Open to looking for best practice elsewhere and adapt for the context**
E.g. United Kingdom's National Primary Care Development Trust to engage patients in self-management using improvement methods-adapted this to launch the “Passion for Life” initiative.
E.g. Learned from experts in the US about ways of transforming care by working at the level of clinical microsystems (i.e., teams working at the front line of service delivery) (Nelson et al. 2002).
Integrating improvement knowledge and skills into clinical education- Partnership with medical school and other health professions
- **Putting quality at the centre of strategic and business planning** at the county council. Called Big Group Healthcare, all executive, clinical and quality leaders and managers across the system meet over five days throughout the year- Expose the good and the bad in the current system, discuss how quality improvement initiatives are (or are not) contributing to these in measurable ways. A “whole systems approach”- co-designing improved plans
- **Provide Incentives and Removing disincentives for improvement**
In conjunction with Big Group Healthcare, the three hospital CEOs began to receive limited incentives (5% of salary) for demonstrating Baldrige-type values in their leadership.
Instead of reclaiming cost savings in the global budget, organizations and units are able to reinvest all of these funds.
- Constancy of purpose
- The Chief Planning Officer is in charge of the new electronic health record and information system. Collection of data on performance and outcomes measurement is prioritised.

h. Israel's Experience of Integrated Care

Demography

The population of Israel is circa 8 million (Israel Central Bureau of Statistics, 2013) with a population density of 377 people per km². Life expectancy is 81.8 years (78.9 for males and 83.5 for females), well above the OECD average (80.1 years). The majority of the population are aged between 15-64 years (62.2%), 27.3 % are aged 0-14 years and 10.5% are aged 65 and over. Similar to the countries studied in the report, Israel has a growing elderly population and rate of chronic diseases. Obesity rates have increased in recent decades in all OECD countries, including Israel heralding increases in the occurrence of health problems (such as diabetes and cardiovascular diseases), and higher health care costs in the future.

There are a number of ethnic groups residing in Israel but the majority of the population are either Jews (75%) or Arabs (20%).

Healthcare System

Israel's primary care health service has a history of significant improvement in recent years. In the 1980s competition between the health plan market led to improvement in facilities, service to patients and physician satisfaction and retention. The creation of family medicine residency programmes offered by the health plans is attracting doctors into the field of primary care. Since 1995, and the passing of the National Health Insurance (NHI) Law, participation in a medical insurance plan with one of the four national HMOs is compulsory for all Israeli citizens. The plans provide universal access to a comprehensive package of healthcare services including primary care. Residents are free to choose from among the 4 non-profit health plans regardless of factors such as age, gender, or pre-existing conditions.

Financing of Healthcare

The state is responsible for providing health services to all residents of the country, registered with one of the four health service funds. To be eligible, a citizen must pay a health insurance tax. Coverage with the Uniform Benefits Package is extensive and includes medical diagnosis and treatment, preventive medicine, hospitalization (general, maternity, psychiatric and chronic), surgery and transplants, preventive dental care for children, first aid and transportation to a hospital or clinic, medical services at the workplace, treatment for drug abuse and alcoholism, medical equipment and appliances, obstetrics and fertility treatment, medication, treatment of chronic diseases and paramedical services such as physiotherapy and occupational therapy.

Health care is funded by means of a progressive health tax, or the National Insurance Institute, Israel's social security organization, which transfers funding to the Health Maintenance Organizations according to a certain formula based on the number of members in each fund, the age distribution of members, and a number of other indices. The Health Maintenance Organizations also receive direct financing from the state's money. The 1995 law also imposed a system of financial and medical oversight of HMOs by the State.

However, availability of services differs by location, as each of the organizations operate their own medical facilities, including private hospitals. In addition, they also operate their own supplementary health insurance programs, under which non-essential health services are funded for an extra (reportedly modest) fee. In addition, non-essential services can also be funded by a citizen sharing the cost with their employer.

There are also private health insurance plans which citizens may pay for in addition to compulsory participation in the national health insurance initiatives. They provide coverage for additional options for treatments. For example, in the area of elective surgery, a participant in a private insurance plan may choose the surgeon, anaesthetist, and hospital anywhere in Israel or around the world. In the area of transplants, unlimited funding is available to ensure a donor is found and the procedure is done without the need for government approval. In the area of medications for serious illnesses, while the "basket of medications" which are funded by the national HMOs is large and updated regularly, private insurance companies give access to a wider range. In comparison with health insurance in other countries, private health insurance in Israel is considered comparatively cheap, but premiums are based on age, gender, and previous medical history.

In Israel, 60.8% of health spending was funded by public sources in 2011, well below the average of 72.2% for OECD countries. In 2011, the share of public spending among OECD countries was the lowest (less than 50%) in the United States, Mexico and Chile, and relatively high (over 80%) in several Nordic countries (Denmark, Iceland, Norway and Sweden) and Japan (OECD Health Data 2013).

