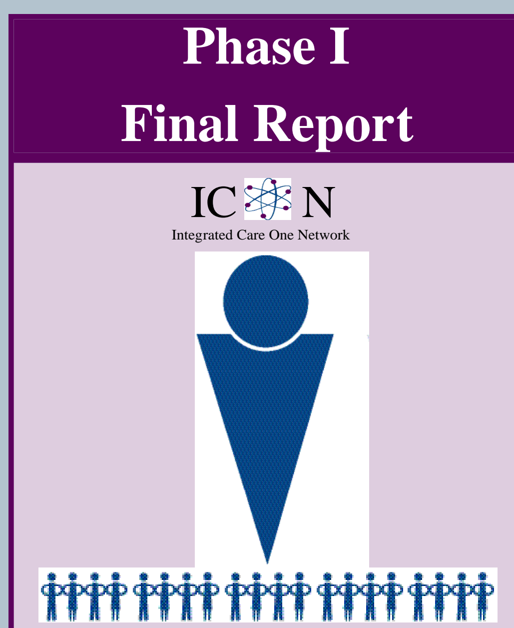
Integrated Primary, Community & Continuing Care
Bunchúram, Cúram Pobal agus Cúram Leanúnach Iomlán

Midland Health Board

"Developing a Model for Integrated Primary, Community and Continuing Care in the Midland Health Board"



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Secta
PARTNERS FOR CHANGE

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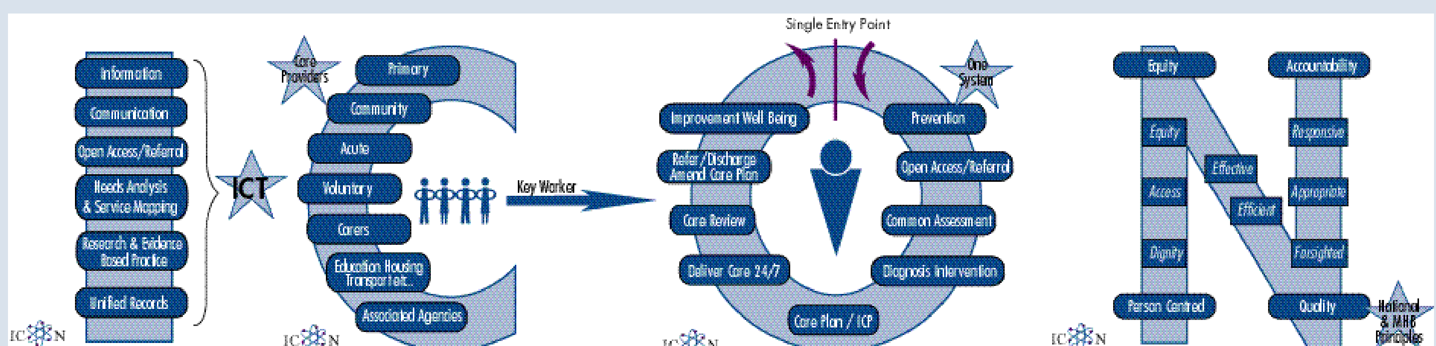
i n t r o d u c t i o n

The Midland Health Board (MHB) wanted to develop a model for integrated care for primary, community and mental health services as a way of avoiding current problems of fragmentation and duplication. The Board identified a need to develop a model for integrated care, so that existing levels of integration between professionals and agencies could be further developed and endorsed within a formal structure.

The MHB has been preparing to invest in information and communication technology, and wanted to be assured that any system being considered reflected and supported not only current but future ways of working. Any system would need to be appropriate for staff delivering the service, and also be appropriate for managing resources and reporting requirements. The MHB prepared a business case that set out the need to design a system for primary, community and continuing care that would be built on the needs and experience of staff working directly with patients and clients. The model for integration needed to be tested and developed, as this was considered to be integral to the IT system required.

People living and working within the Midland Health Board (MHB) area who need health and social care services will experience an improvement in their access to services and in the way that services are delivered if there can be targeting of services, staff and resources in a more productive, efficient and effective way by integrating care at every level.



BRIEF

The Midland Health Board (MHB) invited Secta to submit a proposal to assist with the development of a model for integrated primary, community and continuing care.

In response to the request for external support Secta proposed a team of three Consultants, Grainne Stafford, Helen Tucker and Peter Morgan to work with a Project Team and Steering Group for the MHB (Ref. appendix). Veronica Larkin, Project Manager, Martina Martin and Orla McEvoy became the MHB project team.

The project was divided into three parts:

- The development of the integrated care model
- The identification of high level data needs
- The management of change

The scope of the project was to include primary care, community care and mental health services.

The MHB has given this project a high priority, and encouraged managers and staff to actively participate at all stages. The style of the project has been open, transparent and inclusive. Contributions from all stakeholders have been actively encouraged at all stages. The Steering Group made a decision to extend this exercise to external bodies such as the non-statutory agencies and Government bodies at departmental level.

The group agreed that the involvement of people who have experience of the service would be a crucial contribution to the exercise, and would need to be carried out in a comprehensive way. Therefore user involvement would be scheduled once preliminary work had been carried out, and that users would be part of the consultative group, as well as being represented through non-statutory agencies. A wider consultation process through existing fora and processes would be carried out in the future, as the model is developed.

The project was designed to build on good practice locally, nationally and internationally and therefore required significant levels of research in order to compile a body of knowledge on current practice.

METHODOLOGY

It was agreed that an inclusive and consultative approach would be the most constructive way of developing the model, through a series of interviews, questionnaires and workshops.

PREPARATION

A series of Steering Group meetings were held in December 2002 and January 2003 to plan the project and assemble the staff and resources required. A project plan was prepared by Secta and agreed by the Steering Group, which set out a timescale from December 2002 to June 2003 with key deliverables identified at each stage.

WORKING DEFINITION

A working definition for integrated primary, community and continuing care was agreed as:

"Patient-centred services delivered in a non-acute setting in a continuous and coordinated way"

Integration is typically defined as bringing together elements or components that are separate.

RESEARCH

Secta prepared a discussion paper, which drew on research and good practice in integrated care on an international basis. The paper was widely circulated though the Steering Group, Managers and workshops.

LAUNCH

The Assistant C.E.O. of the Board and Chairperson of the Steering Group Pat O'Dowd formally launched the project in February 2003. The project was promoted through the internal communications systems within the Board, and given a high profile.

QUESTIONNAIRE

A questionnaire was designed to help determine the current level of integration in service provision. Those completing the questionnaire were asked to define what integrated care meant to them, and to suggest ways in which integration may be further developed. Staff were asked to identify the drivers and resistors to furthering integration through a SWOT (strengths, weaknesses opportunities and threats) analysis. 63 questionnaires were completed and analysed, giving a wealth of information across the care groups. (Ref. Appendix).

INTERVIEWS

Interviews were divided into three parts: internal interviews were undertaken by the MHB project team; the Secta consultants carried out interviews with the Steering Group and external non statutory Government bodies. Interviews were either on a one to one basis or were in groups and in the case of internal interviews were used to complete, validate and discuss the questionnaires.

WORKSHOPS

160 people participated in a series of half-day workshops in the week of the 24th March (Appendix A). Five of the workshops were based on care groups, representing the structure of the MHB. A workshop was also held for non-statutory organisations. The workshops were used to describe the project and process, to invite attendees to give presentations of local examples of integrated care, and generate discussion on action required to further integrated working. Participants were divided into small groups and each team was asked to design a model of integrated care, and present this back to the group. Often this was based on a case study, drawing on experience of the problems of fragmented and disjointed care, and describing the benefits of joined up working. The process encouraged creative thinking, and helped to identify common themes and essential elements of an integrated care system. The findings from this were shared via the circulation of the 18 PowerPoint presentations on current good practice, and a display of models at the collective workshop.

120 people participated in the Collective Stakeholder workshop on April 8th. The day was designed to test out elements of models for integrated care, and share the learning from the care group and non-statutory agencies workshops. The collective workshop was endorsed by the CEO and Assistant CEO of the MHB, and benefited from a presentation from Bob Ferguson, a former CEO who has direct experience of establishing and running integrated care services in Northern Ireland. The format of the day was to divide those attending into 11 groups, which were mixed in terms of care group, professions and statutory/non-statutory agencies. Each group was given a topic to discuss which was generated from the previous series of workshops. The day focused on action points, and each group presented its suggestions on action that was needed on an immediate, short term, medium term and long term basis. Priority actions were also identified. The collective workshop benefited from a plenary discussion, which concluded the day.

COMMUNICATION

The project was formally launched, and the email addresses of the MHB internal project team were widely circulated. In addition, an email address was set up specifically for the project, to encourage contributions to be made, request project documentation or ask for further information. Copies of all project documentation have been freely available at each event. The Steering Group have agreed that all outputs from the project, including this report, will be widely available through the website or by contacting integratedcare@mhb.ie

ACKNOWLEDGEMENTS

The Midland Health Board would like to thank SECTA, the Steering Group, the Project Team, the Consultative Group and all who participated in this project to date in particular Helen Tucker, Grainne Stafford and Peter Morgan of Secta and Veronica Larkin, Martina Martin and Orla McEvoy of the Midland Health Board and Bob Ferguson, former CEO South East Belfast Trust (SEBT). The level of enthusiasm for integrated care was remarkable, and the constructive way that this issue was addressed was commendable throughout this phase of the project. The profile that this project received from the top management of the organisation helped to signal the importance of this way of working. The project has proved to be a good example of effective collaborative working, with all concerned sharing a common goal, acknowledging and valuing each other's role, and giving the project a top priority.

"We can now move on from referring to "Integrated Care" as a project and consider it as our established way of working" Quote from Staff Member

"Is féidir linn bogadh ar aghaidh anois agus cuimhneadh ar "Chúram Iomlán" ar an mbealach a fheidhmíonn muid agus ní díreach mar thionscnamh". Deir Ball Fhoirne.

INTERNATIONAL

"Why is integrated care not already practiced everywhere, if the benefits of multi-disciplinary work and continuity of care are so self evident?[1]" This question was posed in a recent editorial in the International Journal of Integrated Care. Integration of care is a feature of many Government policies, and is being promoted and encouraged throughout. The principle of integration would appear to be supported widely, although the translation of this into practice requires significant and radical culture, systems and service changes.

The WHO Study Group on the Integration of Health Care Delivery[2] sees integration in terms of "virtue in its ability to encourage more holistic and personalised approaches to multi-dimensional health needs".

Kodner et al[3] describe integration as "A step in the process of health care systems and health care delivery becoming more complete and comprehensive". They have evaluated models of integration and describe the benefits of improving levels of integration. They question however whether full integration is attainable at every level, such as Government, Corporate and delivery level.

A review of integrated care for frail older people in America[4] illustrated the benefits from two models, SHMO and PACE. In the Social Health Maintenance Organisation (SHMO) 80% - 85% of users of the service were satisfied with the service particularly with access, convenience, quality and competence of care. For the "Programme of All Inclusive Care for the Elderly" (PACE) model, users expressed a greater confidence in their ability to take control of their lives. The authors assess integration on three levels: linkage, co-ordination and full integration. Linkage may be achieved through informal cooperation. Coordination may be achieved through the introduction of systems and processes, but may not be present to the same degree at all levels. The more radical level of full integration requires a unified approach at strategic, funding, operational and monitoring levels.

Studies of integration in Scotland[5] have shown that horizontal integration is typically easier to achieve than vertical integration. Horizontal integration is described as care at the same level such as within community care, and the integration could be on a multi-disciplinary or multi-agency basis. Vertical integration is described as care between levels, such as between secondary care, community care and primary care. Differences in culture and ways of working are cited as factors. Developments in linking vertically have had a focus in Scotland, through systems such as Managed Clinical Networks (MCN) and Integrated Care Pathways (ICP).

The practical experiences in the South East Belfast Trust of implementing integrated care in practice continue to be shared, and have attracted wide recognition. There is a high level of interest in sharing knowledge and learning in the practical implementation of the concept.

Integrated care, seen as an extension of the American model of managed care, is being developed, researched and evaluated globally, and therefore there is an opportunity to learn from the experiences throughout Europe and beyond.

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1 Integrated Care can not flourish with broken windows Guus Schrijvers October 2002

2 World Health Organisation Study Group Integration of Health Care Delivery Technical Report No. 861

3 Kodner D. & Spreeuwenberg C. IJIC Nov 02

4 Kodner D. & Kyriacou C. "Fully Integrated Care for Frail Elderly – Two American Models IJIC November 2000

5 Woods K. Integrated Care in Scotland IJIC

NATIONAL

The National Health Strategy, Quality and Fairness has a foreword by An Taoiseach Bertie Ahern who stated that *"For all parts of the system from Government down implementation will require an effective partnering with people willing to work together and where necessary change the way business is currently done."*

The Minister for Health and Children introduces the strategy by recording that *"This strategy empowers Health Boards, institutions, agencies and voluntary organisations to structure this planning in an integrated streamlined way."* He adds, *"The strategy envisages cross-disciplinary collaboration to achieve new standards, protocols and methods."*

The Strategy *"A new comprehensive model of primary care to meet the needs of patients and clients in an integrated way based on close teamwork between health professionals and direct access to services."*

The National Strategy espouses four key principles:

- Equity
- People-Centeredness
- Quality
- Accountability

It sets four national goals:

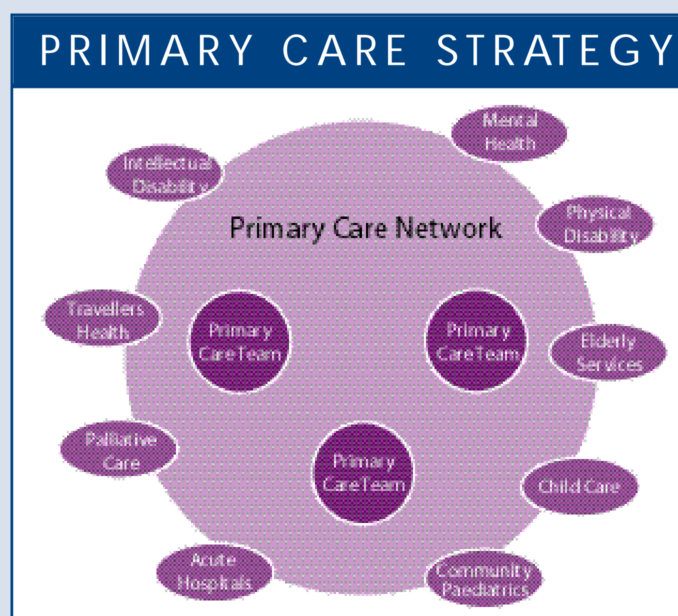
- Better Health for Everyone
- Fair Access
- Responsiveness and Appropriate Care Delivery
- High Performance

The six frameworks for change are:

- Strengthening Primary Care
- Reform of Acute Hospital System
- Funding the Health Services
- Developing Human Resources
- Organisational Reform
- Developing Health Information

The principles, goals and frameworks would need to be reflected in the model.

The Primary Care Strategy, Primary Care, A New Direction sets out a framework for developing primary health care teams within a primary and community care network.



The strategy illustrates the process of moving from single handed GPs working individually to the development of Primary Care Teams (PCTs), whereby GPs join into group or partnership practices supported by teams of nursing, therapy and administrative staff. As primary care teams develop they will be clustered within localities. A wider network of health and social care professionals and services will be formed to work with a number of primary care teams. The development of this infrastructure for primary care will enable primary and community care services to expand, so that patient/clients are better able to be supported within or nearer their own homes. The strategy is a crucial component in the development of a model of integrated care, and the role of the GP within the model is recognised as being pivotal.

When implementing integrated care, providers will be mindful of three reports that are pending which will shape the development of the health services over the next decade, these are the Hanley, Brennan and the Prospectus Reports.

LOCAL CONTEXT

PROFILE

The Midland Health Board has a population of 225,588 across the four Counties of Laois, Offaly, Longford and Westmeath. The population has been increasing over the past ten years. The age profile reflects the national profile, with one quarter of the population being children aged 14 years and under and just 12% of the population is aged 65 years and over. The MHB has 8 beds per 1000 population with 1635 beds in total, 30% of which are acute beds. An analysis of the MHB population is contained in the attached Appendices.