Access to Primary care is reported to be good with between 7.6 and 5.9 community based physicians per 10,000 of the population. Financially only one of the 4 health plans has a system of co-payments for primary care visits and this is reported to be nominal, the remaining 3 are free although the OECD does comment on some inequalities in service provision and rising cost of co-payments.

All of the plans provide continuing care/home care units in every region and there are over 100 such units nationally. These units provide short term assistance to patients in the community after discharge from hospital and care for patients over longer periods in the home setting.

A big factor of the system of care is the development of Information technology in the primary care setting providing universal access to electronic medical records in the primary care facilitating information sharing on a number of levels. Clalit, the insurance provider with the largest market share (54%) is the only plan with an IT system sharing information across the community hospital divide.

The health plans offer a 24 hour telephone hotline staffed by experienced RNs, there are evening care centres available in all major cities, independent urgent care centres and medical home visit services.

Primary care services in Israel rate highly and have been described as “world class” by the OECD (2012). Israel has reportedly maintained tight control on healthcare costs at circa 8% of GDP (7.7% in 2011) below the average of 9.3% in OECD countries amidst a background of rising health care costs. Israel also ranks below the OECD average in terms of health spending per capita, with spending of 2239 USD in 2011 (adjusted for purchasing power parity), compared with an OECD average of 3339 USD.

Despite the relatively low level of health expenditure in Israel, there are more physicians per capita than in many OECD countries. In 2011, Israel had 3.3 practising physicians per 1000 population, just above the OECD average of 3.2. On the other hand, there were only 4.8 nurses per 1000 population in Israel in 2011, much less than the OECD average of 8.7 (OECD Health Data 2013). As was the case for most OECD countries, the number of hospital beds per capita in Israel has fallen over time. This decline has coincided with a reduction of average length of stays in hospitals and an increase in the number of day surgeries. The number of hospital beds in Israel was 3.3 per 1000 population in 2011, much lower than the OECD average (4.8 beds).

Community based medical teams provide access to a broad range of expertise aimed at avoiding unnecessary hospital admission. An example of the success of this approach is the reported low level of hospitalisation for poorly controlled diabetes in Israel despite a comparable incidence of the disease (6.5%) in the adult population. Patient satisfaction surveys report most Israelis are very satisfied with the care they receive in Primary care setting (Gros et al., 2009). In addition the clinical quality of Israeli primary care rated highly with similar levels to the US despite a much higher level of per capita spend in the US (Rosen et al 2011) .

This plan Clalit insurance group uses EMR to identify members of the elderly population that are at most risk of deteriorating health based on economic, socio-demographic and clinical information and adopt a proactive approach to their care. A similar system is in operation for the management of chronic disease states. The group has reportedly eased the role of the PCPs as gatekeepers to specialists care yet at the same time the PCP is retaining its role in integrating care of its patients.

Enablers for the success of the primary care system

Enablers for the success of the primary care system in Israel are the reliance of remuneration systems other than fee for service thus reducing financial incentives for overuse of services. Sophisticated EMR is thought to contribute to quality of care and cost containment. Physicians generally work for only one plan allowing for the development of consistency between physicians and the health plan goals

The existence of a strong foundation in the area of primary care prior to the introduction of the NHI initiatives is credited with facilitating effective change.

The health plan groups actively recruited physicians to work in peripheral locations so as to meet the healthcare needs of their members of the population living in these areas. The health plans provided

organised systems of care and physicians working therein could be encouraged to provide care in keeping with this broader vision.

The hospital and community sector are not sufficiently integrated

Quality of care monitoring in Primary care is easier due to the well-developed EMR system. In addition the health plans compete with each other for market share and need to provide information and accountability data to attract and retain members.

The health plans work effectively with the community physicians and are thought to contribute greatly to the success of primary care in Israel. Some physicians split their time between hospitals and clinics and some community based specialists are physicians whose primary appointment is in a hospital fostering a spirit of co-ordination and continuity of care.

External quality control is monitored through the Quality Indicators in Community Health Care Programmes which tracks performance across 35 key measures. The health plans help primary care clinics by showing them what they are not doing well and how they can improve their performance. This is in contrast to a number of other countries (UK, Australia) where financial incentives are offered to providers who meet their performance targets.

Performance monitoring and information on the hospital system is sparse by comparison with the primary care sector and co-ordination between primary and acute care is reported to be poor (OECD 2012). The lack of a single electronic data system to track and share patient information has been felt to compound this chiasm. In addition, communication between the health sector and the related educational and social services sectors are reported to be inadequate.