The mission statement for the MHB is "The MHB exists to improve the health (health gain) and quality of life (social gain) of the population". In support of this the Board will "Encourage staff to work together to provide the best quality services in the most efficient manner[8]"

The MHB is working to achieve national targets[9] and in particular target 6.7.2 of one national health strategy for Primary and Community Care. "To continue the project for the delivery of an information system based on a person-centred business process for primary care, community care and mental health services. The business processes will be agreed and procurement of the new system started.[10]"

The MHB has set out eight hallmarks of quality. Any model of integrated care would need to work within these agreed principles.

- Equity
- Access
- Effectiveness
- Efficiency
- Responsiveness
- Appropriateness
- Dignity
- Farsightedness

Results of Consultation in the MHB 2001

In Spring 2001 the MHB carried out an extensive consultation process involving 600 staff, a large number of service providers & recipients, the senior management team and the Board of the MHB. The consultation process used methods such as focus groups, interviews, workshops and brainstorming.

In respect of services for older people, community support was considered to be needed through partnership and collaboration. Groups and individuals interviewed with respect of disability services, stressed the need for appropriate structures to be in place to reflect the multi-sectorial approach required for delivering services to disabled persons. There was support for assigning a key-worker to persons with a disability including those with a mild disability. Better and more accessible information was recorded as being required on needs, services available, interventions, standards, and also performance in terms of outputs and outcomes. Those interviewed stated that there should be one point of contact for all services.

Those involved in mental health services identified a need for more communication and consultation between the different partnerships. There is a view that there is a need to set the Partnership Forum on an improved forum so that when non-statutory organisations are at the "table" with the statutory structure there is equality with a genuine commitment to consultation and working in partnership.

[7] Primary Care A New Direction Department of Health & Children 2002

[8] MHB Quality Strategy May 2001

[9] Quality and Fairness 2001 National Goal 4, Objective 2, Action 116 & 117

[10] Service Plan MHD 2003

The report records that mental health services should be client centred incorporating empowerment and consultation within the service planning process. The report states that the prime users of the service must have a voice.

The section on services concerned with womens' health records that those consulted with, observed that there was no integrated system, and in particular there was a need for an integrated patient/client information system such as a smart swipe card which would allow mapping of medical history. For childrens' services it was noted that poor communication between sectors had a resulting negative impact on quality of service to users.

Carers consulted made the case that the service was not seamless, and that carers needed to work in partnership with service providers. Carers noted that communication is extremely poor between members of the multidisciplinary teams. With regard to travellers' health, it was noted that there was a lack of information and support. It was stressed by those consulted that inter-agency co-operation in the delivery of services to members of the travelling community is vital in the context of a holistic resolution to the issues of traveller health. Services for people who were homeless were not considered to be seamless. In particular the existing response to needs was considered as agency based rather than client focused.

Those consulted on acute services observed a continued persistence of the medical model rather than a partnership with the patient/client and a need for continuity of care. Hospice services were considered to be disjointed. Interviews with other agencies raised comments such as "A Holistic approach is needed as no one service will have all of the answers", a "Need to co-ordinate Health Boards with other agencies" and the "Lack of co-ordination of services for patients." There was recorded support for introducing a health impact assessment for all sectors and ensure that they work together to develop a seamless service with a partnership for health at national and regional level.

The wide consultation exercise with stakeholders two years ago identified many of the issues that are still considered to be relevant today, and provide a mandate to proceed with testing out the opportunities for developing and furthering integration within the MHB.

Report on Consultation Process in Primary Care 2000

In Primary Care during 2000, a consultation process took place with key stakeholders in relation to the development of an integrated out of hours primary care service. It was identified that the Board needed to develop an integrated system for urgent out of hours primary care that:

- provides high quality care for urgent health related problems
- is satisfactory from the clients point of view
- supports rather than detracts from daytime/routine primary care
- is provided at an affordable cost

It is recognised that General Practitioners are key players in the delivery of out of hours care, however, the board is conscious of the diversity of needs that occur during out of hours times. The continuum of primary care services may include the following services, which will form the basis for the development of an out of hours integrated system:

- General Practitioner Service
- Ambulance Service
- Child Protection Service
- Pharmacy Service
- Accident & Emergency
- Voluntary Organisations
- Gardai
- Mental Health Services
- Community Nursing Service
- Emergency Dental Service

Report on Consultation Process with Carers 2002

IN 2002 The MHB carried out an extensive consultation process with carers. Illustrations given to the importance of "joining up" the services, improving information and working in a more integrated way have been recorded in some of the extracts provided below.

"As a means of addressing the need to provide more information, the MHB is reviewing the possibility of linking with current national help lines to provide this service to carers. It envisages that the Helpline will act as a central point for information on services, referral service and a listening service." It is noted that carer clinics have been developed in some areas. The clinics function as drop-in centres and could be described as a face-to-face Helpline. The clinics are operated by the Carer Co-ordinators, who provide information, a listening service, mediation and referral to appropriate services. Carers have specifically mentioned the need to have easy and immediate access to up-to-date information on grants, benefits and entitlements.

Carers stressed the problems of access to services and in particular transport links.
"It has long been acknowledged that there is a poor public transport infrastructure in place within the MHB region, which in turn can lead to social isolation." The carers consulted recommended schemes such as the rural transport initiative.

The Carers being consulted suggested that a consultation process be put in place to ensure that ongoing communication/partnership structures between the Health Board, carers and voluntary organisations is achieved. The report recommends that a strategic group be established, in order to produce an action plan for carers based on the research data reported and the goals identified in the consultation report.

MHB Secta Discussion Document 2002

The discussion document prepared for the MHB by Secta[11] sets out the developments in integrated care on an international basis, drawing on examples of good practice in Europe and beyond. The paper describes the integration that is required within and between primary and community care. It cites factors leading to integrated care such as increased demand, staffing limitations, shifts in skill mixes, developments in technology and communications systems, and the shift in health and social care services from institution and secondary care to community and home-based care. The document considers primary care as a generic service, assesses each client group within community care, and moves on to describe the implications for the MHB.

"The model for integrated primary and community care requires a clear structure supported by shared systems that are person-led rather than organisationally led. Each person presenting with a health or social care need should be able to access the service through a clear point of entry, have their needs assessed through a joint assessment process, and have a plan of care that is appropriate to them and their circumstances. Integrated Care Pathways, Care Plans and the Care Programme Approach are all systems that will enable those supporting and caring for people with health or care needs to work in an integrated way. The health and social care systems are complex, and therefore the design of a system to integrate the service so that there is a continuum of provision to individuals takes careful planning. It also requires a high degree of trust and co-operation supported by good communication systems and sharing of information. Once the Midland Health Board has decided on its integrated model, it will be in a position to design its protocols and pathways to support this way of working. A key element to this will be integrated information technology across agencies within the wider health and social care community bearing in mind confidentiality and data protection."

The discussion document has helped to act as a briefing paper and a prompt for debate about the objectives of the project to formalise and further develop integrated care within the MHB.

[11] Discussion Paper Integrated Primary and Community Care December 2002 Secta

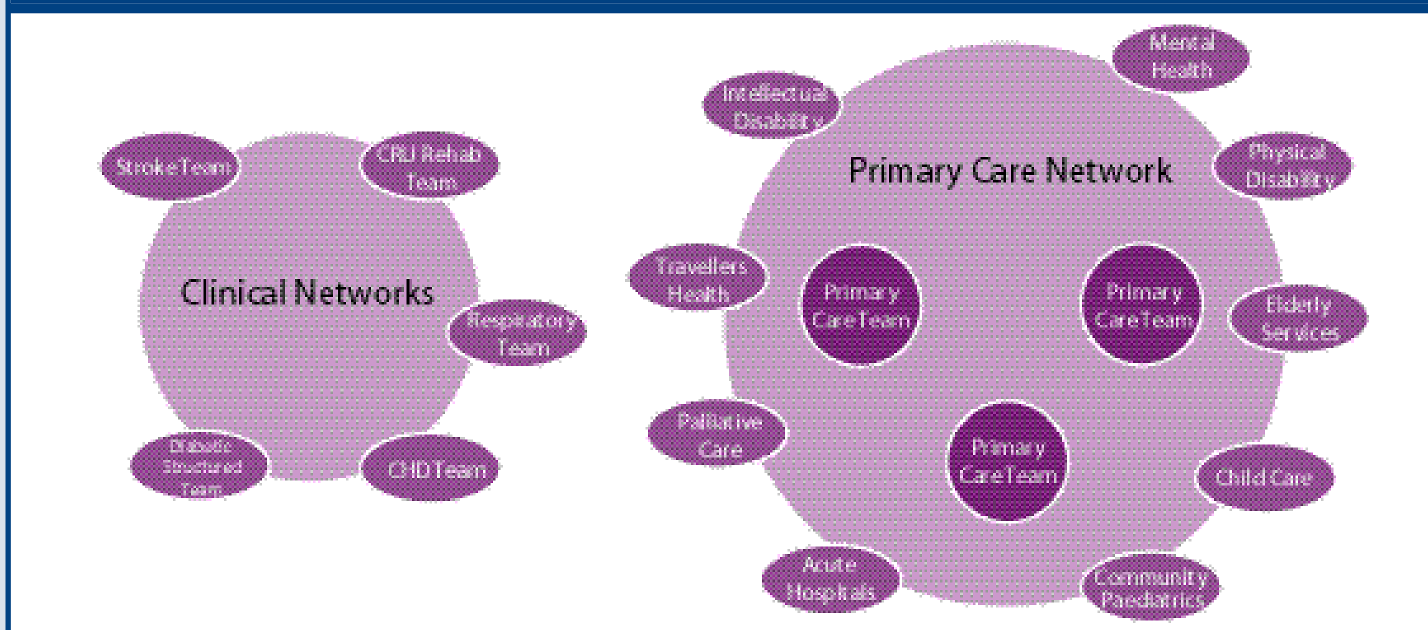
CONCLUSION

The model for integration to be developed for the MHB needs to support the policy shifts within the local and national health strategies, which have been informed by international strategies. The focus on the shift in service provision from acute hospital and institutional care to primary and community care is common to all. The creation of community capacity in order to provide for extended services locally will need the cooperation and support of many agencies and professionals working together. The development of the Primary Care Strategy is a significant step in building teams of professionals working together to extend and enhance health and social care within localities close to people's homes. The adoption of a formal model of Integrated Care for the MHB would provide an endorsement for a way of working that should maximise resources locally. It should enable primary and community care to develop and extend their services so that admission to hospital is prevented, discharge from hospital is accelerated, and that referral for long term or institutional care is avoided or delayed. The increase in capacity and competency within primary and community care, supported by effective team work, improved facilities, new technologies and efficient systems will enable acute hospitals within secondary care to concentrate on specialist services.

The incentive for pursuing integrated health and social care is clear, and the benefits have been illustrated through international studies and supported by national and local strategies. The challenge is to develop a model of integrated care that is appropriate and relevant for those working and living within the catchment of the MHB.

The diagram below is based on the primary care strategy, and is extended to include specialist community teams and specifies mental health services.

Integrated Teams Within the Primary & Community Care Network



DEFINITIONS

Staff of the MHB were asked to describe what integrated care meant to them. Definitions and descriptions contained the following 7 themes and have been taken from contributions in the 63 questionnaires.

a) Person centred
b) Needs based
c) Seamless
d) Accessible
e) Unity of Purpose
f) Supported by Communication and IT
g) Supported by Care management

a) Person Focused

The very strong theme of integrated care being person focussed came out of many of the descriptions and definitions.

Mary aged 29

My husband is in hospital following a road traffic accident. He also suffers from depression. We have had no income for the last four weeks as he is self-employed, so I got a part-time cleaning job. Now a Social Worker has called as someone reported that the children, aged 13, 11 and 9, were at home alone. I am afraid to meet this Social Worker as I don't know what will happen to us. We need help with our problems.

With Integrated Care

Support for this family will be required from the following services: Child Health, Mental Health, Community Welfare, Primary Care and Acute Hospital. A co-ordinated approach will be taken to the management of this case, in order that Mary and her family would be able to cope with this crisis in the best possible way. A key worker will be appointed who will have access to an electronic file. Using this as support, he/she will be able to inform all of the other service providers of the family's needs and ensure they were met with, in the most efficient and effictive manner possible

Quotes from Staff

"Integrated care is a system of providing care where the patient is at the centre of the process. Care is delivered in a co-ordinated and a timely fashion".

"Package of care delivered to a client that is client-focused and comprehensive"

"A unified approach to treatment encompassing a holistic approach with the patient as an active participant"
"Dearcadh aontaithe ar chóir leighis ina bhfuil an othar mar pháirtí gníomhach agus go bhfuil cur i láthair iomlán i gceist"

b) Needs-Based

Providing a service that is based on a process of needs assessment was stressed.

Catherine aged 17

I am 17 years old and am three months pregnant. While in school I had many problems and was very disruptive. I have been taking drugs for the past two years and now feel very lonely and depressed. My family doesn't want to know about me so how will I get through this and look after my baby? I am not capable of sorting everything out myself

With Integrated Care

To support Catherine the Primary Care, Community Care, Community Welfare, Mental Health and Acute Services will work in a co-ordinated and integrated manner. A specific Care Plan will be agreed with Catherine in conjunction with all of the relevant service providers. A key worker would be appointed who will record all the details. These will be logged onto a system for access by relevant professionals with Catherine's permission. To replace the informal system of staff communicating with each other, the formal team, operating an I.C.O.N. integrated care system, will provide Catherine with the reassurance that everyone is working together in the interest of her and her baby.

Quotes from Staff

"A group of professionals coming together to contribute to the holistic care of the person"

" All relevant professionals working together to ensure all the clients needs are met."

" Integrated Care means nothing if it is not needs-led"

c) Seamless

The theme of a seamless service providing continuity came through.

Olive and Peter aged 30 and 35

We have twin girls aged 5, both have a moderate learning disability, Jenny also has Autism. We are totally confused with all of the different professionals and agencies we have to deal with. The following are some of the people we deal with on a regular basis; General Practitioner, Counselling Nurse, Speech and Language Therapist, Occupational Therapist, Psychiatrist, Psychologist, Teacher, Classroom Assistant, Ophthalmologist, Audiologist and Administrators to name but a few. We are so confused sometimes we don't understand the different roles and have so many appointments that clash. Can nobody or no system sort everything out?

With Integrated Care

Olive and Peter will be invited to a case conference which will be attended by all of the relevant disciplines involved in the care of their daughters. A programme of care will be planned collectively and a key worker agreed whose responsibility will be to act in the best interest of the children and to coordinate their care and support by communicating with the many professionals involved using a shared IT system. The programme of care will be reviewed at regular intervals by the team involved in consultation with the parents to ensure that the best possible care is given to the girls.

Quotes from Staff

"Encourages continuity and seamless service"

"Very simple – cradle to grave – all services provided to a client should be totally integrated and seamless irrespective of the type of care, the care provider or the location."

"Services working together to provide complete solutions to housing/health/social problems"

"A service which appears seamless to the user but is in fact backed up by services (to meet the many needs) working closely together, giving a unified and holistic service to the client, thus maximising the quality of care to the client"

d) Accessible

Ease of Access was an important consideration.

John aged 67

I am 67 and live with my wife Mary who is 70. I have diabetes, high blood pressure and recently had a mild stroke. Mary has early onset dementia which I feel is deteriorating rapidly. We don't want to go into a nursing home if at all possible. I feel so confused having to attend so many different clinics and have so many different people to speak to. Most of the time I can't remember all of the details. Who or what can sort this out?

With Integrated Care

A care coordinator will be appointed to support John and Mary in planning a care programme which will suit their needs. John has expressed confusion about the number of people he has to deal with and the number of clinics they have to attend and has also expressed anxiety that they might have to go to a nursing home. The care coordinator will organize the appointments with the relevant clinics using a shared IT system to ensure that they are given at the most convenient times and at the most appropriate locations possible. He or she will also work with the relevant services to ensure that John's and Mary's wishes to remain at home are respected and that the appropriate services are provided in a coordinated and integrated manner.

Quotes from Staff

"The system should be easily navigated by all"

"It means that a client requiring a service should have one point of entry and can move seamlessly from one service to the other."

"One stop shop in the community that users are facilitated in accessing through a single point of contact whatever services they require."