Additionally, certain services were brought under the direct administration of the State, usually by means of the Health Ministry impeding possible integration and collaboration.

i. Netherlands Experience of Integrated Care

Demography

The population in the Netherlands is circa 16.77 million. It is the 24th most densely populated country in the world, with 404.6 inhabitants per square kilometre (1,048 /sq mi)—or 497 inhabitants per square kilometre (1,287 /sq mi) if only the land area is counted. The Randstad is the country's largest conurbation located in the west of the country and contains the four largest cities: Amsterdam in the province North Holland, Rotterdam and The Hague in the province South Holland, and Utrecht in the province Utrecht. The Randstad has a population of 7 million inhabitants and is the 6th largest metropolitan area in Europe (OECD Health Data 2013).

The Netherlands is divided into twelve provinces, each under a Commissioner of the King (*Commissaris van de Koning*), except for Limburg province where the position is named Governor (*Gouverneur*). All provinces are divided into municipalities of which there are 408.

The number of physicians per capita in the Netherlands was 3.0 per 1000 population in 2010, slightly less than the OECD average of 3.2. On the other hand, there were 11.8 nurses per 1000 population in the Netherlands in 2010, a number above the OECD average of 8.7. The number of hospital beds in the Netherlands was 4.7 per 1000 population in 2009, very close to the OECD average of 4.8 beds. As in most OECD countries, the number of hospital beds per capita in the Netherlands has fallen over time (OECD Health Data 2013)..

In 2011, life expectancy at birth in the Netherlands stood at 81.3 years, more than one year higher than the OECD average of 80.1 years. Obesity rates have increased in recent decades in the Netherlands, up from 6.0 in 1990 to 11.4% in 2011, heralding the occurrence of health problems (such as diabetes and cardiovascular diseases), and higher health care costs in the future.

Total health spending accounted for 11.9% of GDP in the Netherlands in 2011, the second highest share among OECD countries and well above the OECD average of 9.3%. The Netherlands also ranks well above the OECD average in terms of health spending per capita, with spending of 5099 USD in 2011 (adjusted for purchasing power parity), compared with an OECD average of 3339 USD. Health spending per capita in the Netherlands was fourth highest among OECD countries, behind the United States (which spent 8508 USD per capita in 2011), Norway and Switzerland.

In the Netherlands, it is not possible to distinguish clearly the public and private share for the part of health expenditures related to capital expenditure.

The public sector is the main source of health funding in the Netherlands, 85.6% of current health spending was funded by public sources in 2011, well above the average of 72.2% in OECD countries (OECD Health Data 2013).

Overview of the Dutch healthcare system

Major reforms have recently taken place in the Dutch healthcare system. A new single healthcare insurance system was introduced at the beginning of 2006, replacing the old two-tier system. All residents (except those with temporary permits or student permits) are now legally required to hold the same basic health insurance package, which can be supplemented by additional optional packages.

The coverage provided by the basic insurance package is subject to ongoing review and change by the government. It generally includes most general healthcare costs, but does not currently cover the cost of dental treatment for adults, some maternity and post-natal care and physiotherapy. Children under the age of 18 are automatically covered by their parents' basic health insurance package, and also receive coverage for dental care.

Individuals can buy their basic insurance policy from any of a number of insurance companies who all legally have to offer the same basic package, and which also offer additional supplementary cover at higher cost. The annual premium for the basic cover is in the region of €1,115 to €1,250, and a tax allowance is available against this for people on low-incomes. Residents can choose between three types of insurance policies:

1. Policy in kind: the insurance company concludes sufficient contracts with health care suppliers in order to deliver health care. The insurance company pays the bill directly to the health care supplier.
2. Restitution policy: residents choose the health care supplier and pay the bills, after which the health insurance company reimburses.
3. Combination policy: part of the bill is paid by the insurance company and the rest is paid by the resident.

It is possible to take out additional health insurance but, unlike the basic insurance policy, the insurance companies are not obliged to accept residents for this additional insurance. The additional health insurance can cover physiotherapy, spectacles, and dental help for persons of 22 years and older as well as alternative medicine such as homeopathy and acupuncture. The contents and premium differ per insurance company. Insured persons can, except when the issue centres on 'treatment' or 'residence', choose between care in kind or a personal budget. A personal budget is a sum of money that residents can use to purchase care, help and support themselves.

The medical care that is available in the Netherlands is generally reported to be of a very high standard with excellent facilities and advanced specialist treatments available.

Alternative treatments, such as homeopathy and acupuncture, are very popular in the Netherlands and the cost of these can sometimes be covered by health insurance.

General Practitioners (GPs) and Specialists

Primary healthcare in the Netherlands is provided by GPs. Residents are free to choose a GP in their area.

Some GPs and specialist require their patients to pay at the time of the consultation and will provide a receipt with which to reclaim the money from their insurance company; others will send a regular invoice to patients which can be forwarded to the insurers for payment, or will send this to the insurance company direct. The majority of specialists work within hospitals; there are very few private specialist clinics.