"Services working closely together to produce a holistic, coordinated and easily accessible service where service users' best interests are paramount"
"Seirbhísí ag feidhmiú go dlúth le chéile chun seirbhís iomlán, comhordaithe atá éasca teacht air agus ina bhfuil leas an úsáidire sheirbhíse ar an gcloch is mó ar an bpaidrín".

e) Unity of Purpose

A single purpose was a strong message, focused around the needs of the person and their family.

Paul & Ann aged 30 & 28

We have just moved to the Midlands from London with our children, for family reasons, to look after Paul's widowed mother who is wheelchair bound. We haven't yet found work and our savings won't last very long. Our youngest child has eczema and asthma. We need to find a General Practioner and know what services are available for us as a family and what if, if anything, we are entitled to.

With Integrated Care

With integrated care, a single assessment approach will be employed to determine the family's needs and entitlements. A key worker will be appointed who will explain the services to them, assist them in availing of all that could be provided to them. A care plan will be agreed for their mother, in consultation with her. This will be reviewed regularly to ensure the best possible care was continuously provided. The family will be assigned a GP of their choice, at which point their entitlement for medical intervention will have been determined.

Quotes from Staff

"The whole team is working in one direction"

"Coordination of care where the team works in a coordinated way together towards an agreed goal"

The relationship between providers of health and social care, across disciplines and agencies was described in many contributions.

"It means communicating clearly and honestly with people, trusting others and being clear on agreements. It means looking beyond your professional stomping ground and encouraging others to provide the best service solutions with you."
"Ciallaíonn sé labhairt go soiléar agus go hionraic le daoine, muinín a chur i ndaoine eile agus bheith soiléar faoi chonarthaí. Ciallaíonn sé breathnú amach ónár gceirtlíní féin agus cur ina luí ar dhaoine an réiteach is fearr a sholathar dúinn".

"Integration means that you collaborate and cooperate with other providers in order that client's needs are met in the most effective way"
"Ciallaíonn Cúram Iomlán go mbíonn tú ag comhoibriú agus ag caint le soláthróirí eile ionas go sásófar riachtanais an chliaint sa chaoi is fearr"

f) Supported by Communication and IT

The importance of good communication systems backed by developing ICT systems was raised by many in their descriptions of integrated care

Michael aged 45

I have a chronic lung condition and am unable to work. In recent times I have become more and more immobile and as a result have also become quite depressed. A number of different professionals call to my home regularly to provide treatment. They include the Doctor, Physiotherapist, Occupational Therapist, Public Health Nurse, Psychiatrist and Community Mental Health Nurse I have also had a visit from the Community Welfare Officer since I stopped working. They all have separate files. I wonder why it can't be one, as I often fear that important pieces of information will get lost or will not be conveyed accurately from one to the other. There must be simple solution to this.

With Integrated Care

Within an integrated care model Michael will be encouraged to be an active participant in his own care. In consultation with all of the relevant care providers an agreed care plan will be drawn up setting out the appropriate care pathway. This information will be inputted onto a system for access by all of the relevant professionals with Michael's permission. He could now be reassured that all of his information was stored safely and available to the relevant professionals as appropriate. His care plan will also be regularly reviewed with him by the team to ensure that he was receiving the best possible care.

Quotes from Staff

"It is impossible in my view without an electronic patient record or at least a linked patient administration systems across the region."

"Good communication systems which support links, electronic patient records and having one database for every client with one identification number."

g) Supported by Care Management Systems

The systems and processes that need to be in place to provide an infrastructure for care management was considered to be part of the way that integrated care could be further developed.

Patricia aged 19

Since my road traffic accident six months ago I am confined to a wheelchair. I can no longer live alone and am currently unable to work. Having had a job and been independent for the previous year it is very difficult to accept that I will always need someone to do things for me. I now need a whole team of people to assist me and provide me with various treatments. While there are lots of people to help, there is no one person who takes overall charge.

With Integrated Care

In consultation with Patricia a care co-ordinator will be appointed to work with her in planning and organising the care she requires. Supported by an integrated IT system the care co-ordinator will bring together, the relevant professionals, to agree with Patricia, a care plan to meet all of her needs. This will ensure that, in an organised and comprehensive manner, all of the relevant services were provided to Patricia, with no unnecessary duplications or omissions.

Quotes from Staff

"A seamless service with a case management approach"
"Seirbhís gan siúnta le cur i láthair ar bhonn cás bhainistíochta"

"The bringing together of all of the relevant services provided by the Board in a structured manner."

"Service to the client with easy access via care pathways within a planned service."

"That there are coherent pathways to support service users in availing of appropriate access to services in different care settings."

MIDLAND HEALTH BOARD DEFINITION OF INTEGRATED CARE

From the interpretations above it is possible to start to draft a definition for integrated care for the MHB that is based on the components outlined above.

"Integrated care is care which is person-centred, offering a readily accessible and seamless service based on the needs and preferences of people who use the service. Team working across disciplines and agencies is based on trust and unity of purpose. Integrated care is facilitated and supported through good communications, well-developed ICT and a robust system of care management."

CURRENT LEVEL OF INTEGRATION

In order to measure the level of integration, and assess the strengths and weaknesses, staff completing the questionnaire were asked the following question.

"How integrated is your service? Please provide up to 3 examples of where the service has strengths, weaknesses, opportunities and threats/challenges with regard to the level of integration."

The responses from the 63 questionnaires have been analysed by theme. The questionnaire responses were analysed by client group: primary care, mental health, older people, children and people with disabilities. A generic category was also created for the many staff who work across client groups.

SUMMARY RESULTS

Rank	Strengths	Weaknesses	Opportunities	Threats
1	Staff attitude	Infrastructure	Appropriate Care	Staff attitudes
2	Client centered	Communication and Information	Comprehensive	Financial
3	Staff skills	Geography and Facilities	Knowledge	Staffing numbers & training
4	Communication	Staff capacity	Networking	Infrastructure
5	Infrastructure	Staff attitudes	Staff training and development	Lack of a model

The five key themes from the SWOT analysis are summarised in the table above and discussed in full in the appendices.

The questionnaires have helped to identify the key strengths and opportunities within the MHB so that these can be capitalised on. The project of developing a model for integrated care has been designed so that it provides an opportunity to build on good practice. Therefore, the sharing of this level of information with staff has proved to be invaluable.

The identification of weaknesses and threats has in turn been highly valuable, and has helped to identify the challenges that will be facing the MHB. The staff have been open and honest about the limitations and restrictions within their services, and have made suggestions about how these can be addressed.

The material from the questionnaires has provided a very rich basis for further work. The themes from the SWOT will be reflected in the action planning.

The information from the questionnaires provides the MHB with a strong evidence base and a mandate to proceed with developing and implementing its new model for integrated care.

CURRENT MODELS OF INTEGRATED WORKING

Managers and staff who completed questionnaires and participated in the workshops have put forward their suggestions of what could be described as integrated care. Some examples are provided in the table below.

	Multi-Disciplinary	Multi-Agency
Primary Care	Diabetes Structured Care Primary Care Team	Travellers Forum Screening Asylum Seekers
Mental Health	Tullamore Integrated MHS Homelessness Care Pathway	Primary Care Entry MHS Smoking Cessation
Elderly	CRU Rehabilitation St Vincent's Model of Care	Housing Aid for Elderly Carer Support Project
Children	Early Intervention Project Developmentally Delayed Children	Specific Language Impairment Schools Vaccination Programme
Disability	Individual Programme Plans Respite Care Service	Springfield Centre Resource Centres

Team Working

The questionnaire asked staff to list any teams that they were currently involved with.

TEAMS IN MHB

Multi Agency 120

Multi Disciplinary 202

Inter Professional 92

National 25

Academic 71

International 3

The responses were taken from the 63 questionnaires and clearly those completing the questionnaires gave many examples of teams within the MHB. Over 200 references were made to multi-disciplinary teamworking. Clearly many teams were referred to several times. But the response to the question showed that there is a sound basis for formalising and developing the integrated care model further.

Assessment of Levels of Integration

A total of 18 case studies on integrated working were presented at the workshops they were as follows:

Ref	Client Group	Topic	Presenter
1	Children	Children with Specific Language Impairment	Lily Lalor Senior Speech & Language Therapist
2	Mental Health	Integrated Occupational Therapy Service	Maria O'Connell Occupational Therapist
3	Mental Health	Waiting List Initiative-Pathways of Care and Stepped Care Model	Conor Owens Senior Psychologist
4	Mental Health	Integrated Mental Health Services in Tullamore Sector	Mick O'Hehir Acting Director of Nursing
5	Children	School Vaccination Programme	Dr Ina Kelly Senior Area Medical Officer
6	Older People	Rehabilitation & Community Rehabilitation Unit	Eileen Leavy Physical Health Nurse
7	Children	Children with Speech and Language Difficulties	Elizabeth Kelly A/Speech & Language Therapy Manager
8	Children	Developmentally Delayed Children	Betty Fox PHN
9	Older People	Multi-agency Support to Carers	Marian Delaney Hynes Carer Co-ordinator
10	Primary Care	Breastfeeding Support Clinic	Mary Healy Physical Health Nurse
11	Primary Care	Early Identification, Prevention & Management of Postnatal Depression	Mary Curran PHN Physical Health Nurse
12	Primary Care	School Vision Screening to Prevent Lazy Eye in Childhood	Dr Marie Houlihan Community Ophthalmic Physician
13	Disability	The Springfield Centre - Physical and Sensory Disabilities	Breege Donoghue Manager Springfield Centre
14	Mental Health	Primary Care Entry Point to Adult Mental Health	Lorcan Martin Consultant Psychiatrist
15	Older Persons	Rehabilitation in St Vincent's Hospital	Catherine O'Keeffe Director of Nursing
16	Children	Early Intervention for Support to Children & Families	Maura Morgan Occupational Therapy Manager
17	Primary Care	The Structured Diabetic Project	Corina Glennon Slattery Manager Community Dietitian Services
18	Primary Care	Ante-Natal Classes	Mary Wallace Senior Physiotherapist

It may be helpful for teams to carry out a self-assessment of the level of integration they have achieved. The levels of integration described by Kodner et al are "linkage, coordination and full integration".

The table below is an extract from Kodner's IJIC article showing the elements that need to be in place in order to attain each stage of integration. The examples of teamwork and integration shared by staff within MHB could be tested within this matrix in order to assess what stage they are at.

For instance, the **"linkage"** stage requires a clear focus, a network of relationships, teamwork and some sharing of information. It does not require any formalised system to underpin the integration, but relies more on a willingness to share and cooperate.

The **"coordination"** stage assumes that all of these are in place and further developed, but that there are also systems to underpin the joint approach such as common assessment and the care management process. It assumes that joint funding or single systems for measuring outcomes have yet to be developed.

The **"full integration"** stage assumes a well-developed common approach and single systems from strategy and management through to operation and monitoring.

Service	Linkage	Coordination	Full Integration
Strategy		**	***
Funding		*	***
Management		*	***
Focus on Continuum of Care	*	**	***
Network of Relationships	*	**	***
MDT Assessment		**	***
Care Management		**	***
Comprehensive Service Package		**	***
Continuity of Coverage & Care		*	***
Teamwork	*	**	***
Information Sharing	*	**	***
Systems & Outcomes		*	***

Table: *Kodner et al Levels of Integration IJIC*

Many of the examples shared within MHB were at the level of informal linkage and coordination based on individual initiative, willingness of parties to cooperate to the benefit of the patients/clients, and a shared understanding to work in a more collaborative way. For some parts of the service, this way of working has been integral for many years, and is not a recent phenomenon. However this way of working has not been formally endorsed or recognised within the health and social care system, and the systems and structures have not been designed to support this way of working. It is therefore to the credit of individuals and teams that they have achieved so much, and this has given a strong basis to progress integrated care on a more consistent and comprehensive basis throughout the Board.

The evidence-based self-assessment tool developed by Kodner et al would provide a useful basis for developing a system of appraisal of levels of integration, using agreed criteria by the MHB.

Staff of the MHB developed some examples of integrated care systems in diagrammatic form. These diagrams have helped to illustrate the elements required for a potential model for integrated care and how staff see the system working.

The models described below are:

1a Circle of Need
1b The SPAR Model
2 Local Centre Model
3a Centipede Model
3b Disability Systems Map
4a Network Model
4b Features of Network Model
5 Open Referral Model
6 Christmas Tree Model
7a Spiders Web
7b Client Journey
8 Open Door Model
9 Jigsaw Model

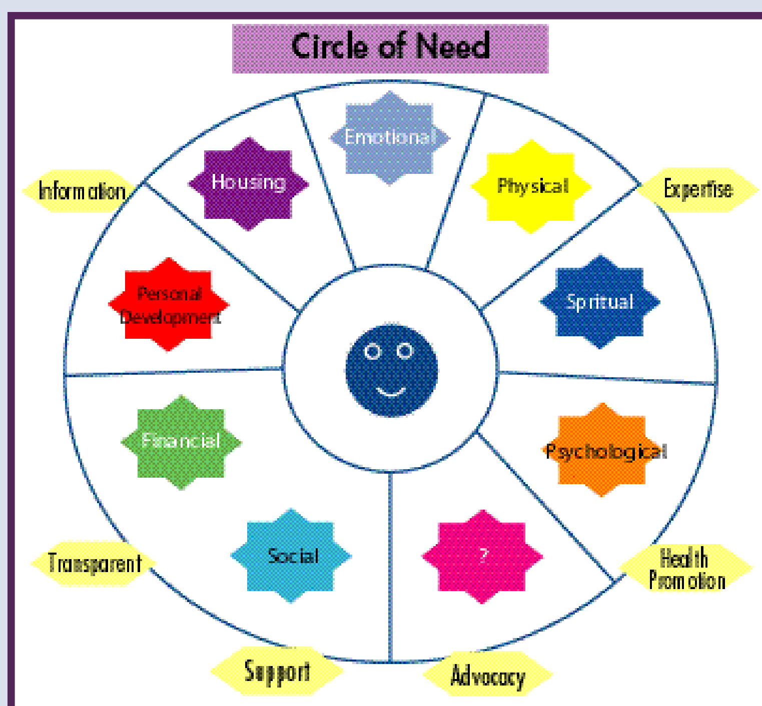
The models contain common elements of information to patients/clients, open referral, ease of access, a managed care system, regular review and shared practices and information. Each of the models starts with the patient, client or person at the centre. The models illustrate the complexity of health and social care support, and also the range of disciplines and agencies that may be involved in a person's care.

It is clear from these models that the process of planning, managing, delivering and monitoring health and care needs to be structured and managed on a shared basis, integrating all of those concerned with improving the health and well being of the people who live in the MHB.

The models below are shown in full size in the appendix.

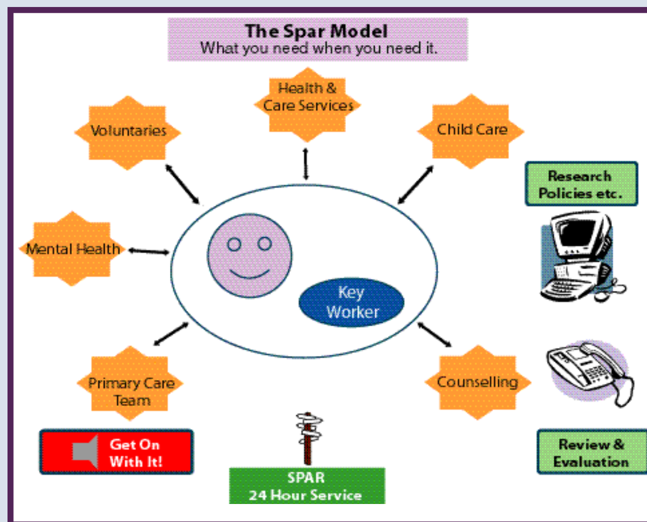
Model 1a Circle of Need

This model describes the range of needs of individuals, expressed in terms such as spiritual, psychological, housing and including needs not identified by the person concerned. The person is in the centre of the network. How these needs are translated into requirements for services are shown outside the circle, including advocacy, health promotion, and information. The system needs to be open and transparent at all stages.



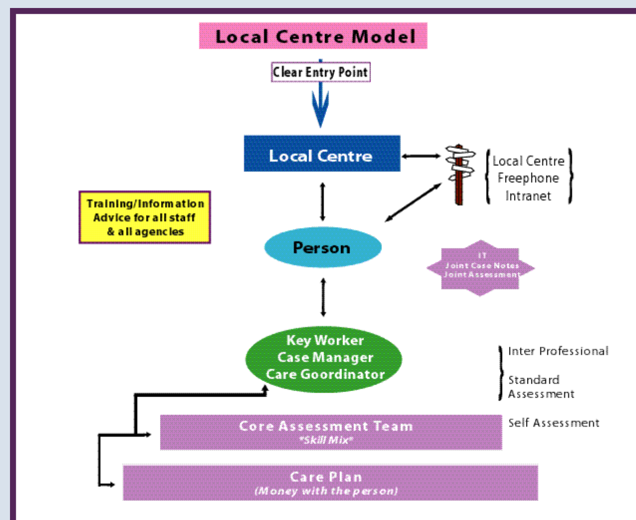
Model 1b The SPAR Model

Stage 2 of the above model is translating the needs of an individual into a range of services. The role of a key worker is considered to be crucial for the planning and coordination of support. Services need to be evidence-based supported by research and working to agreed policies and protocols. Services to individuals need to be regularly reviewed and evaluated. The SPAR resource centre (what you need when you need it) may be a "signpost" for individuals onto other services or facilities. The designers of the model stressed the need to "get on with it", acknowledging that much could be done with immediate effect.



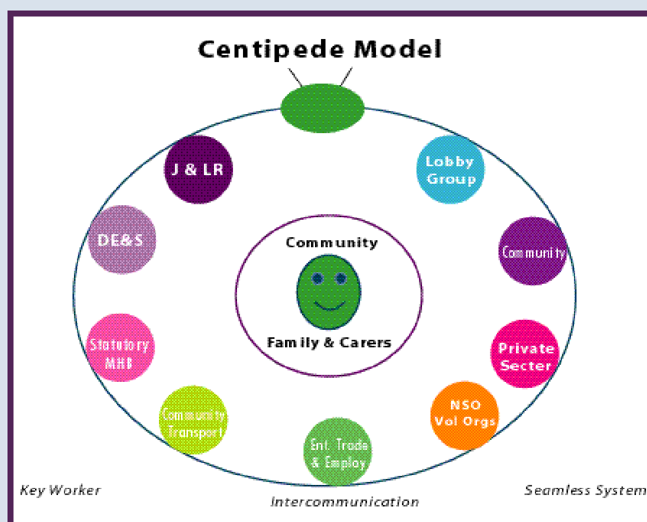
Model 2 Local Centre Model

The Local Centre model stressed the clear entry point into a centre, which provides information, advice and support for all. The centre may be staffed and supported on a multi-agency basis. Communication and information methods would include an MHB freephone plus the intranet & internet. The steps in the process would be assessment and care planning supported by a care co-ordinator, with joint case notes, IT and processes in place.



Model 3a Centipede Model

The idea for the centipede came in the description of the key players in the provision of services for people with disabilities. The model illustrates multi-agency involvement including health, employment, training, transport and education. The need for intercommunication in order to deliver a seamless service is shown in the model. Disability is a complex area involving several departments such as health, education, finance, justice, environment etc. The model is a systems map.



Model 3b Disability Systems Map

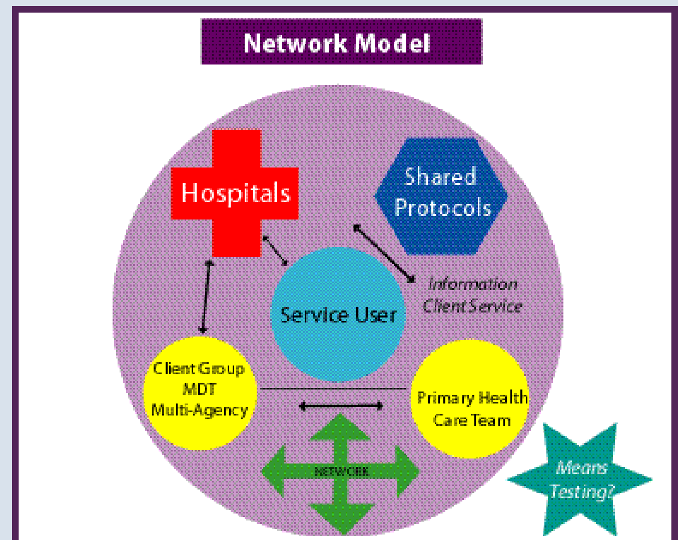
These points are made to show the aspects of the model that need to be in place. For instance, services need to be available 24 hours a day 7 days a week. An Integrated Care Pathway can be developed for many common client needs. Teams working together need to share a common goal, and the needs assessment should be joint and shared. This list of criteria was developed by the disability working group, although the points would be common to all care groups.

Disability System Map
"Currently described as Centipede with all legs going in all directions"

- Need Systems map that integrates care "Holistic Approach"
- Common goal
- Maximise Potential, Quality & Outcome
- Prevention, Education & Research
- Care Pathway
- Inclusive Model - All Stakeholders
- Service 24/7
- Communication, Information, Choices
- Needs Assessment
- Respect Rights Choice & Dignity

Model 4a Network Model

The model shows the service user in the centre of the model, with aspects of services such as primary care and hospital care within the circle. The importance of shared protocols through each stage of health and social care services is shown, and the need for joint assessment, training and shared protocols. The use of information across MDT and multi-agency was stressed by the group. The issue of means testing was raised with a question mark with regard to equity of access and the provision of seamless services.



Model 4b Features of Network Model

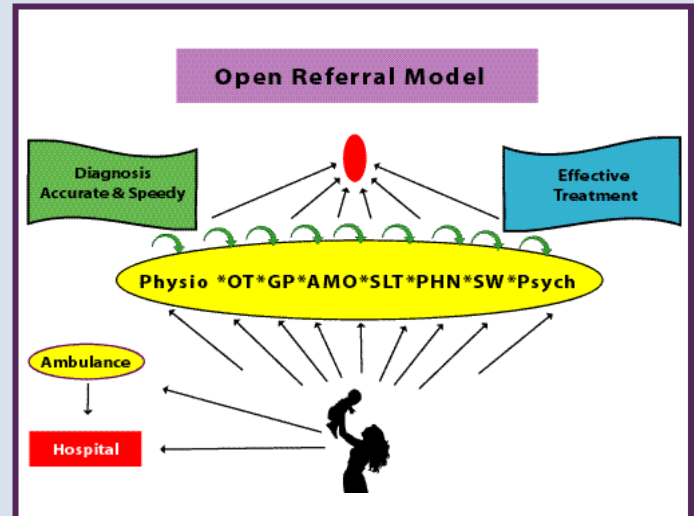
The group listed the criteria for the network model above. This includes access, a client centred and seamless integrated service. The group stressed the need for a full MDT, acknowledging recruitment difficulties leave some teams being established, short staffed, particularly for specific therapies. The need for a combined health record was listed as a criteria.

Features of Network Model

- Accessibility
- Client Centred
- Good Communication
- Awareness
- Seamless Integrated service
- Common Health Record
- Visibility
- Resources
- Full Multidisciplinary Team
- Build Services Around Client
- Standardised Approach

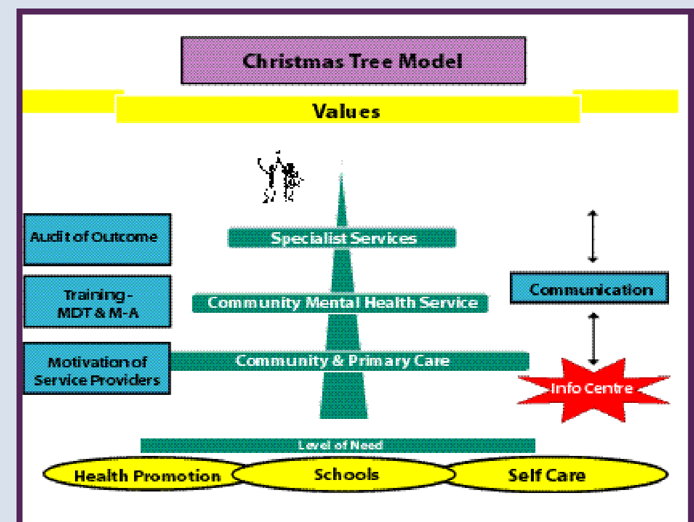
Model 5 Open Referral Model

The primary care group who developed this model noted that GPs currently are the gatekeepers to many services, but not all are well placed to refer on appropriately. The group explored the benefits of opening up the referral system in a way where there is a common assessment and ease of cross referral. It was considered that this team approach may help lead to speedier diagnosis and early intervention for a number of clients. It was thought by some members of the team that this extended primary care team would benefit from being co-located, although others believed that "virtual teams" may be more likely. Shared systems were considered essential for the implementation of this model.



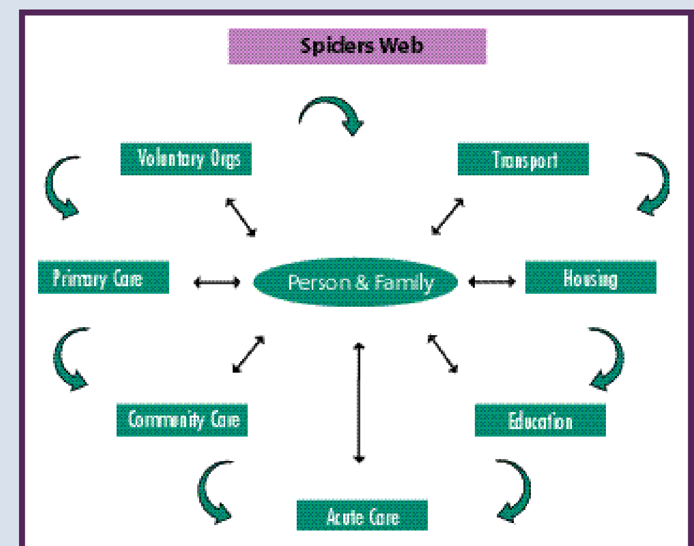
Model 6 Christmas Tree Model

The mental health group who developed this identified the need for integration at the prevention stage and that this could be carried out in schools, through health promotion and self care. Entry into the service would be according to need via an information centre. Specialist services would be available through referral, and that outcomes of care would be audited. A higher number of people would be treated in primary and community care and only those people who need it would be referred on to specialist care.



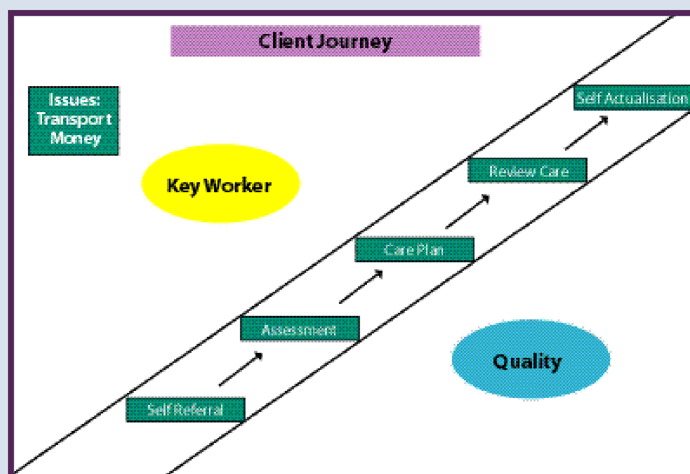
Model 7a Spiders Web

The children's group who developed this model described the need of the child and family and the links between these services and organisations. The links between and across each aspect of the service was described as a spider's web.



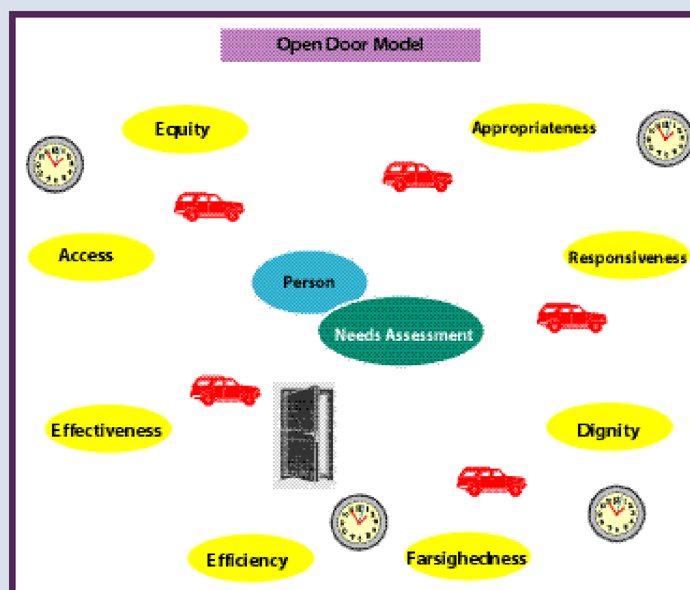
Model 7b Client Journey

The client journey was a follow on from the spider's web. Once needs were identified the patient/client would go through assessment, care planning, review and would have a goal of self-actualisation. A key worker would guide the process, and the journey would be underpinned by hallmarks of quality. Issues raised by the group included problems of access to services (transport) and the lack of financial resources within some families (benefits) leading members of the group to describe models that took the service to the client.



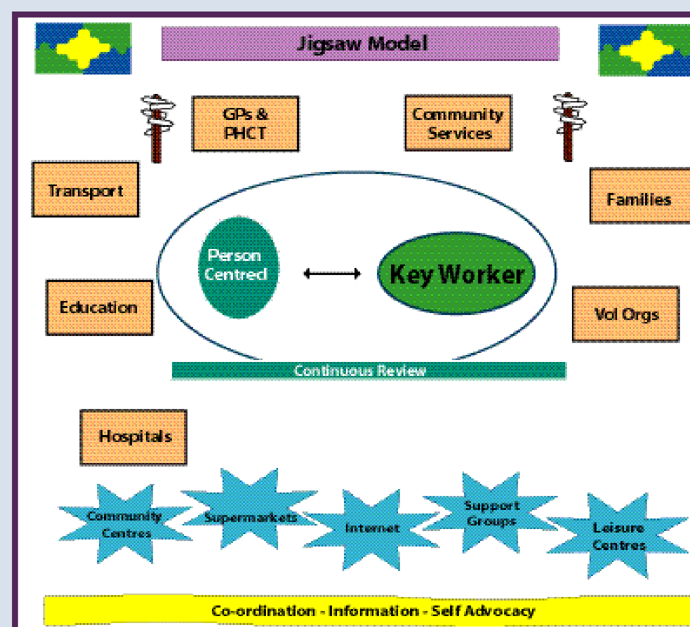
Model 8 Open Door Model

This group described the model of integrated care using the 8 values for the MHB. The person is at the centre of the model, and the model is described as an open door, indicating open referral and ease of access to service. The clocks indicate 24/7 care and care and support that is timely. The cars illustrate the point about the need to help with transport to enable service users to access the services that are provided, as this is currently a significant limitation.



Model 9 Jigsaw Model

The group showed the client along with their key worker in the centre of the model. The group showed that the service that they received was under continuous review. Information on services to be provided through systems such as through support groups, the internet, via local supermarkets, leisure centres and community centres. The range of services and support is shown signposted around the client. The model is underpinned with information, coordination and self-advocacy.



features of proposed MHB model

Attributes for the model were identified by those who contributed through the interviews, questionnaires, and in the workshops. The descriptions of integrated care models led to the development of common themes.