Specialists require a letter of referral from a GP and as such the GP acts as a gatekeeper, preventing unnecessary activity in the acute sector. A copy of the referral note from the GP will also usually be required by the insurance company for reimbursement.

All dental services in the Netherlands are provided by private clinics, most of which consist of a single dentist and their assistant, although there are some joint dental practices which also include dental hygienists. Dental charges are relatively high in the Netherlands, and cannot be reclaimed under the

basic insurance package, except for children under the age of 18. Dental services are tightly regulated by the government, which sets the charges for different dental procedures and ensures that the standards of dental care are consistently high. Dental specialists such as oral surgeons, periodontists and orthodontists generally work within hospitals in the Netherlands, and a referral from a dentist is usually required in order to see a specialist.

Hospitals

The Netherlands has a large number of hospitals including eight university hospitals, as well as a number of hospitals which are run by community or religious organisations. Traditionally, all hospitals in the Netherlands have offered the same range of specialist services, but under the new reformed healthcare system, the government is encouraging hospitals to specialise in particular areas of treatment. Although all hospitals generally offer the same high standards of care, the University hospitals, where medical research is conducted, often have the most up-to-date facilities and use the most advanced medical techniques.

Pregnancy and Ante-Natal Care

The Dutch have a very natural approach to childbirth; around 30% of babies are delivered at home, reportedly the highest percentage in the western world. The costs are fully covered by every medical insurance company. In the Netherlands, midwives are the mostly commonly used primary carers for women throughout pregnancy, childbirth and the post-natal period. It is fairly uncommon for gynaecologists or GPs to provide this service, although this can be requested if the pregnant woman has strong preference for this type of care. GPs also look after women during pregnancy in some remote areas where no midwife is available.

Childbirth and Aftercare

There is an excellent aftercare programme in the Netherlands, in which insurance cover provides for a maternity assistant to visit the home of a new-born baby every day for up to a week after the delivery, whether or not it was a home-birth or hospital delivery, to help look after mother and baby, teach new parents how to look after their child, and even carry out light housekeeping duties, cooking or shopping for the family.

The GP Cooperative

Around the millennium, out-of-hours primary care was reorganized from small-scale call rotations into large-scale GP cooperatives, with generally 40 to 120 GPs taking care of populations ranging from 50,000 to 500,000 inhabitants (van Uden Giesen et al., 2006). In 2005, more than 120 GP cooperatives in the Netherlands were set up covering more than 90% of the population.

Most GP cooperatives are situated near or within a hospital but have not formally regulated patient flow in conjunction with the hospital or its emergency department. This means that patients with a medical problem during out-of-hours times can choose either to attend the GP cooperative or the hospital emergency department. There are no financial incentives for any particular behaviour.

In the Netherlands, there are 60 GPs for every 100 000 inhabitants, which is quite moderate by international comparison.

GP networks

For research and education purposes, departments of family medicine of most Dutch universities have primary care networks consisting of GPs from different practices in the region. There are currently **11 GP networks in the Netherlands** which do not overlap. The networks are independent and there is no routine dataflow to a national database. These GP networks collect computer based information about patient care using uniform data collection and registration methods. At regular intervals the information from local registration systems is fed into a central database. On the national level, two GP networks exist that collect data on morbidity, prescriptions and referrals. The aim of regional and national networks is to collect data about primary care in a standardized way, suitable for scientific evaluation.

GPs administer primary health care 24 hours a day, 7 days a week. Most GPs in the Netherlands work in private practices and are self-employed, although a growing number of GPs are being contracted by community health centres. Many GP practices are solo practices, but support each other through 'cooperatives' to provide out-of-hours care, usually within one of the 105 regionally distributed out-of-hours centres. However, some insurers, such as Menzis, are beginning to open their own primary-care centres to serve the patients it insures in order to lower costs.

In the Netherlands, the government has been implementing components of the Chronic Care Model for at least 10 years (before the model was formally conceptualised). Their Transmural Care Programme aims to bridge the gap between hospital and community care.

Secondary and tertiary care:

As in the NHS, patients reach secondary and tertiary care through A&E or with a GP referral. More than 90% of Dutch hospitals are owned and managed on a private not-for-profit basis, with specialists working on a self-employed basis.

Willcox et al., (2011) report on reforms and achievements in Australia, the UK, the Netherlands (Table 1). They report that, similar to the UK and Australia, the Netherlands have been striving to implement integrated care. One of the strategies has been the implementation of midlevel primary care organizations both to coordinate primary care health services and to serve other functions, such as population health planning. Better coordination of primary health care services is also the objective driving the use of patient enrolment in a single general practice. Dutch payment reform has stressed financial incentives for better management of chronic disease.

The Netherlands is recognised as having a well-developed primary care infrastructure and a track record of strong performance. Primary healthcare is provided free of charge to all through universal access. General practitioners (GPs) provide primary care services and act as "gatekeepers" for patients' access to most specialist services and hospitals. This gatekeeper requirement places primary care at the centre of the health system, effectively ensuring that almost all patients have a regular primary care doctor or GP group. General practices in the Netherlands are effectively small private businesses providing a range of family medicine services. Funding is through universally mandated private insurance coverage in the Netherlands.

One notable difference in primary care provision between the UK, Australia and the Netherlands is the average size of GP practices (Table 1). Dutch practices tend to be smaller than their English and Australian counterparts, with 40 percent of Dutch GPs operating solo. In contrast, the share of GPs in solo practices in Australia has halved over the decade from 2000–01 to 2009–10, with about six of every 10 practices now employing five or more GPs. Another significant organizational change has been the growing presence of practice nurses, who now are part of the general-practice landscape in all three countries.

There is evidence for improved access to primary care, after hours care and team based care in the Netherlands (and the UK and Australia) since the introduction of health care reforms.

One of the approaches to enhancing coordination of care is the requirement for patient enrolment with a local GP which has been mandatory in the Netherlands since 2006 coupled with the creation of regional GP co-operatives.

Primary care organisations in the Netherlands (regional GP co-operatives) are directly involved in providing patient care. They were initially set up to provide afterhours care but have evolved to support GP practices and may offer a range of administrative, IT, data collection and professional services to practices. GP co-operatives have recently entered into contracts with health insurers to provide disease management services to patients. These cooperatives were incentivised by government through financial reimbursements covering organisational and material costs.

Payment methods to GPs have been changing and in recent times, a "blended payment approach" has been brought in, whereby incentives for desired behaviours amongst practitioners are funded alongside the usual capitation based system. The challenge has been to find the right balance between capitation and fee-for-service.

Table 1. Primary Care Organisations UK, Netherlands, Australia

Country	Population size (avg)	Roles	Funding
Australia: divisions of general practice (replaced by Medicare Locals 2011-2012, see below)	200,000	Provide GP services, support GPs IT, education, projects to improve service integration	Core provided by Australian government-additional project funding
Australia Medicare Locals Since 2011/12	380,000	Co-ordination of primary care ,local health planning, address gaps in service	Core funding from Government
UK Primary Care trusts (replaced by commissioning consortia April 2013, see below)	300,000	Population health focus. Contract funds for services for population served–moving to commissioning consortia April 2013	80% of total NHS budget
UK GP commissioning consortia	Range from 18,900 (3 practice GPs) to 672,000 (83 GPs). Avg. 35 GPs serving 239,000	Commissioning NHS services acute and community sectors	National Commissioning Board according to person-based risk adjusted formula.
Netherlands GP Co-operatives	100,000-500,000		After hours care is funded under the basic care package. GP co-ops get extra payments for disease management under contracts with health insurers.

The Chronic Care Model in the management of chronic disease states sees tasks delegated to practice nurses covered by additional fees paid for by health insurers. GPs are required to provide performance indicators. The government determines the maximum budget for primary care services and most prices for primary care.

Evidence for improved care is suggested by reported low rates of avoidable admissions in hospitals. Overall satisfaction amongst the Dutch for their health system is reported to be high. The out of hours service is characterised by a single regional telephone number for each co-op with most services situated close to hospitals—a significant 45% of after hour consultations are telephone only. The shared electronic health records between the coops and the patient’s usual GP practice facilitates continuity of care. The phones are serviced by triage nurses who have access to national evidence based clinical guidelines (especially in the Netherlands) to enhance standardisation of care, transparency and performance measurement.

In the Netherlands, as in the UK and Australia, a robust primary care infrastructure has been key to service integration with patient enrolment being a key feature of health systems in both the UK and the Netherlands. The use of IT for out of hour’s continuity of care is important. The focus on chronic disease management including mental health has seen investment for better coordination of such care in the Netherlands.

The GP co-operatives having been set up voluntarily have the advantage of professional ownership. Different countries have adopted different approaches to governance and influence. The role of the professional is well recognised in the Netherlands approach as well as a focus on local provision of care.

Willcox et al., (2011), recognise that there is no single solution that can strengthen primary care and initiatives include changes in organisation & governance and influencing norms and behaviours amongst healthcare professionals, changing roles and engaging consumers in their care. Regulation is important to improve quality of care and is encouraged through vocational training of GPs, accreditation of practices and the use of clinical guidelines.

3. Critical Review Papers on Successful Health Systems Integration

The following section is based on 2 critical reviews of successful health systems integration. Both reviews were undertaken to guide decision makers and others to plan for and implement integrated health systems.

1. The first publication by Suter et al., (2009), is the result of a systematic literature review of organisations where **10 universal principles** of successfully integrated healthcare system were identified. Below is a summary of the findings.