The key features of the model have been analysed and are presented under seven main headings:

a) Value-Based
b) Person-Centred
c) Accessible
d) Flexible
e) Transparent
f) Timely
g) Measurable

a) Value-based

The values of dignity, rights, respect, trust and choice were cited as a basis for the development of an integrated model. The four principles in the National Strategy (equity, people-centredness, quality and accountability) have formed the framework for the model. These are also in keeping with the eight hallmarks of quality within the MHB strategy, which were endorsed as a sound basis for developing and testing the model. These are equity, accessibility, effectiveness, efficiency, appropriateness, responsiveness, dignity and farsightedness. If all providers, planners, commissioners and budget providers of health and social care sign up to these values and principles it follows that all decisions on a macro and micro level would be tested to ensure that the service is being underpinned by these values and principles. All agencies and professionals would need to demonstrate a willingness to work in an integrated way, and to work formally in accordance within agreed and explicit values.

b) Person Centred

The critical importance of the person being at the centre of the model was stressed by all concerned and is one of the four principles in the National Strategy. The termonology used to refer to people who have experience of the service varied and included patients, clients, service users, consumers and residents. The point was made strongly however, that integrated care needs to begin at a stage before a person formally becomes diagnosed or recognised as a patient or client, at the preventative stage. Therefore, referring to a "person-centred" approach acknowledges that it is a model for all stages of health and social care support including health promotion, prevention and self-care. The model is seen to be a way in which the person can be empowered and to make choices about their own care.

c) Accessible

The access to services was a common theme for all client care groups. The current difficulties of access were described in terms of lack of public transport, a large geographical area for the MHB, the lack of physical access for people with mobility difficulties, and financial barriers. Those consulted stressed the fact that excellent services could be developed, but that if service users and their carers or families could not have ready access to these services then these services would not be reaching those in need. An integrated model of service would need to provide a clear access route to the service, clear or open referral processes, and systems to support service users to navigate through the services. Where possible, services should be taken to where the people who need the service are located (home, school, local clinic etc). Attention to barriers that prevent access to services of all types would need to be addressed in an integrated, multi-agency way.

d) Flexible

The planning and delivery of health and social care services would need to be flexible in accordance with the needs of individuals and communities. Examples were given of appointments being offered to coincide with known transport availability, carers providing personal care within an individual's home early in the morning or late at night, and the location of the service being changed to suit a families financial circumstances. The needs, wishes and preferences may be taken into account more formally within a care management system that places the service users at the centre of the process. The formal system would also take in a holistic view of the person's circumstances, considering also the informal carer and family circumstances in a managed way. Attention would be given to continuity and consistency of support.

e) Transparent

Open access to information on services and facilities supported by effective communication were themes that came up throughout the process, and in particular within the workshops. The priority action for furthering integrated care was agreed to be the raising of awareness of what services are available to the MHB population. It was suggested that publication of a directory of services with information about eligibility criteria and access through a range of media

systems such as leaflets, internet, posters, free phoneline, low cost calls, promotions, newsletters etc. would help start the process of raising awareness for staff as well as the public. Service mapping in the area would help to identify gaps, duplications and pressure points. Sharing information on service demands, unmet need, waiting lists, activity levels etc on an open basis across agencies would help to identify service priorities and potential areas for collaboration on services and resources. IT systems that allow information on services and clients to be shared across health and care providers will facilitate this. Technological advances such as palm top devices, text messaging, telemedicine and SMART cards may facilitate this sharing. An open and transparent system with regard to service availability and access will be an essential feature of effective multi-agency and multi-disciplinary working.

f) Timely

Professional staff identified one of the key frustrations to joint working was the lack of a system to underpin the process, which may mean that a large number of professional and other care staff may be supporting a person at any one time. The inability to link these inputs is a problem, and can lead to duplication of effort. In addition, not all professionals would be available to work with the service user concerned at the same time. This would depend on waiting list, availability and other demands. This means in practice that a service user may receive assistance from various clinicians, social care staff and therapists at different stages of their illness or condition in a way that does not coordinate that care to maximise the benefit for that individual. Integrated care needs to be underpinned by a system of care planning and care management, which enables the care to be coordinated and delivered in a timely fashion. Another factor, which can be considered under the theme of timeliness, is the requirement to deliver the support to service users on a 24 hour a day 7-day a week basis, according to their needs. Interruptions to a person's care package over a weekend or evening is often counter-productive and can lead to a lack of continuity of care and an inability to optimise the outcome for individuals. The lack of out of hours care may also prevent some people from being discharged from hospital or institutional care. This was expressed as the need to "provide the right care, in the right place, by the right provider, to the right people at the right time".

g) Measurable

Participants to the process stressed the need for measurable outcomes from delivering integrated care. This refers to the need for a shared and common goal and a unity of purpose for team members, role clarity, clear accountability, and an explicit output and outcome. The outcome would need to be appropriate for the person being supported and agreed with them. A model for integrated care would need to be capable of being evaluated and audited. Therefore performance measures would need to be in place. These features present a challenge to the process, as the very nature of shared undertakings and fully integrated services often means that the contributions of individual professionals is meshed in with the overall work of the team. In complex care packages requiring multi-agency support this would require a sophisticated system of identifying objectives, inputs and outputs. The need to introduce quality measures that are agreed by all parties, including the service user, would be fundamental to the success of this part of the process. Measures such as efficiency, effectiveness and appropriateness could be used within formal quality assurance systems. Integrated care may then be tested to assess whether it maximises the use of staff and resources to the benefit of the service user.

CONCLUSION

The seven themes identified by staff and agencies within the MHB are in accordance with international studies on integrated care and within the National Health Strategy. Participants in the process were agreed on the attributes or features of a potential model and typically could describe a number of case studies from current services where these features were not in place, to the detriment of the person concerned and/or their family. The challenges of working within a service that is often fragmented, not designed around the service user, and not equitable concerned professionals. The need for change has been demonstrated. The identification of examples of good team working and the start of integration provided useful illustrations of the importance of the seven features, endorsing the key themes above. The themes link with the definitions and descriptions of integrated care given by those completing the questionnaires, referring to person-centred accessible services.

This therefore provides a useful building block for the development of a potential model.

components of proposed MHB model

The elements of the model have been taken from the analysis of the questionnaires, interviews and workshops. The element or components describe the infrastructure needed to be in place to support and facilitate integrated care.

a) Prevention
b) Access and Referral
c) Common Assessment
d) Care Co-ordinator/Key Worker
e) Care Package Design
f) Care Plan & Review

a) Prevention

The participants in the process stressed that integration starts before people formally come into contact with health and social care services. Much can be achieved through health education and prevention of illness at an early stage, such as within schools, community centres and start up centres. Much can be gained by targeting at risk groups and indicated prevention. A shared approach to prevention such as for teenage pregnancy and coronary heart disease could be highly effective over time. The proposals for increasing communication with the community on health issues include making available information on promoting healthy life styles and improving a self-awareness of maintaining health. The creation of central information centres such as through resource centres, internet and leaflets, supported by multi-agency teams working with the community could prove to be highly beneficial. This would follow current initiatives such as "healthy communities" and "healthy towns".

b) Access and Referral

The need to make the services accessible to all service users, carers and families was stressed throughout the project. Sharing information on what services were available was considered to be a useful first step. Therefore, a Directory of Services and Facilities was put forward as a top priority. This would be a compilation of services provided by both statutory and non-statutory agencies, and would include health care services, social care services and other associated support services.

Making this information readily available was considered to be the next step and considered to be in keeping with the Freedom of Information Act. Suggestions included the creation of Local Health and Care Resource Centres or Information Centres, which would be strategically placed in communities to provide advice, information, support and signposting for all. This could be along the model of the Citizens Advice Bureau, or developed in partnership with existing advisory bodies such as Comhairle and Local Authorities. The MHB is already progressing the introduction of IT information points and the principle of a call centre.

Information could be made available through the distribution of leaflets, using shopping centres, libraries, pharmacies, GP surgeries and other public places. Other means could be via freephone lines and the Internet. There are many good examples of this from statutory and non-statutory agencies.

Opening up referral routes is also considered to be important in encouraging people who would not otherwise use the service to come forward. The example given of open referral to speech therapy, supported by a structured triage system and a sharing of information with GPs, has helped to manage demand, prioritise treatments and deal with waiting lists. It has been suggested that working with those who refer patients/clients to help in identifying preliminary tests to be carried out, advice on initial treatments and eligibility for referral has proved to be productive. For instance, managing mental health service referrals through working with GPs and providing professionals support within the practice has helped to manage referrals and waiting lists. Open referral would need to be consistent with best practice, professional standards and ethics.

It is helpful to design a system whereby each service sets out in a common format its eligibility, ways of accessing the service, what is being offered etc. A flow chart to assist referrers to navigate the process may also help to provide a visual display of the options and how services interconnect. Secta has designed such systems, which have proven to be highly effective.

Cross referral has been shown to be an issue for the MHB. Staff have expressed support for more open cross-referral without patients/clients having to go back to the originator of the first referral, typically the GP. This process of cross referral would need to be supported through a shared information system.

Opening up the service, giving the whole service more transparency for the community who use the service as well as for the staff working within the service is an essential first step to furthering integrated care.

c) Unified Assessment

Staff expressed frustration on the repetition of information gathering and assessments, either within the same disciplines or across disciplines and agencies. From the perspective of the service user, the need to repeat the process of completing forms and undergoing the same or similar tests signals a very fragmented service. Anxiety was expressed at the confusion and lack of confidence in the current system. This is particularly the case for people who are vulnerable. Staff were unanimous in wanting a unified assessment process. In this respect, as soon as a person enters the system, their registration details would be taken and logged, and then shared with other professionals as appropriate.

It was acknowledged that a unified assessment process would need to be staged, so that not all service users were subject to an assessment beyond their requirements. It would be reasonable to have several stages of assessment according to the complexity of need. Consideration would need to be given to the type of health and social care support required by the individual – whether episodic, chronic, degenerative or terminal for instance.

A unified assessment process could be developed using internationally recognised tools, informed by local good practice. It is understood that each profession would add a "layer" of their own specific tools and instruments used, but that these would be readily accessible to all. This sharing of an assessment process would need to be supported by a shared system, shared training and ongoing review.

The development of a unified or common assessment could build on existing good practice within the Board, such as the common assessment for continence and the common assessment being developed for older persons.

d) Care Coordinator/Key Worker

Those participating in the project identified the need for one professional to take a clear responsibility as a named person to support an individual receiving care. This professional would be appropriate to the needs of the individual concerned. For instance, a service user may have a public health nurse, occupational therapist, social worker or psychologist as their key worker. The professional would need to have a good working relationship with the service user, and the profession appropriate to the care being received. It is noted that GPs have been referred to as a "key workers by default". That is to say that there is no formal system of allocating a key worker for service users, and the only individual that sees that patient/client through each stage of their acute, episodic, or chronic illness or disability is the GP. In practice GPs are unable to act as key workers for each client on their panel listings. As primary health care teams develop and supporting community teams expand, the opportunities to identify care coordinators or key workers from teams of professionals from a range of agencies will expand.

e) Care Package Design

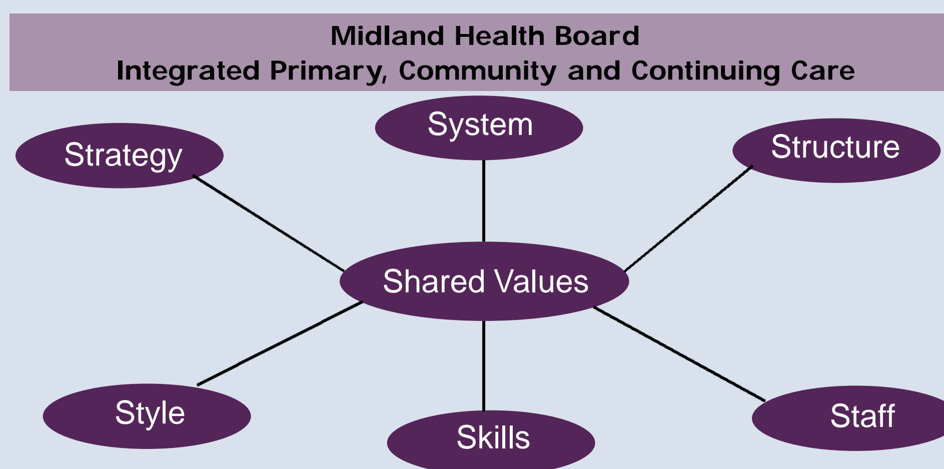
Following the assessment and along with the identification of the care coordinator, a care package for people with chronic illness, disability or vulnerability would need to be designed. This ideally would be designed by the service user, supported by professionals who are able to provide the individual with a service directory and advice on choices. Individuals receiving care often require help in order to take on this responsibility, which may be given by carers family, advocates or staff. Constraints on the ideal care solution are inevitable, and professional staff would be working with the service user to identify what is reasonable and practical within available staff, service and financial resources. Developing this process will help to progress the empowerment of individuals to manage their own care and support. Integrated care has been shown to facilitate this, and place the person being supported within the centre of the process.

f) Care Plan and Review

Following the design process a care plan would be produced. This would be written in the first person, and done in consultation with the person concerned or their advocate. The plan would typically set out goals, personal care needs, lifestyle preferences, specific support needs and any additional information on the individual relevant to their care. There are already examples of Care Plans and Individual Lifestyle Programmes locally and nationally that could be used as a basis for the development of a care plan.

Integral to the care planning system is the need for regular and frequent reviews, to ensure that the care being provided continues to meet the needs and expectations of the individual. These reviews are often viewed as a review of the contract between the provider of the service and the individual. They may also be used to guide the review of contracts between the statutory agency and non-statutory providers. Care plans or their equivalents are appropriate for episodic and long-term care, and there are equivalents for children, adults and older people already in use within the MHB.

The development of this model requires a significant investment in the design and development of systems, processes, policies, procedures and protocols. Such a development requires consultation and cooperation on a multi-agency and multi-disciplinary basis.



The seven "S" model developed by Peters and Waterman[12] is a useful way of appraising a healthy organisation. The view being that if all of these elements were in balance, then the organisation would be in a strong position to develop. It is also a useful diagnostic tool.

The analysis of the interviews with staff within the questionnaires showed that the shared values, style, staff, skills and overall strategy for the organisation for integrated care were well developed. The gaps or deficiencies could be labelled under the remaining two "Ss", which are systems and structure.

The systems to underpin this way of working will include shared information systems, shared notes and shared training. There would need to be unified systems across the MHB. A joint strategy and business plan would need to be developed with a management structure that supported pooled budgets and clear accountability.

The overall clinical and social governance model for the MHB would need to be reviewed and enhanced to take into account integrated working within and across sectors, agencies and disciplines. Risk Management and Performance Management need to be considered in the redesign of all systems. The structure to support and facilitate integrated care would also need to be assessed.

Seven aspects of the management infrastructure in terms of system and structure required to support integrated care provide key themes to the points made within the questionnaires and workshops, and drawn from research material from elsewhere.

a) Strategy and Business Plan
b) Clinical and Social Governance
c) Systems and Processes
d) Structure
e) Information System
f) Communication Systems
g) Training and Development

a) Strategy and Business Plan

The Strategy for the MHB and the key messages within its plans and proposals draw on the importance of working in an integrated way around the needs of the patient/client. It may be helpful to revisit this, strengthen the message, and ensure that working in an integrated way is expected to be integral to clinical and care practice for all staff at every level. It may be helpful to ensure that this is incorporated into job descriptions, person specifications, induction training, supervision, performance review and appraisal so that there is no doubt about the expectations from staff. It was noted in the questionnaires that there was no incentive for working in an integrated way. Team working

[12] "Structure is not organisation" Peters T. and Waterman R. Indiana University

often means that individual accountability will be shared or even blurred. It would be helpful to build into the strategy and business plan performance targets that recognise integrated care. An example of this may be to prioritise clinical audits and research that are multi-disciplinary and/or multi-agency. Reporting to the Board, and cascading good practice throughout the organisation may have a focus on successful integrated working in accordance with the new model, and this will continue to raise the profile at all levels of the organisation.

b) Clinical and Social Governance

Clinical and social governance is a framework through which organisations are accountable for continuously improving their quality of services and safeguarding high standards of care by creating an environment for excellence in clinical and social care.

Elements of health and social care governance include:

- Person-centred care, with the patient/client, public and the community being engaged with their care and the provision of service at all stages
- Auditing of clinical and care practice to inform continual improvement
- Clinical effectiveness, drawing on published research and applying evidence-based practice
- Risk management for clinical and social care, including systems for risk assessments, prioritising risk, incident reporting and improving performance by integrating clinical and non-clinical risk management
- Providing an appropriate environment and management for staff to enable them to work effectively and efficiently and also carrying out structured workforce planning incorporating innovative ways of transferring skills and enhancing the scope of practice across disciplines.
- Providing staff training, development and continual professional development, and supporting team working and effective collaborations across clinical networks and clinical pathways.
- Improving the use of information, through from the design and implementation of IT systems to support clinical and care practice to the analysis of information to manage resources to the application of information for sharing throughout the organisation
- Ensuring that the organisation has the strategic capacity to take forward clinical and social care governance as well as corporate governance.

It may be helpful for the MHB to formally adopt a clinical and social governance framework that incorporates a new formal model of integrated care.

c) Systems and Processes

Systems to support integrated care are those relevant to "managed care" or care management systems, such as assessment, care planning, review and monitoring.