An important finding from the literature review is that one size does not fit all, in the bid toward integration, allowing organizational flexibility and adaptation of models and processes to local context.

Suter et al. (2009) found **10** frequently and consistently presented **principles associated with successful integration** regardless of the type of integration model, healthcare context or patient population served. The authors' findings are listed below.

Ten key principles for successful integration

I Comprehensive services across the care continuum

- Co-operation between health and social care organizations.
- Access to care continuum with multiple points of access.
- Emphasis on wellness, health promotion and primary care.

II. Patient focus

- Patient-centred philosophy; focusing on patients' needs.
- Patient engagement and participation.
- Population-based needs assessment; focus on defined population.

III. Geographic coverage and rostering

- Maximize patient accessibility and minimize duplication of services.
- Roster: responsibility for identified population; right of patient to choose and exit.

IV. Standardized 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.

V. Performance management

- Committed to quality of services, evaluation and continuous care improvement.
- Diagnosis, treatment and care interventions linked to clinical outcomes.

VI. Information systems

- State of the art information systems to collect, track and report activities.
- Efficient information systems that enhance communication and information flow across the continuum of care.

VII. Organizational culture and leadership

- Organizational support with demonstration of commitment.
- Leaders with vision who are able to instil a strong, cohesive culture.

VIII. Physician integration

- Physicians are the gateway to integrated healthcare delivery systems.
- Pivotal in the creation and maintenance of the single-point-of-entry or universal electronic patient record.
- Engage physicians in leading role, participation on Board to promote buy-in.

IX. Governance structure

- Strong, focused, diverse governance represented by a comprehensive membership from all stakeholder groups.
- Organizational structure that promotes coordination across settings and levels of care.

X. Financial management

- Aligning service funding to ensure equitable funding distribution for different services or levels of services.
- Funding mechanisms must promote inter-professional teamwork and health promotion.
- Sufficient funding to ensure adequate resources for sustainable change.

2. The second publication by Grant (2010), is based on information obtained by speaking with healthcare organisations (either individually or in panels) who have succeeded in implementing integrated care.

Grant (2010) states that regardless of the approach to health care integration, successful organisations share a common trait, *they design all stages of care delivery around what is best for patients*. She suggests the approaches used can be grouped into three broad categories:

- ¹⁾ *Integration between primary care and secondary care*. The author gives the example of Polikum, the largest provider of integrated outpatient health services in Germany to exemplify this approach. "Its guiding philosophy is that patients should be able to obtain all types of outpatient care under one roof. At its polyclinics in Berlin, patients can consult primary care physicians, specialists, nutritionists, and other health professionals; they can also undergo diagnostic tests and have prescriptions filled. Polikum executives have estimated that within a year of adopting this approach, the company's hospitalization costs were reduced by about half."
- 2) *Integration between health care and community care*. These efforts coordinate a wider range of services, including social services and community nursing services. The author gives Sweden as the country exemplifying this approach in the care of elderly or disabled patient. Regarding discharge home or to a step down facility, a physician from the hospital and a case worker from the municipal social services agency must jointly develop a plan to ensure appropriate follow-up services. This results in faster discharge and means patients were not kept in an acute bed for longer than necessary.
- 3) *Integration between payors and providers*. This results in better co-ordination of planning, commissioning, and delivery of healthcare. The organisation chosen to exemplify this approach is Kaiser Permanente in acute coronary event management.

Grant (2010) advises that "Even the organizations that are best at providing integrated care did not attempt initially to integrate every aspect of health and social care".

She advises that an organisation must;

- be clear about why it is conducting the pilot
- know what it hopes to accomplish
- be realistic about what it can achieve in any one pilot
- focus on where it can have the greatest impact.

Grant (2010) advises that decisions around integrated care **"should be based on the needs of the community and the context within which the organization is operating"**.

Grant (2010) then asks the following questions to help organisations piloting integrated care.

1. Which patients and clinical pathways should be integrated?

The answer to this question can be narrow, expansive, or somewhere in between.

An example of a narrow focus would be a single clinical pathway. The author recommends this approach if the goal is to optimize health outcomes in a specific patient population. E.g. Bolton Primary Care Trust in the United Kingdom built a diabetes network to address the region's high prevalence of that disease. The network, which includes primary care, secondary care, social services, volunteer groups, and patient representatives, has enabled Bolton to ensure that diabetes patients get high-quality care from well-trained local teams. Another example listed is in Germany,

where integrated disease-management programs are being used by payers to improve care delivery to patients with specific conditions (diabetes, heart disease, and asthma, for example).

A broad focus might include all patients in need of long-term care or like Geisinger Health System in the United States all patients with chronic conditions..

A mid- sized focus might consider all patients who use specific types of services (for example, home nursing care).

2. How many people should be included?

The scale of the effort will depend on the clinical pathways selected for the pilot, the financial (Return on Investment, ROI) and clinical viability. Thus, the population included can be anywhere from a few thousand people to hundreds of thousands. Consider collaborating/contracting with other regions/organisations to achieve adequate numbers for cost effectiveness and viability with an integrated care initiative.

3. Which services should be included?

The answers to the two previous questions determine which professionals need to be involved.

The author suggest that a key consideration is whether payors should also be involved and suggests that involvement can help ensure that all incentives are appropriately aligned. In Germany, for example, the public payor AOK has used incentives to strengthen coordination among GPs, hospitals, and nursing homes and thereby improve the services delivered to elderly patients.

4. Which model of integration should be used?

Here, there are basically two choices: structural and virtual. Structural integration requires that different organizations either be merged or have some sort of formal partnership or joint-venture arrangement. Virtual integration requires only that the organizations work closely together. In both cases, the best results are achieved when effective governance mechanisms, including strong performance management, are in place.

The Veterans Health Administration (VHA) is a good example of the value of structural integration. VHA, the largest integrated health care organization in the United States, delivers a wide range of health services to retired military personnel. It outranks many other US providers in the quality of care it delivers, the outcomes it achieves, and the efficiency of its care delivery.

However, full integration into a single organization is not a necessity. In some countries, physicians in private practice have banded together to form independent practice associations (IPAs) e.g. in Canterbury New Zealand . These associations help physicians in their negotiations with payors; in addition, they encourage collaboration and increased efficiency in care delivery. The physicians remain autonomous, but the IPAs give them incentives to coordinate care.

As structural integration is not always possible the author suggests that the organization should put **other governance mechanisms in place to ensure that care is coordinated.**

5. What other organizational enablers are needed?

The author proposes **Five factors** that can help maximize the results obtained with integrated care:

1. *Patient self-care.* Integrated care achieves best results when patients take control of their own health.
2. *Team responsibilities and accountability (the “panel approach”).* Integrated care is provided by a team of professionals who must work together to deliver the necessary services. For the team to function effectively there must be *clarity about who is responsible for what.*

Grant (2010) suggests that If possible, **a single person should have ultimate accountability for each patient**; this helps ensure that all appropriate services are delivered without duplicate or wastage. **However, a single point of accountability may not always be possible, especially when integration is virtual. In such cases, all care providers need to understand what they are accountable for, develop and then agree to follow protocols for how care will be delivered, and communicate regularly with other team members.**

3. *Information infrastructure (a “registry”).* All care providers need easy access to up-to-date patient records through a strong information system.

Electronic patient records improve care during individual patient visits; make it easier to plan for future care needs, with more accurate risk profiling and facilitate more robust performance management.

4. *Clinical leadership.* The author suggests that it is crucial that clinicians (especially physicians) play a prominent role. as partners in—and, ideally, leaders of—the change effort.

Those who want to assume leadership roles should be given appropriate training and additional compensation.

5. *Governance and provider incentives.* An integrated-care pilot must be predicated on a strong **vision**. The author stresses the importance of a clear governance structure; either a single board should be in charge of the effort or the involved organizations should have an agreed-upon plan for how decisions will be made.
 - Clearly communicated responsibilities for all involved and an emphasis on performance measurement (individual and collective).
 - Incentives (both financial and non-financial) should be offered to all participants to encourage improved care quality and increased productivity.

Ideally, all of these factors should be in place if the integration effort is to maximize its ability to improve outcomes and reduce costs. However, **which of these factors are most important to the success of the effort will depend on the pilot being conducted and the setting in which that pilot takes place.**

The author gives the example of Knappschaft, Bahn, See, a German payor and hospital system, *focusing first on getting physicians' support by having them help develop the clinical pathways and on developing the IT infrastructure needed to support the pathways' use.*

Making integrated care work

The author points out that most change programs fail, and “most of those failures arise from cultural factors—either senior managers are not supportive of the change or employees are resistant to it.”

If an integrated-care pilot is to succeed, therefore, strong support for it must be developed among **all participants**, which is part of the reason that appropriate incentives and clinical leadership are so important. A good communication program can also help in this regard. E.g. Torbay experience of integrating community care and health care providers in 2005. The trust began by communicating a clear and concise vision to all staff members of how they—and their patients—would benefit from integrated care. In addition, they also physically co-located the health and social care professionals to signal that they would collaborate from then on.

The author points out that enthusiasm alone is not enough for successful care integration. A deep transformation of attitudes and behaviours is required of all participants. The author suggests that the conviction among Kaiser Permanente's physicians and nurses that hospital admissions often represent a failure of care as central to its successful integration of care. This belief unites the staff around the common goal of keeping patients healthy.