The principle of adopting unified or single systems that are common across agencies, disciplines, sectors and localities would be very helpful in determining an integrated approach. The translation of this deceptively simple principle into practice within a complex health and care system will require a high level of commitment at all levels of the organisation.

The development of networks and pathways to guide staff and patients/clients through the process are useful tools to help plan shared care and integrated working. For example an Integrated Care Pathway (ICP) is a useful process for identifying the role of each agency and discipline to be engaged in a patients/clients care.

ICP are particularly appropriate for episodic care. Integrated Care Pathways provide a methodology for setting out the stages of care for conditions that are predictable and manageable. For instance an ICP for a hip replacement would set out the stages of the process from pre-operative care, the procedure, post-operative care, rehabilitation, reablement and return to home. Each stage would be timed and include each professional contribution, treatments and interventions and likely outcomes. ICPs are protocol driven and evidence based. There are examples of ICPs for conditions such as stroke, asthma and diabetes. ICPs are particularly relevant for vertical integrated care that is to say care that is shared across primary, community and secondary care. The process helps to identify the contributions of each of the team and agency members, and most crucially the contribution of the patient/client and carer.

d) Structure

The MHB is currently structured by client care group, and this has enabled a focus to be given to the specific needs of clients within each of these care groups. It has allowed a devolved budget to be created by client group, and for priorities to be accorded in respect of each of the client groups.

It may now be helpful to review this structure and progress this further. There is support for re-engineering the organisation so that "form follows function." That is to say that the model for integrated care would not be well supported within a structure where there are client and care group boundaries, so this will need to be reviewed. A structure that was based on localities and was more generic in nature may now be appropriate. This structure would reflect the developments in the primary care strategy, and the opportunities to assess and meet the needs of communities as a whole. This structure would support the holistic approach to health and social care, and may provide other agencies an opportunity to work constructively with the MHB within each patch. In reviewing the structure it is noted that there is no "ideal" solution, and that each structure considered will have its boundaries and limitations. The MHB will want to consider the "best fit" in respect of working within an integrated model of care.

e) Information System

The MHB is aware that in order to support shared working, staff need to be utilising a computerised information system that readily links up the information on care support being given to an individual. It is noted that the current system requires the service user to repeat registration and assessment details to each professional they are coming into contact with. This is particularly problematic for patients/clients who are confused or have a level of cognitive disability or intellectual impairment.

The staff identified the need for a clinical information system which would primarily support them in their operational work. This would include basic details on the patient's/client's history, diagnosis, care package etc. Features could include direct booking. It would be assumed that the system would be password protected for various levels of data as appropriate to ensure security. Whilst the priority need is for a clinical information system, an administration and management system for recording and reporting would be a by-product of this. National developments, such as the introduction of a unique patient/client identifier will be critical to the success of such a system, particularly if services users are to be tracked beyond the MHB to other agencies and Boards.

The MHB is already actively pursuing IT developments, and the adoption of a formal model for integrated working would feed into these.

f) Communication Systems

Those participating in the process identified a range of communication systems relevant to the way that people live and may be receptive to.

Examples of communication to the general public include:

- Text messaging traveller families about immunisation and vaccination
- E-mailing for GP appointments
- Internet for information on services
- Phone consultation by nurses in primary care
- Leaflets on health education given out with prescriptions
- MHB staff running Health Weeks in schools as part of the curriculum
- Health Fairs in High Streets, Colleges and Public Establishments
- Information Centres in libraries and supermarkets
- Freephone number for advice and information on health and social care
- Newspaper articles and free press journals
- Attendance at pre-school nurseries and playgroups
- Crèches for parents wanting to attend health promotion courses

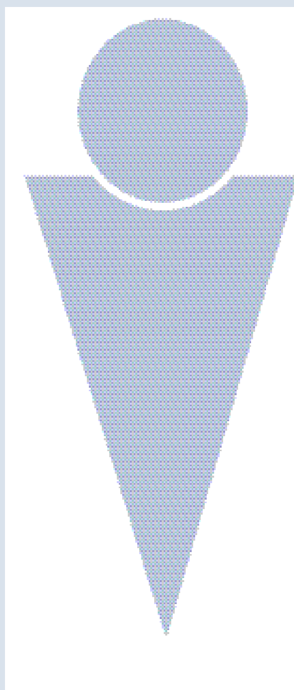
This project has enabled staff from different sectors and agencies to share ideas about how to target particular sections of the population and open communication channels.

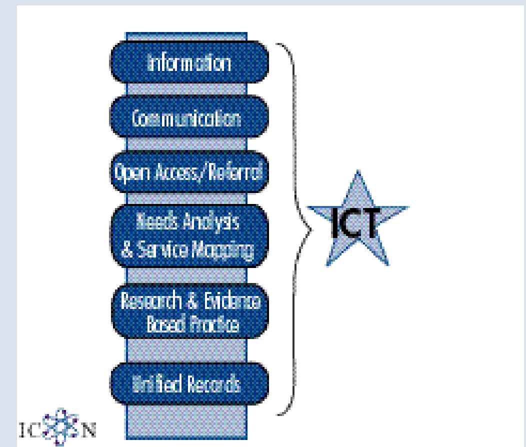
g) Training and Development

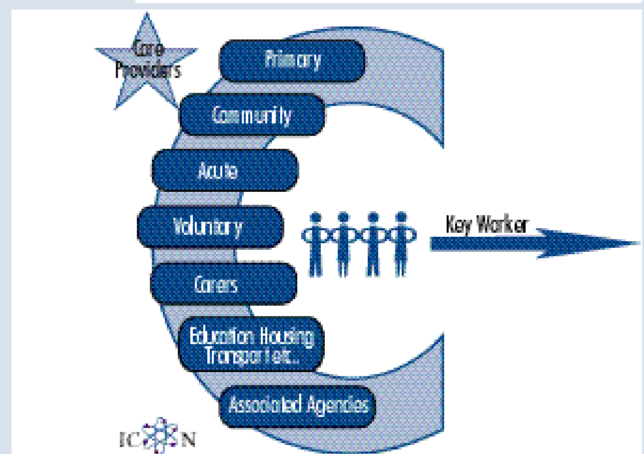
An identification of the need to establish a clear training and development programme came through the workshops and the discussions. It was established that there was a need to offer specific sessions for teams, such as teambuilding courses, Myers Briggs learning, and management development courses. Joint training across agencies was considered to be a very positive aspect of this proposed training programme. A skills audit could be undertaken, with staff currently working within the Board being trained up as trainers in teambuilding, so that knowledge and teaching can be cascaded throughout the organisation.

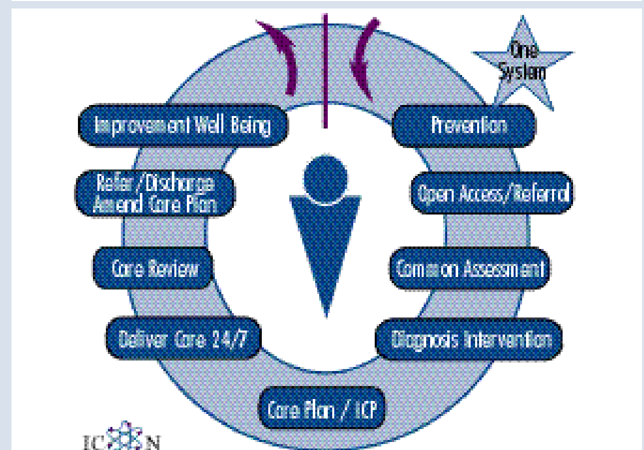
CONCLUSION

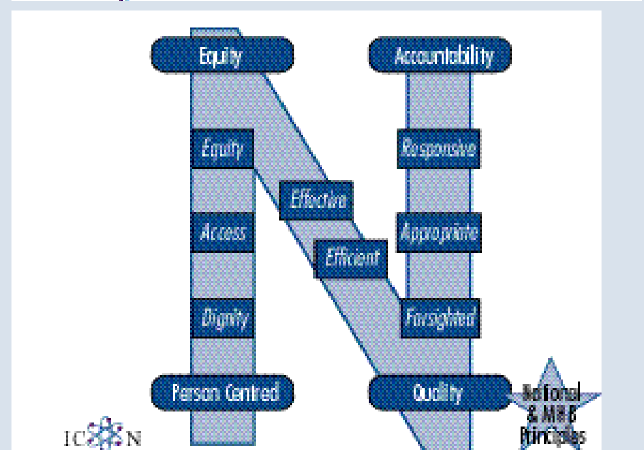
The analysis of the management infrastructure has shown that attention paid to systems and structure may help to facilitate the development of integrated care throughout the MHB.











A major Collective Stakeholder Workshop was held by the MHB in April, involving over 100 people. Tables were set out for 11 groups of "mixed" representation, encouraging a wide spread of views and perspectives. The day was structured with presentations, plenary discussion and group work. It represented a considerable investment of time for the MHB and signalled the prioritisation of developing integrated care.

Participants in the process identified some key issues that would need to be addressed before progressing with the development of a model for the MHB. Part of the Collective Stakeholder Workshop was devoted to joint discussions on these topics, so that ways of addressing them could be agreed on a multi-agency and multi-disciplinary basis.

An important topic which was not included in the list was the question of how to engage service users in the process of furthering integrated care, and at all stages of planning, managing, delivering and monitoring health and social care. This question was considered to be integral to all topics, as the strong message coming throughout the day was person-centred care. Non-statutory organisations and staff were able to start the process of advocating for people that they were supporting.

A total of 10 topics were chosen by the participants in the client-specific and non-statutory agency workshops. Presentations were made on the actions required to address these issues in respect of priority, immediate, short term, medium term and in the longer term.

The topics in summary are:

a) Information
b) Teambuilding
c) Referral
d) Streamlining Input
e) Communication
f) Public/Private Health care
g) GPs and Primary Care
h) Managing the Change
i) Access
j) Managing Care

a) Information

Issue

How to share information whilst safeguarding client confidentiality

Summary

The participants working on this topic emphasised the need for the development of a database on a macro-level (needs and service mapping) as well as at a micro-level (shared client case notes). The group stressed the importance of the Board making a strong and explicit policy statement on the management of information, and the need to develop ICT solutions to support care management and associated systems. The group also recognised the need to invest in staff training and development in ICT.

b) Teambuilding

Issue

What is the best way to develop teams & clarify accountability when working within an integrated model of care?

Summary

The group addressing the topic of teambuilding proposed setting a baseline of teamwork, and the questionnaire results provide a good starting point for this. The group suggested identifying effective team practice, and building on the experience gained from this. The group stressed the fact that the service user was a member of the team, and that accountability within and across the team needed to be clear.

c) Referral

Issue

Within integrated care, how do we open up access to services whilst managing referrals and waiting lists?

Summary

The participants considering the issue of opening up the referral process whilst managing demand started with improving information to the community by way of one-stop shops, one start shops and resource centres. This may lead to more appropriate referral, and opportunities to empower people to self care or find alternative ways of addressing need (not always a medical solution). The group proposed the development of key workers, the introduction of a common assessment process and a more structured and formal approach to managing access to care.

d) Streamlining Input

Issue

When managing the inclusive nature of MDT & multi-agency service provision, how do we ensure that the patient/client is not overwhelmed?

Summary

The group considered the implications of integrated care in respect of the high number of staff who may be involved collectively in an individual's care. Sharing information with the patient/client and between professionals and agencies was given a priority, and also streamlining the process through assessment, a key worker system and care management. Devolving budgets was also a factor in managing care packages.

e) Communication

Issue

How do we get the message across to and between staff & clients when providing integrated care?

Summary

The group considered the lack of information about services, staff roles, what other teams had to offer, and what is available for patients/clients and carers across the MHB from the wide range of agencies offering health, social care and associated support. Suggestions for improving communication included informal contact to be encouraged between staff and the public, information available on the Internet as well as within resource centres, health fairs and in directories. Proposals included a health fair. The group discussed the implications for confidentiality regarding shared information on specific clients, and agreed a protocol was required to be agreed across agencies.

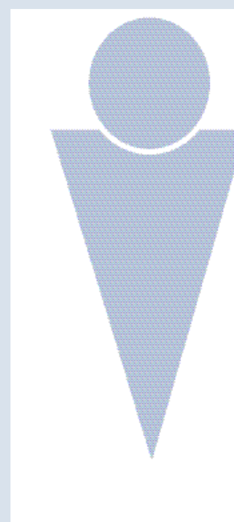
f) Public/Private Health Care

Issue

With a two-tiered health service how do we ensure that care is integrated?

Summary

There was concern that a fair, equitable and open system would be compromised by the current two tier system whereby the services offered by the GP as the gatekeeper attracted a fee from those not on medical cards. The group concentrated on systems that would integrate staff across disciplines at the planning and delivery stage. The group stressed the principle of respecting patients/clients rights and proposed a patients charter that incorporated the integrated care model thereby building in choice.



G) GPs And Primary Care

Issue

When developing integrated teams with GPs as independent contractors how do we ensure the best service for the client?

Summary

The group considered the role of the GP as integral to the model, and discussed ways of genuinely engaging GPs in the development and implementation of the model. The group considered incentives such as sharing workload, improved use of resources and improving the range of services offered to patient/clients. The group noted the increased collaboration between GPs with the introduction of the out of hour cooperative. The group also considered the disincentives for GPs which included the potential loss of income on the way that services were currently reimbursed, and the reduction of autonomy with increased shared working. The adopting and implementation of the primary care strategy was considered to be a key part of developing the integrated care model.

H) Managing The Change

Issue

With the introduction of models for integrated care how do we effect improvements in culture, systems & structures?

Summary

The group described the process of managing the change as re-engineering the organisation and the teams working within it. Teams would be reviewed as to their role and purpose, with an aim to increase the level of clarity and knowledge. The group stressed the need to research good practice in integrated care, and to use an evidence base in implementation so that the organisation and staff can build on lessons learnt from elsewhere.

I) Access

Issue

How can we improve access to services, location of services & transport? How do we best address access issues whilst ensuring care is integrated?

Summary

The group wanted to start with assessing the needs of people who require a service and build up the services and systems of access from that. Systems for sharing information more openly were discussed by the group. The group supported the proposal that a central focal point for information and services for health and social care should be provided, such as through a one-stop or one-start shop.

J) Managing Care

Issue

How can we design & implement a care management system that is appropriate for all, consistent, manageable & in keeping with integration?

Summary

The group were concerned with auditing and evaluating current practices and building on good practice in respect of a care management system. It was recognised that staff would need training and support to implement this more structured way of working. The systems to underpin care management such as effective IT systems were stressed as important by the group. The group also wanted to raise the awareness of the benefits to the patient/client, carer and community of implementing a consistently applied care management system across the Health Board.

organisation/agency specific issues in MHB

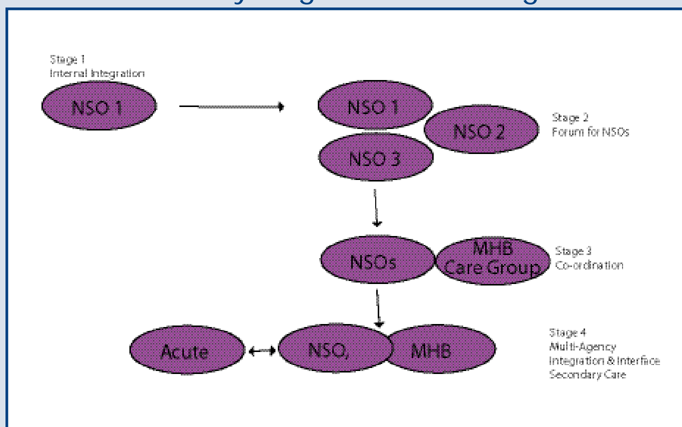
The process of developing a model for integrated care has engaged not only the staff and managers within the Health Board, but also external stakeholders such as the Non-Statutory Organisations and Government bodies. A summary of their perspective has been drawn from a number of interviews and workshops.

Non-Statutory Organisations

The MHB has service agreements with a large number of Non-Statutory Organisations that provide services for a range of client groups, in particular for people with intellectual disabilities, physical disabilities and older people.

The representatives Non-Statutory Organisations who contributed to the workshop made the point that before they could successfully engage with the statutory sector in an integrated model of care, they needed to first ensure that they were integrated within each of their own organisations, and also between other Non-Statutory Organisations supporting the client group. Therefore there was a staged process. This is represented in the diagram below. This model could be used to describe the process needed for sectors of the services within the MHB, such as within and between primary care and also the secondary care sector.