4. Summary of Key Themes and Learning from International Experience with Integrated Care

- Integrated Care is a **Journey**. Many countries recognised as having made significant advances in the area of Integrated Care have been working on the concept for 2 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. Healthpathways in Canterbury DHB integrating care around disease states/conditions
 - E.g. Care Programmes in elderly care & Mental Health in Northern Ireland
 - E.g. Pursuing 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 & 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 & 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 patient care in Torbay trust. It is not clear if the co-ordinator is accountable for patient care.

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PRINCIPLES FOR
GOOD GOVERNANCE
IN PUBLIC SERVICES



NOVEMBER 2013
DR KATHERINE GAVIN

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1. Six Core Principles of Good governance

The Independent Commission on Good Governance in Public Services identified **6 core principles of good governance** (CIPFA/OPM 2004);

1. Focusing on the organisation's **purpose and on outcomes** for citizens and service users
 - e.g. Clear purpose and outcomes
2. Developing the **capacity and capability** of the governing body to be effective
 - Ensuring “governor's” have knowledge , skills and experience to perform effectively
 - Develop capability of people and evaluate performance as individuals and as part of team
3. **Engaging Stakeholders** and making **accountability** real
 - Understanding formal and informal accountability relationships
4. **Performing effectively** in clearly **defined functions and roles**
 - Being clear about functions of governing body and various responsibilities
5. **Promoting values** for the whole organisation and demonstrating **good governance** through **behaviour**
6. Taking **informed, transparent decisions** and **managing risk**
 - Having and using good quality information, advice and support

2. Perspective of the Chartered Institute of Public Finance & Accountancy International Federation of Accountants(CIPFA/IFAC)

CIPFA/IFAC describes a governing body as “a group of one or more individuals that is explicitly responsible for providing strategic direction and accountability” (CIPFA/IFAC 2013).

The **composition of the group** can vary and may include;

- Independent and non-independent members and various subcommittees.
- Executive members.
- Separate governing and management functions with a non-executive governing body overseeing an executive management group. The non-executive division contributes to strategic decision making, ensuring management arrangements and teams are in place. They hold the executive to account for performance in fulfilling the responsibilities delegated to it by the governing body.
- A two tiered structure including a top elected supervisory tier with similar roles to the non-executive board.
- State owned enterprises have governing bodies with a mix of executive and non-executive members commonly appointed by ministers of state. In such organisations, transparency over ministerial involvement is thought to be crucial to good governance.

CIPFA/IFAC state that the **function of good governance** in the public sector is to ensure **entities act in the public interest at all times**

This requires;

- Strong commitment to integrity, ethical values and the rule of law
- Openness and comprehensive stakeholder engagement

In addition, they state that **good governance in the public sector also requires** the following;

- **Defining outcomes** in terms of sustainable economic, social and environmental benefits
- **Determining the interventions necessary** to optimise the achievement of intended outcomes
- **Developing the capacity** of the entity, including the capability of its **leadership** and the individuals within it
- **Managing risks and performance** through robust internal control and strong public financial management
- Implementing good practices in **transparency** and **reporting** to deliver effective **accountability**

3. Perspective of the Institutional Development Division (GIDD) Commonwealth Secretariat

Menocal A. R. (2011) describes **6 Key Principles of “Good Governance”**;

- **Effectiveness**-performing key functions and delivering basic services
- **Transparency**-clarity and openness of decision making.
- **Efficiency**-government effective and responsive regulatory framework in place.
- **Participation and inclusiveness**-participation and ownership by a broad range of stakeholders.
- **Accountability**-decision makers responsible for their actions.
- **Respect for institutions and laws.**

4. Other Perspectives on “Principles of Best Corporate Governance Practice” (www.best-practice.com)

- Ethical approach.
- Balanced objectives.
- Each party plays his/her part-roles of key players.
- Decision making process in place and reflects principles 1-3, gives weight to all stakeholders.
- Equal concern for all stakeholders-some have greater weight than others.
- Accountability and transparency- to all stakeholders.

Five Golden Rules

- **Ethics**-having a clear ethical basis (for the business)
- **Align (*business*) goals-clear and achievable** & arrived at through creation of suitable stakeholder decision making model
- **Strategic Management**-an effective strategic process to achieve goals, incorporating stakeholder value
- **Organisation structure** suitable to effect good corporate governance

- **Reporting systems** structured to provide transparency and accountability

They describe the **essence of success (in business)**;

- Having **clear and achievable goal(s)**
- Having a **feasible strategy** to achieve the goal(s)
- Creating an **organisation appropriate to deliver** the goal(s)
- Having a **reporting system** to guide progress

5. Key Principles of an Effective Board

The International Committee of Sports for the Deaf (ICSD) (2012) describes the **Key Principles of an Effective Board** for Good Governance. An effective board;

- Understands its **role**
- Ensures the **delivery** of the organisations **vision and purpose**
- **Is Effective** as individuals and as a team
- Can **exercise control**
- Behaves with **integrity**
- Is **open and accountability**

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