Non Statutory Organisational Integration



The attendees from the Non-Statutory Sector (NSO) described the model of service that they provided as being more within the "social rights-based model", rather than the medical model. For many of the providers, they described their services as home and community based: ranging from information; advice; day centres; care and carer support within homes; day care; supported housing and nursing home care. The Non-Statutory Sector representatives considered their role in helping to develop non-institutional and non-medical models of service, offering choice to service users, carers and the community.

Those present described their role as complementary to the statutory sector, and all expressed a view that they supported the principle of furthering the level and degree of integration at all levels. This included the planning of services on a collective level to the delivery of care and support to an individual.

The service agreements with the MHB are described as focusing on quantitative rather than qualitative information, and require reporting on a monthly, quarterly and annual basis. It was recognised that some agreements would benefit from being fundamentally reviewed so that they more accurately reflected the way that the service was developing in accordance with the needs of service users and their families. It was noted that although there are national performance indicators there was no formal benchmarking, value for money or best value studies across the options of providing services across each of the statutory and NSO providers, and that this exercise could be beneficial.

Examples of integration were provided by the non-statutory sector for each of the client groups. In particular the role of the Independent Living Centres for people with disabilities, the role of the Irish Advocacy Network in developing the Mental Health Strategy, the role of Barnardos in Children's Services, and the level of provision of service provided for people with Intellectual Disabilities by the Sisters of Charity of Jesus and Mary. The Midland Alliance for Mental Health formed in March 2001 was cited as an example of good practice in combining the Non-Statutory Sector and Statutory Organisations within a forum to raise awareness, share information, support joint training and contribute to policy and service development.

The representatives of the Non-Statutory Sector stressed that they wanted to be treated as equal partners in an integrated care model, and a formal recognition of their role and contribution to the overall health and well being of the population. The Federation of Voluntary Bodies in MHB was seen to be a potential vehicle for combining effort across the non-statutory sector.

The Non-Statutory Sector representatives contributing to the process supported the development of a formal model for integrated care, and wanted to actively participate in its creation and development.

EXTERNAL AGENCIES

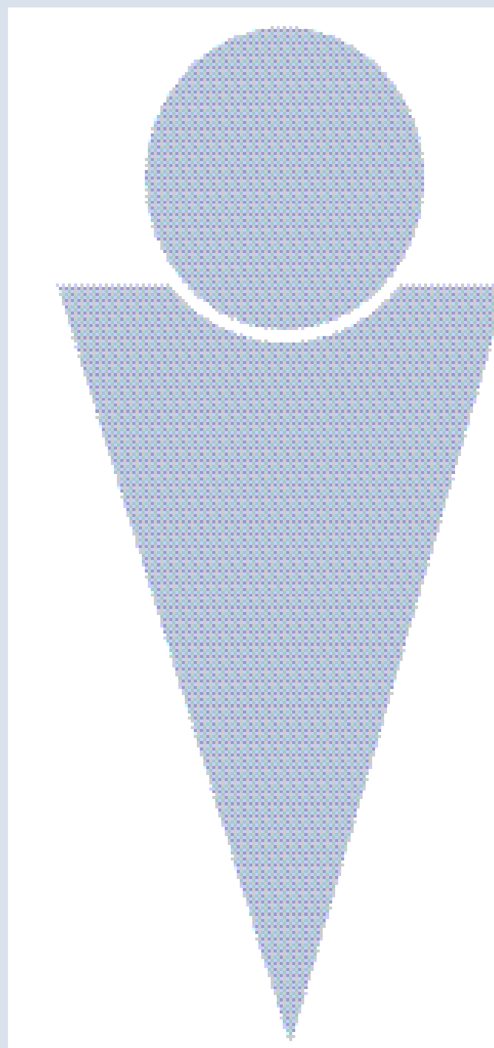
As part of the process consultation took place in the form of interviews with key people from a number of Government bodies and agencies. The purpose of this was two fold –

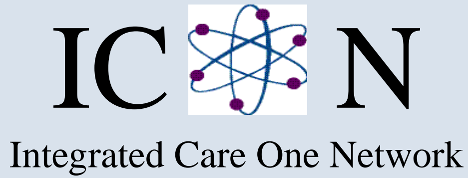
- to garner information from the organisations on their role and function and how they saw integrated working currently
- to advise the organisations on the current work being done in the MHB on developing a model for integrated care.

The organisations consulted included the Department of Health and Children, HeBE, Health Research Board, Mental Health Commission and County Development Boards.

Main issues addressed by the those interviewed were:

- Major initiatives both regionally and nationally should be co-ordinated
- To ensure compatibility with developing projects nationally and in particular ICT and the child care MIS project.
- For the MHB to promote the work it is carrying out on integrated care and in particular to make a presentation to HeBE.
- Overall the agencies welcomed the opportunity to be informed of the current work and wish to be continuously advised of the work as it progressed.





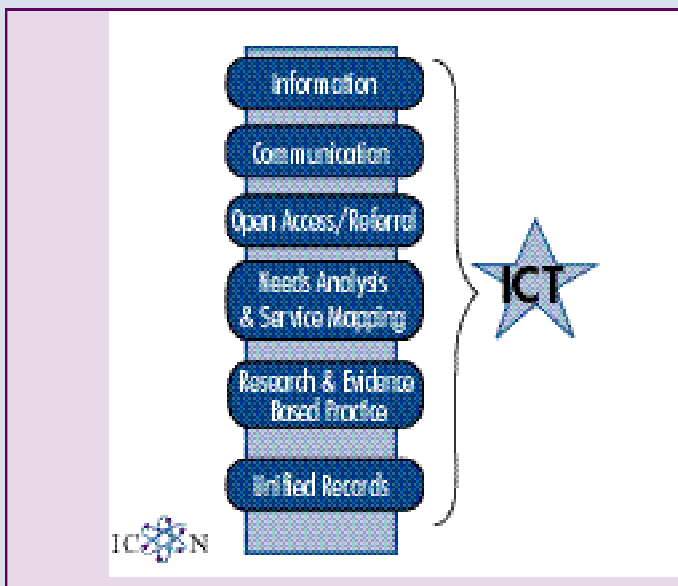
INTRODUCTION

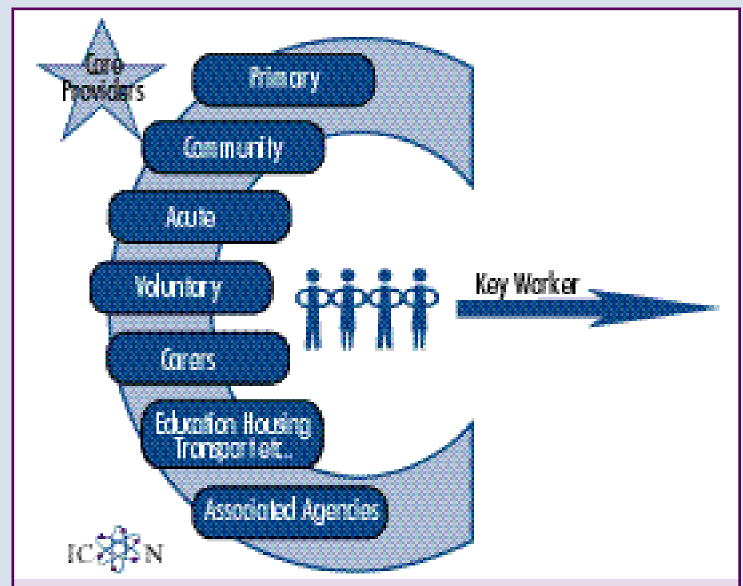
The introduction to the model shows the person at the centre of the model. This message is echoed throughout the four sections that make up the model.

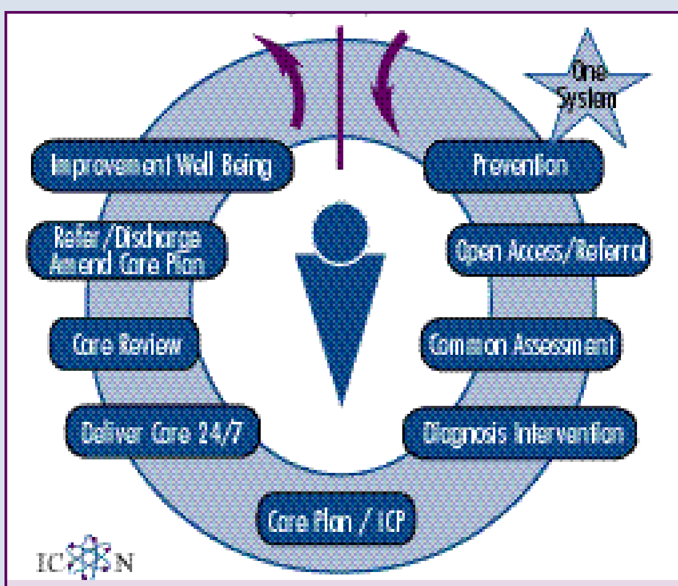
SUMMARY OF THE PROPOSED MODEL

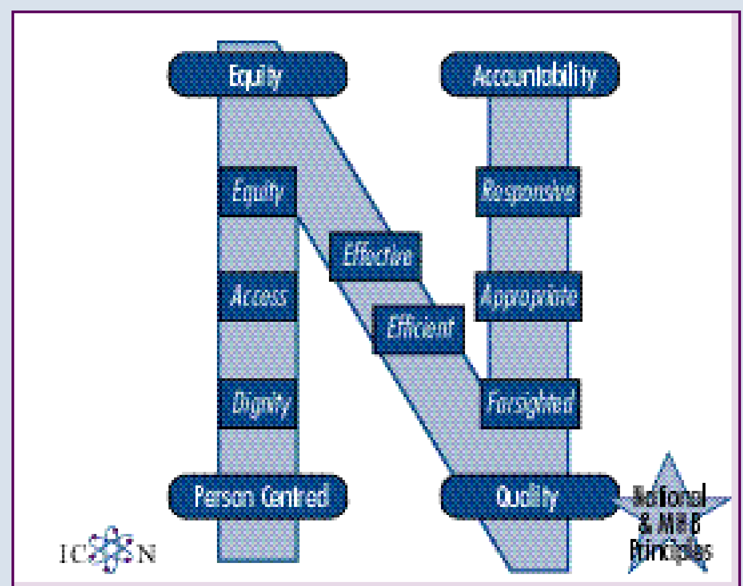
The model is built around the four letters of ICON.

I	Information
C	Care Providers
O	One Care Management System
N	National Principles



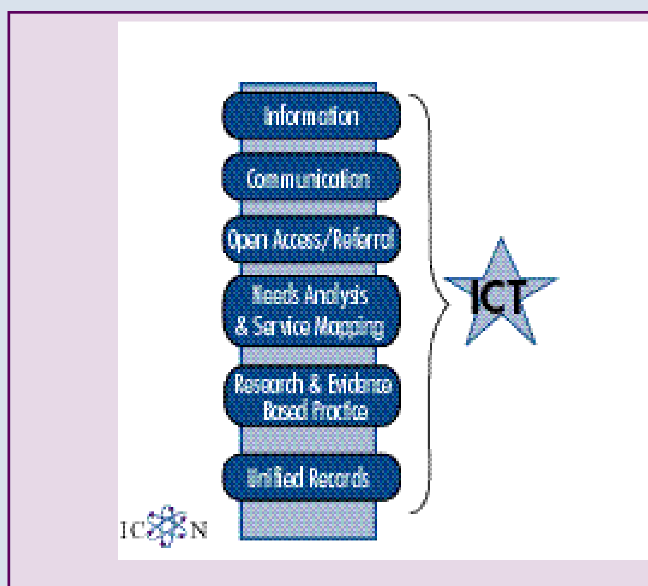






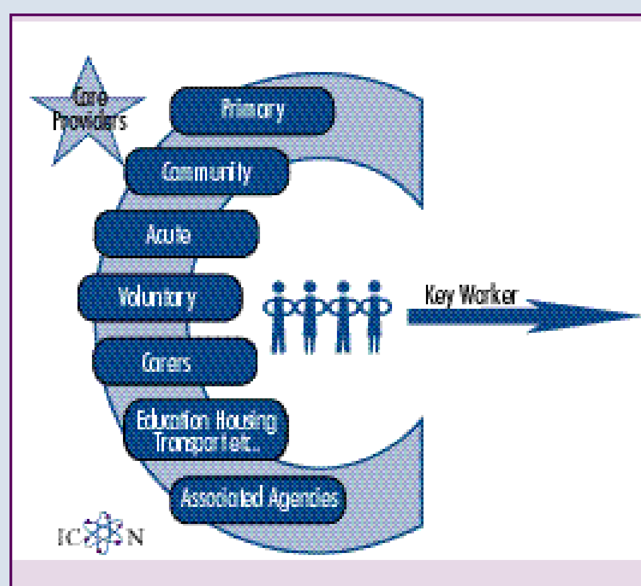
INFORMATION TECHNOLOGY

This element of the model runs alongside the left hand side of the model and is integral to all. The strong message from participants is that integrated care needs to be supported by a robust and integrated IT system. Improvements to sharing information at all levels need to be made. The need for a culture of openness and transparency, unified systems and open communication across agencies and disciplines would benefit from fostering.



CARE PROVIDERS

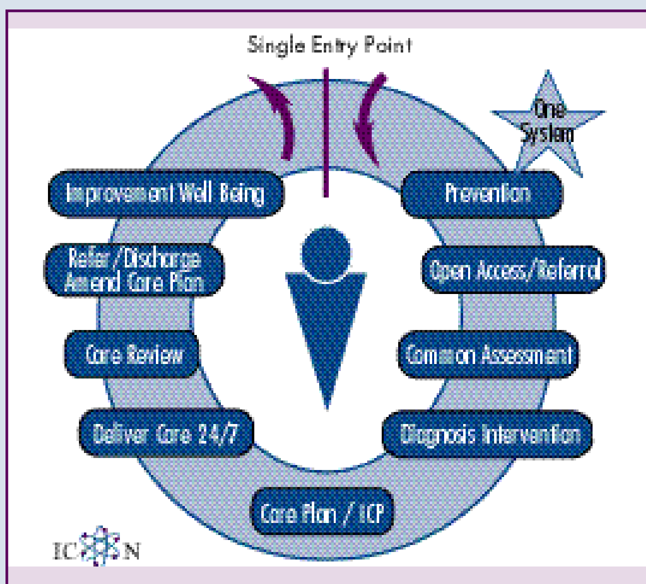
This second element of the model shows the range of individuals and agencies who may be involved in the care of an individual. The diagram shows how the various agencies need to form an appropriate team that can proceed to support an individual requiring care and support. Within this part of the model needs to be built in role clarity and accountability for individuals and the team as a whole.



proposed model for MHB

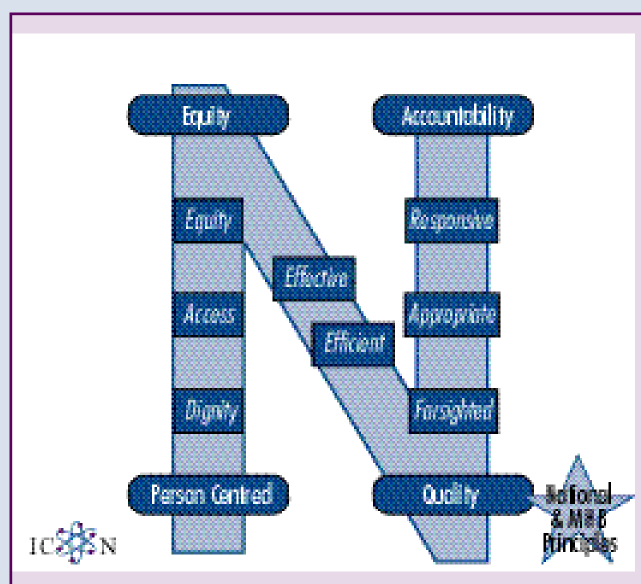
ONE CARE MANAGEMENT SYSTEM

The circle represents the care management system. The integration starts at the level of prevention and health promotion. Entry into the care management system is open and this represents a single entry point. From here an individual is assessed using a common assessment framework and referred on as appropriate. A diagnosis is made and a care plan designed with the person to be supported. The plan is regularly reviewed. The client owns the goals set within the plan, and is supported in achieving these. The circle of care shows the person being discharged if appropriate, although many will continue to require a level of care and support, particularly those with chronic ill health and degenerative conditions.



NATIONAL & MHB PRINCIPLES

The final element of the model incorporates the principles in the National Health Strategy. Person centred will be fundamental to the model. Measures of quality will be built into the design and monitoring of the system. It is an intention that the service is open and equitable, and people supported to access the services they require. The accountability systems will be designed for individuals and teams, and within clear quantitative and qualitative performance measures. It is understood that these principles will be continually measured and monitored.



NATIONAL FRAMEWORK

The model incorporates both the principles of the National Health Strategy and also the MHB Hallmarks of Quality.

NATIONAL HEALTH STRATEGY

The National Health Strategy, Quality and Fairness defines four principles:

1. People-Centredness
2. Quality
3. Equity
4. Accountability

These principles have been enshrined within the new model for integrated care. These principles are incorporated in the eight "Hallmarks of Quality" of the MHB, which pre-date the strategy.

MHB HALLMARKS OF QUALITY

The MHB mission statement is as follows. "The MHB exists to seek to improve the health (health gain) and quality of life (social gain) of the population of Laois, Offaly, Longford and Westmeath."

The model has been tested against the 8 principles adopted by the MHB.

- Equity
- Accessibility
- Effectiveness
- Efficiency
- Appropriateness
- Responsiveness
- Dignity
- Farsightedness

Equity

The service will be more equitable, as there will be a clear process for patients and clients refferals, and the care management system will ensure a common assessment and triage of each person according to their need. The adoption of single, common or linked system will introduce a degree of structure and equity to the system.

Accessibility

The model increases the accessibility to the service for the MHB community with health and social care needs. The model will enable services to be open and transparent, opening up the service to scrutiny by publishing information on services and eligibility.

The creation of information centres will empower local residents to seek information and take control of their own health and social care needs, and to adopt self-care or alternative support solutions if they choose to. The opening of the referral process will mean that clinicians and social care staff will be able to prioritise on the basis of need.

Effectiveness

The integrated care model brings together the components of health and social care, and provides the infrastructure for staff across agencies and disciplines. The fact that the needs of the patient/client are considered in a holistic way, with staff working as a team to agree with the patient/client the optimum way of supporting that person, should increase the level of effectiveness. The principle of person-centred care will improve the likelihood that the care management solutions will be effective, as they will be designed around the needs and preferences of the individual to be supported.

Efficiency

The current system is deemed to be inefficient, as the fragmentation and lack of communication leads to a duplication of services and resources. Careful planning of a person's care, combined with the agreement of the appropriate team members to support the individual should create the best use of resources. The single assessment process will mean that time-consuming assessments will not be repeated unnecessarily, and that staff will share information on the patient's/client's condition and care needs. The process of shared care management and team support should result in synergy, that is to say that the sum of the parts is greater than each of the individual components.

Appropriateness

The model espouses person-centred care, and in that respect the care to be provided should be appropriate for that individual. The model builds in support and advocacy for people who may not be familiar with expressing their own needs and contributing to the design of their own care package. Over time, people will become more familiar with understanding the range of options open to them and making choices on care and support arrangements and also on the providers who are able to deliver this. Engaging patients/clients at every stage of the process, not only in individual care and treatment choices but also in the planning, management, delivery and monitoring of health care should over time increase the likelihood that the services being delivered is appropriate to the needs of individuals and the community.

Responsiveness

The model has built into the system a design of a care package and the regular review of the care and support arrangements. Therefore, the model has as an integral part of the process, a regular re-assessment of the service being delivered from the perspective of the individual and the staff. As the culture and ethos will be open and transparent, demands from patients/clients will be more explicit, and the responsiveness of the service will be tested. This should lead to continual improvement in the service.

Dignity

The model places the person in the centre and provides the individual with the information required in order to make an informed choice about their treatment and support. This accords the individual patient/client with their rights and dignity, and empowers them to take control of their own health and well being. The model builds in a regular review of the support being provided, and choices at each stage.

Farsightedness

This principle describes the need to be proactive in meeting care needs, and to anticipate the demands made on the service in the short and medium term, on an individual and collective basis. For instance, a system of assessing the health and social care profile, using research-based methodologies, enables health planners to predict demands on the service and potential patient/client flow. The development of integrated care pathways means that an individual patient journey is managed and planned, and resources assembled in anticipation of the need. The use of an information system across agencies and disciplines will mean that professionals will share knowledge about patients/clients, carers and families and be prepared to respond to known needs. The management of health and social care systems is a highly complex process, and the development of an infrastructure to manage and anticipate demand will increase the ability of the MHB to meet the needs of its residents individually and collectively.

Conclusion

It is clear that the ICON model being developed sets out the national principles and the MHB hallmarks of quality as an integral part of the model. The ICON model is value-based, and can be successfully validated against the national and regional frameworks.

The MHB in commissioning this project identified that phase two of this process would be to develop the data requirements for a model of integrated care, and also to design systems for managing the change.

Data Needs

The data requirements will need to be specified at a high level. There are examples internationally, such as the Department of Health & Children project on the "National Specification for Integrated Care Records Service" in England based on supporting National Service Frameworks that will help to inform the process. Similarly the work on the Single Assessment Process (SAP) and the Care Management systems already in place internationally can be applied and tailored to the needs of the MHB. Developments on the Electronic Patient Record (EPR) and e-health are dynamic and evolving rapidly, and knowledge can be drawn from this.

The Board will want to develop these high level needs into a more formal specification. This may then be compared to ICT solutions already commercially available, to see which would be the most appropriate to meet local needs. The MHB have already been appraised of systems such as the PARIS system, which is in place in Trusts in Northern Ireland.

Management of Change

The MHB will be designing a system for managing the change once the integrated model of care is formally endorsed.

The process for the development of the Integrated Care model has been inclusive and participatory across disciplines, sectors and agencies. The Steering Group has indicated that this will now be followed by a wider consultation process involving more services users and other stakeholders. This introduction to the process of working within a more formally integrated way should help to provide a sound basis for taking this model forward. The investment that the Board has made in this project should mean that there is a high level of "buy in" from staff and agencies. The model has been designed from the perspective of those who use and deliver the service, and this "bottom up" approach should mean that the resulting model reflects the needs within the service. The MHB should be confident that it has a mandate to proceed with this model. There are processes of validating the model at each stage. The model has been designed on the basis of national research, local views and external consultants experience.

In order to successfully manage the change, the project should have a clear objective with defined benefits or success measures. The case for change should be clearly made and shared by all. A mandate for change should ideally be achieved by engaging all those who will be affected by the new way of working. The MHB has set out a clear objective, encouraged staff to identify the difficulties in the current fragmented way of working, and sought views on the design on the new way of working. The Board has signalled its intention to continue to work with all stakeholders and ensure that it has a mandate to proceed. The process has encouraged champions for integrated care to come forward, and an enthusiasm for integrated care to be expressed.

The MHB is preparing to implement the following recommendations

Communication & ICT

The MHB should research and procure an IT system to support all aspects of integrated care in order to improve service delivery to the patients/clients, support, enhance the work practices of service providers and provide information for the effective planning, management and development of services.

1. Continues with its plans to designs high level data requirements based on the proposed ICON model.
2. Carries out a base-line assessment of IT systems in place to support all aspects of MHB primary, community and continuing care and the interface with GP systems and acute care.
3. Explores the potential for new technology such as e-health, telemedicine, EPR, and hand-held computers for community staff.
4. Offers staff training and support in the use and application of IT, including General Practitioners.
5. Introduces protocols for sharing information between staff and agencies that are compliant with F.O.I., data protection and confidentiality.
6. Continues to explore IT solutions for care management.

Collaborative Advantage

All aspects of service delivery within the MHB should work towards achieving accreditation in integrated care through ICON thus ensuring that the patient/client receives a consistent, comprehensive and integrated service in line with best practice.

1. Considers the suggested ICON model of Integrated Care as a basis for a formal model.
2. Continue to consult widely on the principle and design of the model.
3. To develop an "ICON" accreditation process which will recognise levels of integration being achieved. The criteria and principles for ICON accreditation will be developed through consultation, and will be appropriate to each service whether it be clinical, social services, management, administration, support services etc.
4. Agrees a working definition of integrated care.
5. Works on the design of the change management process.
6. Aims for a consistent and comprehensive model of service, building on the good practice identified and encouraging the extension of these throughout the Board.
7. The implementation, monitoring and continual evaluation of the integrated way of working will be a specifically designed process leading to continual improvement.
8. Continue to review the model in the light of evidence, research-based good practice and local experience.
9. Formally acknowledge where uni-disciplinary working is appropriate.

Clinical & Social Care Governance

The MHB develops appropriate structures, systems, processes and resources to support integrated working.

1. Formally develops a Clinical and Social Care Governance Policy and Framework that supports integrated care and is within the Corporate Governance systems.
2. Considers reviewing the current structure of the Board from care groups to a more locally-based structure which would facilitate integrated working.
3. Develops and supports structures to facilitate collaborative working across agencies, such as Fora and Networks.
4. Tests out the full impact of re-engineering the organisation in order to optimise integrated working at all levels.
5. Sets out performance measures for outputs and outcomes that are qualitative and quantitative.
6. Defines the structure for the planning, delivery and implementation of appropriate levels for integrated care so that it becomes integral to the business of the Board.
7. Takes a whole systems approach to integration, looking beyond primary, community and mental health services to the integration and interface with the secondary and tertiary sectors and other services.
8. Assesses the financial implications of the model and explore the implications of devolving budgets to teams, closer to the service.

Comprehensive Services

MHB to develop a range of appropriate services which will be reflected in a consolidated directory of services that is easily accessible to all through the widest variety of means.

1. Undertakes a needs analysis for the area in conjunction with the community and non-statutory organisations using research-based practices and researched methodologies.
2. Carries out a service mapping exercise identifying all services and facilities for health and social care serving the population of the MHB for all client/patient and care groups, across all agencies.
3. Creates a comprehensive Directory of Services with details of eligibility, access, referral routes, services offered, and any activity and quality information.
4. Makes available information on services through a variety of media including a Directory Handbook, on the internet, through a freephone line, advertised in public areas such as pharmacies, libraries, leisure centres and community centres etc.
5. Supplies all staff working across health and social care with ready access to information on services and facilities.
6. Continues the development of Information and Advice Centres, which would provide people with signposting to the appropriate agency, and information on choices available.
7. Considers the creation of one-stop or one-start shops, which may be extended primary care centres or diagnostic and treatment centres.
8. Considers extending the number and range of open referral services, accessible through drop in centres, advice centres, primary care facilities and community centres.
9. Develops common service proformas across care groups and agencies, which summarise the services offered, eligibility and access.

Clinical, Care and Support Staff

MHB would empower and support staff in working towards a fully integrated service and that all of the necessary infrastructure would be put in place to facilitate this.

1. Reviews job descriptions and incorporates integrated working as an integral part of the requirements for post-holders.
2. Identifies teams on an inter-disciplinary, inter-agency and intra-professional basis, and offers teambuilding development courses to support further integrated working.
3. Helps teams to identify their unity of purpose whilst respecting individual professional views.
4. Supports staff in utilising self-assessment tools to measure the level of integration using tools such as shown in this report.
5. Builds on the good practice of existing teams and integrated working.
6. Carries out workforce planning for all staff, reviewing the staffing levels and skill mix and exploring opportunities for trans-disciplinary working.
7. Offers training and continuing professional development, supported through appraisals, supervision and mentoring systems which will incorporate an expectation of integrated working.
8. Engages GPs and primary care staff in the process, and continues to raise the profile of the Primary Care Team pilot.
9. Involves staff associations and trade unions at the appropriate juncture and employs the Partnership approach.

Clinical Effectiveness

The MHB would promote person-centred evidence-based integrated care, building on good practice and incorporating regular audit, evaluation and review .

1. Develops a robust person-centred care management system incorporating regular review.
2. Encourages research, audit and the application of evidence-based practice in clinical and social care, and in particular around integrated working.
3. Encourages the further development of Integrated Care Pathways and Clinical Networks.
4. Promotes the links between the medical model and the social model of care where appropriate.
5. Supports the proposal that the Board funds a number of formal and independent evaluations of models of integration as a way of identifying good practice and providing an evidence-base for extending new ways of working to other areas.

Consultation

MHB will continue to adopt an inclusive, open and transparent approach by consulting widely with all of the relevant stakeholders to ensure the effective and appropriate development for integrated care.

1. Actively pursues the engagement of people who use the service, their carers and families in the next stage of developing and refining the model of integrated care using consumer panels and other appropriate mechanisms.

2. Works with support groups, fora, patient/client participation groups and others to further discussion and gather suggestions on the design and implementation for integrated care.

3. Reviews service agreements so that appropriate performance measures are incorporated around integrated care.

4. Continues to work in partnership with the non-statutory organisations to bring about improvements to the service.

5. Engages with the non-statutory organisations through supporting fora and partnership boards, and sharing information at all levels.

6. Encourage use of the County Community Fora.

7. Contributes to sub groups of the County Development Board such as the social inclusion measures group and the health, education and security group.

8. Raise the profile of good practice at Departmental and regional level.

9. Ensure compatibility with national and regional ICT models emerging such as Childcare and County ICT plans.

10. Monitor the output of the Primary Care Task Force and in particular on Quality and Integration standards.

Change Management

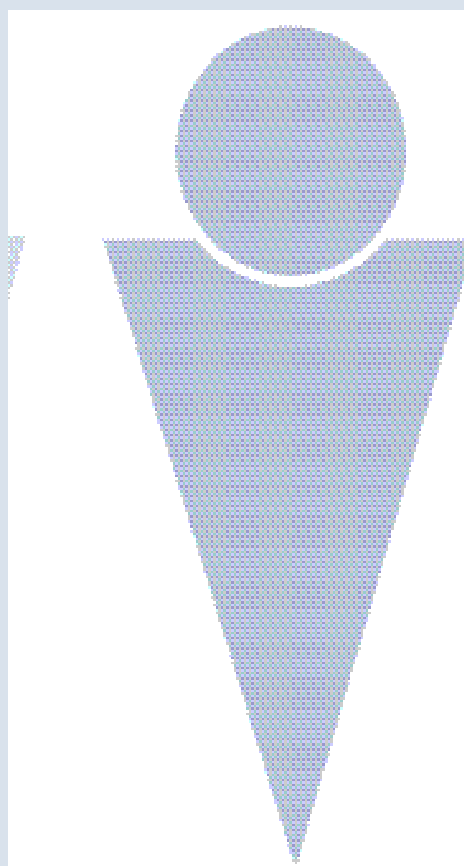
The MHB would foster an appropriate culture to support integrated care and would develop a structured change management programme to facilitate improved working practices to the benefit of all concerned.

1. Develops a project plan for managing the change over a 3 to 5 year period with agreed 6 monthly deliverables. The action plan will have specified tasks and identified responsibilities.

2. Continues to develop a culture whereby integrated care and innovative practice that improves patient/client care is recognised and valued.

3. Encourages champions of integrated working, and shares experience across the organisation.

4. Involve stakeholders in the design of the change management process in order to build on good practice and ensure the implementation, monitoring and continual evaluation of integrated ways of working.



conclusion

The Midland Health Board has invested in the development of a formal model for integrated care that its staff will sign up to. It has based the design of the model on contributions from staff, managers and associated agencies. The process has delivered a rich source of material, and provided the inspiration for the ICON model.

In particular, case studies presented gave a very clear illustration of the limitations of the current ways of working, and the benefits to patient/client care with the synergy gained from professionals working collaboratively.

It was the intention of the MHB to develop a model that demonstrated collaborative advantage, and illustrated connectivity. The project sets the way forward and meets the national and social agenda ahead of its time. It provides a structured approach to working in an integrated way, with a readily identifiable ICON model to work to. The introduction of an accreditation system whereby teams and services may achieve levels of ICON according to agreed criteria would help to formalise, recognise and value integrated care.

It is hoped that those who have participated in the process recognise their suggestions and contributions, and are prepared to develop this model further. The model will need to be tested for each care group, sector and locality, as well as across agencies. It is hoped that the model and the definition of integrated care provided give a good basis for further discussion, and enable the project to proceed to the next stage.